Breakthrough Britain

Volume 4

Addictions

Towards Recovery

“If we concentrate on restoring people’s lives, most of the public health and crime issues will take care of themselves.”

Preface

The urgent need for appropriate and effective treatment of addiction and for its prevention is set out in this policy review through the voices of those most affected as well as through formal analysis of policy research and outcomes data. For the first time experiences and views of recovering addicts, their families and those working with them – their counsellors, substance misuse workers, addiction psychiatrists, drug action team managers, voluntary sector providers and academics have been listened to and reported.

"A true reflection of the strengths of a society should lie in its ability to care for each other, look after the ill, disabled or those with drug and alcohol problems. Unlike life in the jungle, the wounded and disabled should not be annihilated.

Drugs of abuse have enormous power over the lives of people who are addicted who are often slaves to the brain structures responsible for the pursuit of pleasure. However we can offer hope and help break the chains that shackle them.

I believe that our society and the state have a responsibility to give a clear message to young people: 'I do care about you, and would like to help you with your predicament, but I would like to bring the issue of responsibility back on to your shoulders."

Dr Kah Mirza, Hon. Senior lecturer and Consultant Adolescent Psychiatrist, Institute of Psychiatry, London and South London and Maudsley NHS Trust

Contents

Section 1
Executive Summary: Towards Recovery

1.1 Introduction

Over the last ten years the British government has spent more on its 'war on drugs' than on its combined operations in Iraq and Afghanistan.[1] UK spending is relatively generous and reflects the scale of the problem we face – one of the largest in Europe. Even so, we are spending less per head than those countries (such as Sweden and Holland) that are today more successfully facing the problems of drug abuse.[2]

Yet this spending is often wasteful, unwise and misdirected. For example, to meet the 'Janus faced' requirements of centralised 'treatment' targets and devolved administration, bureaucracy has grown dramatically. National Treatment Agency staffing has gone from 30 to 150 employees in five years, matched by burgeoning local Drugs Action Team administrations. Spending on prescribed methadone alone has reached £111 million per annum.

Nearly every reform of policy requires some up-front investment; all the more so when the underlying problems are getting worse. Under this administration, while alcohol harms have gone up, the gulf between treatment and need has widened. Yet spending on alcohol treatment currently runs at only 6 per cent of the drugs budget.3

It is likely that spending on drugs and alcohol addiction treatment may have to more than double from the current £400 million per annum in order to get people into recovery and to bring us to Swedish and Dutch levels of success.[4] This, however, is a modest investment, against the **£39 billion that drug and alcohol abuse is estimated to cost society every year** – or by comparison with the £13 billion a year derived by the Exchequer from alcohol duty alone.[5]

---

1 The Today Programme, BBC Radio Four, 12th May 2007.Gordon Brown cited £6 billion for the combined operations. Ian Martin, Head of the Drug Strategy Unit, Home Office has cited £7 billion, 13th March 2007.

2 The budget for a problem drug user in the UK is 2,300, compared to 20,000 in Sweden and 4,500 in the Netherlands.

3 Figures obtained by David Burrowes MP under the Freedom of Information Act showed PCTs spent an average of £256,315 on alcohol treatment compared to £4, 118.164 for drug treatment.

4 The National Treatment Budget for 2007/08 is £398 million, but this does not include all available funding from other sources

5 The additional benefit of reducing consumption and therefore harm is detailed in 3.1.1

Investment of this nature is clearly required to break the socially destructive and economically costly cycle of addiction; and is justified by the moral, social and financial necessity of reform.

The depth of the problem

The statistics are now well known: with 327,000 problem drug users of opiates and cocaine alone we have a significantly higher percentage of the population addicted than any of our immediate neighbours. Our mean alcohol consumption is higher than theirs too, costing the nation some £23 billion as the outcome of alcohol harm.

Poly-substance abuse is one of the chief characteristics of dependency today. Three quarters of problematic drug users use two or more of the main illicit target drugs and more than half use psycho-stimulants (mostly crack cocaine). Many have highly problematic patterns of drinking.[6]

While heroin use has 'plateaued', cocaine use has grown dramatically, with 5 per cent of 15-39 year olds using the drug.

The age of initiation has consistently fallen.

Care leavers, the homeless and young offenders have disproportionately higher levels of problematic drug and alcohol use than the rest of the population. A reasonable estimate is that **half of the UK's near 80,000 prison population are problem drug users**. Drugs are now a rural as well as an urban problem.

Some **350,000 children have drug addicted parents and one million have alcohol addicted parents.** Of the 77,928 drug dependent parents surveyed for the 'Hidden Harm Report', 54 per cent had children living elsewhere.[7]

> "It's often seen as parents losing their children, but if you are a child care worker, I am sorry, but it is the child losing a parent"
>
> Tom O'Loughlin, Bolton 360 service

> "I went from having no money to having a wage every Friday. So then, I started buying cannabis in bulk, and I started selling it to my friends. This was at the age of 16. I smoked cannabis daily; I was smoking twenty joints a day, every day."
>
> Eddie, recovering addict at the Maxie Richards Foundation, Glasgow

The most widely used drug, cannabis, is now known to involve significant mental health risks - the risks of psychosis are higher for those who initiate earlier - and to affect cognitive functioning. Last year use by 10 and 11 year old boys grew by one per cent. There is no evidence base about mean consumption or any longitudinal health data. Testimonies of recovering addicts suggest high and intense consumption of

6 Gossop, Marsden, Stewart, NTORS, *Changes in Substance Use, health and criminal behaviour during the five years after intake,* National Addiction Centre, 2001

7 *The Hidden Harm Report*, ACMD, Home Office 2003

cannabis in their teens, possibly mirroring the evidence for alcohol consumption amongst adolescents that 'more alcohol is going down fewer throats'.[8]

Young people's drugs services and drugs education programmes remain premised on a philosophy of harm reduction, though there is little evidence of this being a safe or effective approach to the prevention of substance abuse.[9]

The collateral damage of addiction in all layers of society was set out in our interim report.9 Though more concentrated and cyclical amongst those with the fewest 'safety nets' for whom dependency cements deprivation and exclusion, our research and evidence showed addiction to be a societal condition or problem. The view, still held by influential policy opinion formers, that the use of drugs in this country is predominantly harmless, is, we believe, unsustainable.[10] Their argument that alcohol harms are 'greater' than drugs harms in this context is also misleading. These harms may be absolutely greater, reflecting the numbers using alcohol. Nevertheless, drugs harms are relatively greater.

1.2 Reasons for the failed government strategy

Drugs Policy

The failure of the Government's drugs harm reduction strategies to positively impact on this damage, despite unprecedented 'treatment' investment, is not the mystery that the recent UK Drugs Policy Commission report would seem to suggest.[11] **The conclusion of our policy review is that the Government has failed to address drug and alcohol problems, either in terms of breaking the cycle of addiction, or in terms of recovery.**

> "We need to challenge the hegemony of harm reduction over other models and reflect on its philosophical and ideological undercurrents. It has been argued, for example, that provision of lifelong methadone or injectable heroin would help reduce crime, especially crimes against people. I often wondered what message this gives to young people with addiction: "We don't really care about what would happen to you, as long as you do not kill or mug anybody. You may go along and shoot yourself to oblivion in our Heroin Galleries and live in the land of your bliss as long as you like" Harm reduction has a place in treatment. But it should open many other doors including the path towards abstinence."
>
> Dr Mirza, Senior Lecturer and Consultant Adolescent Psychiatrist at Institute of Psychiatry

The philosophy, purpose and practice of drugs policy, particularly in the treatment domain, historically has been dominated by an ethos of management and maintenance. Ignoring the issue of addiction and the challenges associated with its treatment, has over the years, contributed to

8 Poulin, C "*Harm reduction policies and programs for youth*" in Harm Reduction For Special Populations In Canada Addictions, Dalhousie University, August 2006

9 Breakdown Britain Interim Report Volume 3

10 RSA *Commission on Illegal Drugs, Communities and Public Policy*, March 2007

11 The Today Programme, BBC Radio Four 18th April 2007, The Launch of the UK Drugs Policy Commission.

> "Addiction is a progressive disease, which means the drugs that keep me happy today won't keep me happy in a week's time or a month's time so I need to continue to take more and more. It's not only the physical addiction that gets (progressively) worse, but it's a sort of emotional crisis that is being pushed away. My belief is it's a spiritual crisis that is being batted away by taking drugs. And the trouble is, the more drugs you give an addict, the more drugs an addict needs."
>
> Former addict and repeat offender

the growth of the problem rather than lessened it.

Under the ten years of Labour's drugs strategy, policy itself has become an intrinsic part of the problem. It has been a costly investment in failure.

The combination of centralised targets and a 'medical management' approach to treatment has further entrenched addiction, adding to intergenerational cycles of substance dependency which are particularly damaging for children.

Chances of recovery and rehabilitation from drugs, challenging in any circumstances, are seriously undermined in this misguided system of social control.

Maintenance methadone prescribing which perpetuates addiction and dependency has been promoted under current policy while rehabilitation treatment has been marginalised and crucial family residential services run down.

A 'colonisation' of the voluntary sector as the third arm of the state in 'harm reduction' drugs service provision has stifled innovation and holistic services.

The response to the crisis in adolescent drug and alcohol use is a plethora of unaccountable, and adult oriented 'services' rather than robust treatment intervention or prevention.

The same system of counterproductive targets and maintenance 'treatment' undermine the efficacy of criminal justice treatment interventions. The gulf between need and treatment in the prison service, which houses the largest addict population in the country, remains unbridged.

The Government's commitment to controlling the supply of drugs and to middle-level police enforcement appears weak.

The preferred harm reduction approach to drugs education in schools, promoted by government though lacking a sound evidence base could be doing as much harm as good.

Alcohol Strategy

By contrast with its highly interventionist approach to drugs policy, the Government's approach to the 'alcohol problem' has been remarkably *laissez faire*. Whilst willing to legislate on alcohol to liberalise licensing laws, it has given no signal that it views alcohol as a potentially dangerous commodity.

From a public health perspective this is disturbing: under the Labour Government we have seen increasing levels of harm due to alcohol, and a growing culture of drinking especially amongst young people. Yet there has

been no equivalent government spend on, or policy commitment to, either the treatment of alcohol dependency or to the control of its harms.

The alcohol strategy exists on paper only. Many health areas across the country have no alcohol treatment provision at all.[12] Yet neither the NHS, nor the statutory social work services use Alcoholics Anonymous as effectively as America does, if at all.[13]

> "Addiction is a progressive disease, which means the drugs that keep me happy today won't keep me happy in a week's time or a month's time so I need to continue to take more and more. It's not only the physical addiction that gets (progressively) worse, but it's a sort of emotional crisis that is being pushed away. My belief is it's a spiritual crisis that is being batted away by taking drugs. And the trouble is, the more drugs you give an addict, the more drugs an addict needs."
>
> Former addict and repeat offender

> "Political leadership of a kind willing to connect the main issues around alcohol related harm and to invest both political and financial capital into undermining the main drivers of that harm is patently lacking and urgently required."
>
> Srabani Sen, Chief Executive of Alcohol Concern

Further, there has been little attempt by government to control supply or availability of alcohol. Government policy has, perversely, been to work with the alcohol industry relying on its promises of self regulation while liberalising the main drivers of consumption: the regulation and taxation of alcohol. Yet the rising levels of alcohol misuse in recent years, the state's power to sanction the manufacture and sale of alcohol, its potential for controlling the availability and price of alcohol, give government the responsibility to minimise the harm it causes – not least because of its cost to the public purse.

Inadequate explanations

The view that the high level of 'problem' drug use in the UK is due to prohibition, is in our view one dimensional and incorrect. Countries with broadly similar legislative frameworks which spend far more on the control of supply and on enforcement have far less of a problem.[14] In general we found that the significance attached to the Misuse of Drugs Act by some, whether as a cause of or as a solution to the drugs problem, to be overemphasized. Nor did we find either view to dominate or reflect the concerns of those most afflicted – the families of those who have died.

---

12 Suffolk (Ipswich) is a case in point. Evidence from Dr Nadir Omara

13 AA operates a 'twenty four hour, seven day a week 'free' service with 3500 meetings across the country a week.

14 The UK spends just 28% of its overall drugs budget on control of supply and enforcement. This is far less than either Holland (75%) or Sweden (54%). Section 4 A perspective on comparative Drug Policies and Implementation in the Netherlands, Sweden and the UK

> "Drugs cannot be dealt with on one level only. Firstly we believe that those who are addicted need support. Not a methadone programme within the community - this only replaces one drug with another and methadone itself is unsatisfactory. It needs to be long term support with continuity and in many cases needs to be residential rehab. Secondly, are the icons that young people wish to emulate. Whilst the media and big business support known drug users and they appear to be 'cool' young people will continue to experiment. Thirdly, children and adults alike need to be educated in the dangers of addiction, the type of drugs, and the dangers they provide. Most importantly of all they need to know what the condition 'addiction' means. Fourthly, cannabis should be re-classified as Class A. The strength of the drug today can cause permanent schizophrenia."
>
> Marilyn Shaw, The Luke and Marcus Trust

> "Evidence from neuroscience is loud and clear. A period of abstinence is often essential for recovery from the subtle, structural changes brought about by chronic substance misuse to the hard wiring of brain!! "
>
> Dr Mirza, Senior Lecturer and Consultant Adolescent Psychiatrist at Institute of Psychiatry

The importance of the law is primarily as a marker for those behaviours which as a society we countenance. In light of the multiple and growing evidence of harms of drug use we ignore this at our peril. Drug use is a disproportionately damaging activity in which a minority (even amongst young people where the levels of use are the highest) not the majority, is engaged.15 We therefore believe the law needs simplification to enable its more effective communication. In addition, within the current framework, the law needs to make a strong statement about cannabis, through its reclassification to Class B.

However an over preoccupation with reform of the Misuse of Drugs Act risks diverting attention from the prime need – expressed to us by parents, practitioners and addicts in recovery alike – for a societal and political commitment to understanding, addressing addiction and its treatment. The moral and practical case is compelling. Government must prioritise this and focus on recovery as the goal of policy.

1.3 Policy Proposals

The task we have ahead to reform the system is 'herculean' and involves treatment reform, harm prevention and child protection.

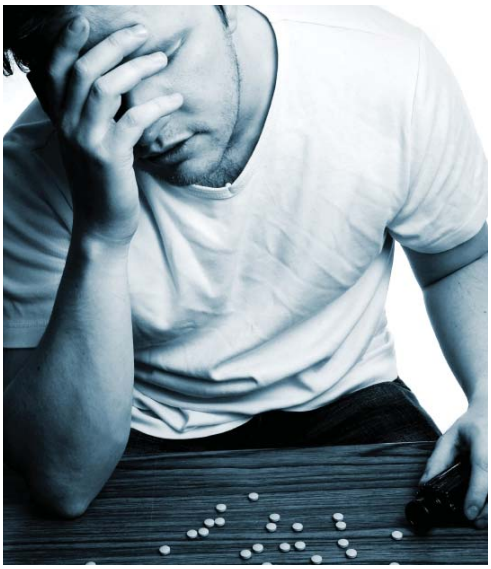
Treatment Reform

There is no point in advocating the need for more residential rehabilitation without an understanding of how radical a reform of treatment is needed

15 'Last month' prevalence any drug use for 16 -24 year olds was 17.2% BCS 2003/4

towards holistic and abstinence-based approaches. It is about facing the fact that abstinence is the most effective method of treatment, and the only appropriate one for many addictions.

To redress the acute and chronic imbalance in treatment provision and to break the cycle of addiction we propose:



- An **integrated addiction policy** to replace the separate drugs and alcohol strategies, led by a National Addiction Trust responsible to a Cabinet Office Second Chance Unit and in charge of a Treatment Trust Fund
- A **devolved responsibility to local Addiction Action Centres** for identifying local need, working alongside One Stop (treatment) Shops ensuring clients progress to supported abstinence treatment and an improved response to clinical and public health needs.
- An **expansion of third sector proven provision of 'holistic', value added, abstinence-based treatment**, both day treatment and residential, prioritising much needed family residential centres and adolescent residential development.
- A new method of **'reward' driven funding by personal treatment vouchers** deriving from the Treatment Trust Fund will 'incentivise' both system change and client change.

Criminal Justice Interventions have an important role to play in breaking the cycles of addiction. We propose:

- **The further development of experimental, dedicated drugs courts**, raising their treatment threshold and provision requirements.
- **Replicating the highly successful abstinence programmes run by RAPT and Phoenix Futures amongst others aiming for a dedicated wing in every prison across the estate.**

Harm prevention

The best way to reduce harm is to prevent it in the first place through policies aimed at an overall reduction in consumption of both alcohol and drugs.

The relationship between the affordability of alcohol and the level of consumption provides government with an effective tool for controlling levels of consumption within society through the levying of a tax on the product. This tax would in turn provide the funding needed to meet the social and economic costs of alcohol related harm, such as police enforcement measures resulting from binge drinking and violence, health service costs and treatment for addicts.

We also propose a renewed commitment to the control of supply of drugs by providing a more transparent record of seizures and interceptions, by plugging the gap left by SOCA and by proper local level drugs teams enforcement.

Finally we recommend further implementation of innovative third sector interventions for stopping drugs trafficking.

Protecting children and confronting cannabis

Neither addiction treatment or harm prevention will work without addressing the need to mend families, and to set boundaries to protect children and give them something to live positively for.

Our most widely used illegal drug should not be in the category which conveys the impression to parents or children that we need to be less concerned with it than the other drugs classified. The government should be giving out a clear message that cannabis use is regarded as a serious matter – one that should be actively discouraged and certainly not seen as something that is rather a fruitless waste of police time.

As stated above we propose

- the reclassification of Cannabis from Class C to B as part of a **national action plan** to discourage cannabis use.
- a radical reassessment of appropriate responses to adolescent substance misuse. This requires first **a formal assessment of adolescent needs** – not just for their substance abuse problems but also for associated mental health, family and social issues, and secondly **a general adolescent 'services' review in view of their diverse development under this government**.
- the development of **residential treatment for adolescents** which would should provide the informal setting for **juvenile drugs courts**, as being experimented in Sweden (see next).
- the introduction of **Juvenile Treatment Orders for drugs offences which would be totally expunged after a five year period of clean record**.

The efficacy of random or other modes of **drug testing in schools** has never been properly trialled and researched in the UK. We believe that government should tender for well designed systematic experimental trials to be conducted in different parts of the country and across different school settings. In this context we also propose the **trialling of effective addiction education** in schools, again inviting well designed research applications

Together these reforms will result in a dramatic improvement in the quality of treatment and access to treatment for recovery. They will introduce financial efficiencies, simplify budgets and create the right incentives for holistic, committed and integrated care. Furthermore by applying more stringent standards, these reforms will promote public health, reducing death and infection, and prevent drug use and criminal involvement.

Section 2
Entrenching Addiction

2.1 A history of chronically relapsing policies

2.1.1 A review

Drugs policy regimes in the UK since the 1950s have swung between 'medicalisation' models, 'public health' models and 'criminalisation' models. The last fifteen years have been dominated by a harm reduction ideology which has drawn on all three in an attempt to control public health and crime outcomes. This approach has relied on 'medicalisation' as the major tool of engagement and social control. There has never been a 'recovery' model.

Political pre-occupation with these highly selected outcomes of drug use has diverted attention and resources from drug use itself, from its association with more widespread addictive behaviours, particularly alcohol addiction, and from more enlightened and challenging approaches to treatment and recovery. At the same time the study of addiction has remained largely the property of a medical-scientific community, marginalising other approaches to the subject.[16]

> "We used to have your alcoholics over here and drug users over there and they didn't meet. If you think about it logically, most people who are now under 65 will have grown up with drugs around so the interchange between drug and alcohol use has become much more fluid. In terms of drug use, alcohol is a part of that drug use. If our drug users relapse on anything at all it's normally vodka or cider or something like that. I don't think you can ignore it… "
>
> Brian Arbury, Chief Executive of Adapt

As drug use has become more common, this medical 'ownership' and focus on the substance rather than the user, has become ever more inappropriate and damaging. A treatment system which excludes alcohol associated dependency is fundamentally flawed

Equally, the idea that the success of a policy should be based on the 'numbers retained in treatment' for a population whose prime characteristic or problem was 'dependency' is inherently flawed.

---

16 MacGregor, S Drug Treatment Systems and Policy Frameworks: A Comparative Social Policy Perspective, European Addiction Research 1999, 5118-125

The most notable result of the Government's commitment to 'treatment' is the 'capture' of a quarter of the problem drug using population, some 80,000, into substitute drug (mainly methadone) maintenance and community prescribing. Despite the spin there has been little improvement in public health,[17] re-offending rates, or in the levels of drug using population.[18]

At the same time the Government's contradictory commitments to national targets and to a locally devolved responsibility for meeting them, has ended up with the worst of both worlds.

The engagement of the third sector – traditionally the main provider of holistic drug services and of treatment 'choice' – through competitive tendering, has stifled its freedom and marginalised the very services and programmes that offer life changing opportunities for addicts.

The addict, his or her family, and society are all losers in this newly expanded national medico-clinical hegemony.

Finally, the implications of creating and maintaining a dually dependent population - both drug dependent and economically dependent - appear neither to have been understood nor thought through. These implications cannot be resolved by the current 'performance' framework which continues to drive an ever expanding dependent clientele into maintenance, despite the best efforts of the National Treatment Agency to try to reduce the scale of the problem.

2.1.2 The dominant 'medico-clinical' model

Historically, addiction treatment in the medical profession and statutory services has focused on finding an appropriate pharmacological intervention, and establishing dose levels to substitute the need or craving for the individual substances used - traditionally opiates.[19] This approach focuses on the substance as the problem rather than on the 'person', his behaviour and its psycho social antecedents. It is a medical approach without a 'spiritual' or 'value' dimension.

> "The models of treatment that have come up have been based around medical models of fifteen-minute clinics with doctors, tell me what you're using, give you a script, off you go."
>
> Former Substance Abuse Worker

An historical preoccupation with heroin by leading addiction psychiatrists in the UK has persisted through to the present day. Today this is seen in medical establishment support for the Randomised Injecting Opiate Treatment Trials, known as RIOTT (although the ascendant 'Class A' drug of the 21st century is cocaine, not heroin) in which the treatment of long-term heroin addicts with pure heroin is being tested.[20] This preoccupation has shaped a treatment

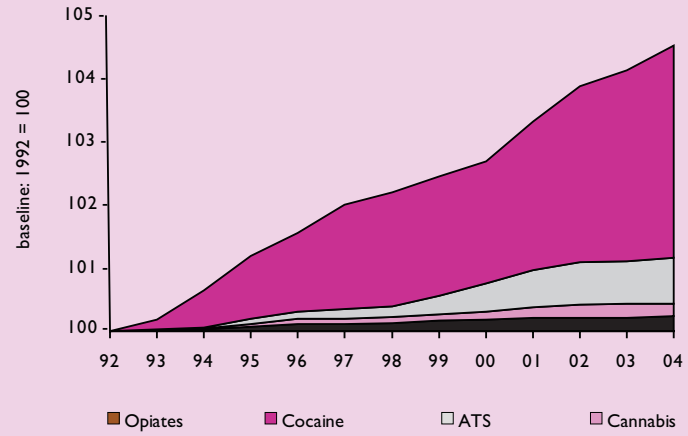
17 Measures include the levels of overdosing addicts and Hepatitus C infection

18 *Breakdown Britain* interim report, Volume 3

19 There are no pharmacological interventions for stimulants

20 RIOTT-The Randomised Injectable Opioid Treatment Trial (RIOTT) is a multisite, prospective open-label randomised controlled trial (RCT) examining the role of treatment with injected opioids (methadone and heroin) for the management of heroin dependence http://www.iop.kcl.ac.uk/departments/

system geared towards single male opiate addicts, in spite of the changing profile of drug use both globally and within the UK.



Source: UNODC, 2006 World Drug Report

Drug user profiles have also changed. The gender divide has narrowed with women using more, the age of initiation is dropping, there is increased adolescent use, and increased use in rural areas.

'A chronically relapsing condition'?

The medical paradigm of drug addiction was, and still is, of a 'chronically relapsing condition' with little hope of recovery. This became both an articulated philosophy and a rationale for the treatment of a condition which had otherwise defeated most doctors. The doctors working in the first NHS Drug Dependency Units (DDU) in the 1970's held this view. They believed addicts should be treated in a non-stigmatising manner, responding to the dire health needs of a previously alienated addict population.

The DDUs marked the end of heroin prescribing by the minority of GPs engaged in this practice who, whether subject to corruption or to the machinations of addicts, had systematically over prescribed and were the catalyst for the original expansion of the illicit heroin market in the UK and a focal point for addicts from abroad.[21]

'Stabilisation'

Doctors and addiction psychiatrists working in DDUs focused on minimising the health harms to the addict, reducing mortality rates and attempting to stabilise such a chaotic lifestyle. They did this through prescribing substitutes.[22] This approach today, more than anything else, influences the commissioning

21 Gossop and Strang '*Heroin Addiction and the British System, Vols 1 and 2*' Routledge, 2005
22 Ibid

of drugs services across the country by 149 Drug Action Teams, the bodies representing the police and social services, as well as the medical and psychiatric professions. It has culminated in 'mainstreaming' such interventions into the NHS. As such it is the key achievement of the 'harm reduction' movement of the last 15 years, but one driven as much by the Government's crime reduction goals as its public health goals.

The persistence of the medical psycho-pharmacological approach is reflected in the expertise, interests and connections of the current membership of the Home Office's Advisory Council on the Misuse of Drugs. It is an approach so embedded in the government's drug policy that most accept it unthinkingly. It has stifled the expansion of recovery oriented philosophies, innovations and investigations which have often been regarded with extreme scepticism by the medical profession.

Psycho-social interventions as introduced into statutory services in recent years remain adjuncts to 'treatment' rather than central to it, and are neither holistically targeted nor delivered. They are in dire need of audit and evaluation.

A Stigmatised Population – Needs or Rights?

Concern for a stigmatised and untreated population of addicts in the 1970 and 80s – then considered a deviant fringe of society - also resulted in the emergence of a 'street agency' voluntary sector. Interlinked with addicts' equal rights to receive health care alongside other members of the population grew another assertion: the right to use drugs and the right not to be criminalised. From this developed a lobby which today argues for acceptance of the reality of widespread 'harmless use' of drugs in the population. The logical corollary of this argument is that it is the prohibition of drugs that is the problem, not drug use itself. They argue that prohibition drives highly profitable and uncontrollable crime thereby exploiting and corrupting socially vulnerable communities, both criminalising individuals and infringing their human rights.[23] In the brave new world of legalised drugs the optimistic scenario projected is one in which 'harmless' drug use would go up, while 'harmful' drug use would go down – a projection which flies in the face of all that is known about rising parallel trends in alcohol use and harms.

Abstinence based approaches, which were never part of mainstream statutory provision and today still operate on its margins, were, in the 1980's, the key response of an emergent voluntary and private sector.

2.1.3 The arrival of abstinence (the social response to addiction)

Why Abstinence?

The voluntary sector led the field in abstinence programmes, where for the first time addiction was understood as a family illness, and treatment for addiction was offered to people who wanted to get better.

23 Transform Drugs Policy Foundation

Why Abstinence?

Before I embraced abstinence as the way forward I would try and cut down, control and drink more safely…The guilt and shame at not being able to manage fuelled my consumption. I had no 'professional' voice exhorting me to abstinence, rather all sorts of advice about making my drinking more manageable.

When, at last, I had had enough and decided to seek alternative help through AA I was told "Stay away from one drink, one day at a time and everything else will fall into place." … My journey into recovery started there…I thank God for the wisdom of AA... I learnt that anything that 'artificially' changes the way I feel awakens the part of my being that craves continual sedation/stimulation.

I am still aware of the part of me that lies dormant within. Occasionally it opens one eye and reminds me that it is alive and well, just sleeping. There are many voices out there (and within) that would seduce me into thinking that perhaps it would be different this time - that I have done so much work on myself psychologically, perhaps I could drink safely. But no. I have to avoid all unnecessary medication and keep taking the medicine of abstinence.

Clinical director of an abstinence based programme and recovering alcoholic

Early residential treatment programmes addressed all dependencies, from alcohol to benzodiazepines, from heroin to amphetamines and eating disorders. Modelled on the innovatory Alcoholics Anonymous and Narcotics Anonymous 12 step programmes, they concerned themselves with the person not the substance, and established the possibility of ongoing recovery from addiction through abstinence. AA and NA informal networks spread across the UK forming what remains the only 24 hour and seven day a week service for those with acute dependency problems. They influenced a range of peer support and self help networks.

Most of the early residential centres were charitable foundations such as Barley Wood, Yeldall Manor and Clouds. Such organisations made themselves available for anyone in need of treatment, regardless of their circumstances, acquiring the necessary funds from both charitable donations and social services.

> "I did not think that rehab was for the likes of me. I just thought it was for celebrities like Kate Moss"
>
> Julie, 'Graduate' of Rapt 12 step programme programme[24]

24 Former offender and addict, speaking at the 25th Anniversary of the Rehabilitation of Addicted Prisoners Trust, April 2007

However the notion of 'rehab' being the prerogative of the rich and run by the private sector remains a powerful misconception which persists to this day.

Some 90 per cent of this sector has always been charitable, although many health practitioners have voiced concerns over the 'big business' element to service provision.[25]

Today, despite the commissioning of a formidable array of drug services, access to residential rehabilitation treatment has not expanded and is currently at an all time low. In 2003/4 there were only 4,601 residential admissions out of a total population in 'treatment' of some 180,000.[26] The introduction of a dedicated pooled treatment budget has not been used to secure or protect residential rehabilitation. Funding streams remain complex, insecure and unavailable.

> "The last few years have seen a major growth in the money allocated by central government for the treatment of substance users. However there has been little guidance or control over how funds are spent other than by the imposition of targets relating to total numbers in all forms of treatment and more people receiving methadone scripts. This has had a negative impact on residential services where the unit cost is higher but the long-term abstinence goal is more effective."
>
> Excerpt of an official letter from Brian Arbury, Chief Executive of Adapt

A crisis in community care funding for residential referrals to detoxification and rehabilitation programmes has left half of the beds lying empty with closures and specialist staff made redundant.[27]

Except within the prison service, where there is a minority provision of therapeutic and 12 step programmes, the take up of holistic abstinence oriented approaches to treatment has been near to non-existent in the statutory sector. The introduction of effective psycho-social interventions, for example cognitive behaviour therapy, relapse behaviour therapy and motivational interventions in recent years are largely as adjuncts to 'psycho-pharmacy' and are rarely delivered in holistic settings.

2.1.4 The public health model

HIV Fears – a ground for policy?

HIV prevention and harm reduction measures were identified as a priority in UK national drug policy in the mid 1980s. The driving force of policy was the need to mitigate public health harms rather than an aspiration to cure the addict population of their destructive dependencies. This shift in drugs policy and provision towards preventing HIV infection, suggested by the Advisory

25 A G.P in correspondence with the SJPG this year.

26 NTA and NHS, *Tier 4 drug treatment in England: Summary of inpatient provision and needs assessment* June 2005

27 Russell White "*Empty Beds - A Crisis in Residential Referrals*" Breakdown Britain, Volume 3

Council on the Misuse of Drugs in 1988, became the principal priority for services in the drugs field.[28]

Subsequently, most drug treatment programmes began to incorporate interventions targeting the injecting and sex risk behaviours of their clients.

In a seminal paper at the end of last year Professor Neil McKeganey questioned whether the ACMD was right in prioritising HIV/AIDS over drug abuse. In view of the dramatic rise in Hepatitis C amongst injecting drug users he suggests that the low level of HIV/AIDS amongst the same population may be less to do with harm minimisation interventions than with the possibility that the threat of AIDS was overestimated.[30]

In 1988 the Advisory Council on the Misuse of Drugs published the results of its enquiry into the growing problem of AIDS and HIV in the U.K. Contained within the council's "AIDS and Drug Misuse: Pt 1" report (1988) was a sentence which proved to be more influential than any other in the history of UK drug policy. That sentence identified the need for a fundamental shift in drug policy and provision as a result of the belief that the: **'...spread of HIV is a greater danger to individual and public health than drug misuse'** (ACMD 1988:17)

In the wake of that statement the principal priority for services working in the drugs field, as well as for drug policy more broadly, became one of reducing drug users' risks of acquiring and spreading HIV infection.[29]

Not only, he argues, has the subsequent and rapid expansion of needle exchanges and other harm reduction services failed to stem rising overdose, mortality figures (in which methadone after heroin is the key agent), Hepatitis C or problem drug use numbers[31], but the quest for 'harm reduction' has diverted attention from the much wider and more significant social harms of drug use itself and from the urgent need for its prevention.

The efficacy of methadone in substitute prescribing as reducing mortality is also in question. Some recent European studies have suggested a lower risk of fatal intoxications in drug dependent patients under buprenorphine compared with methadone treatment. In one study the researchers found that their data indicated that methadone was involved in 35 per cent of drug deaths, whereas buprenorphine was involved in just one.

In spite of unprecedented investment in treatment the Government has failed to reach its mortality reduction target[32], putting a question mark on the validity of the underlying thinking.

Today, the major achievement of the harm reduction movement lies more with the engagement of harm reduction services by the 149 DATs than with their efficacy. [33] 97 per cent of DAT areas have harm reduction services and 87

28 Neil McKeganey, University of Glasgow, Centre for Drug Misuse Research '*The Lure and Loss of Harm Reduction, Addiction Research and Theory*', Vol 14, 6 December 2006 pp557-588

29 Ibid

30 Ibid

31 Between 2000 and 2004 there were 5551 deaths involving cocaine, heroin or methadone. Hepatitis C rather than Aids has emerged as the real problem, with 90% of all Hepatitis C cases being drug injectors.

32 Hamid Ghodse et al *Drug Related Deaths in the UK* 2006

33 Drugs Action Teams were established by the last Conservative Government to commission treatment services for which abstinence was still a key aim

per cent provide access to prescribing services. Harm reduction has been mainstreamed into the NHS via shared care agreements between DATs and local Primary Care Trusts, funded by the National Treatment Agency's Pooled Treatment Budget.

2.1.5 The evidence base

The National Treatment Outcome Research Study (NTORS) – an evidence base for treatment efficacy?[34]

In 1994, the last Conservative Government commissioned the NTORS project. This gathered information about the treatment outcomes of a large sample of drug misusers who had been treated within the existing national system of treatment services. The sample of predominantly white males with a mean age of 29, was characterised by their entrenched drug abuse - primarily heroin but also poly substances.

NTORS has since been referred to as the key British research to demonstrate that 'treatment works' in terms of reducing health and crime harms of drug use: that 'treatment' has a positive effect on risky behaviours such as overdose and suicide and on rates of criminal involvement.

The research gave credibility to cumulative anecdotal and testimonial evidence that addiction was a recoverable condition as well as a chronically relapsing one. Importantly it pointed to distinct differences in 'abstinence' outcomes between residential patients and community methadone maintenance patients. It revealed that almost half of the former (49 per cent) were abstinent from heroin after five years, a significantly higher number than for community methadone treatment. This was despite the fact, that, as the report noted, the clients in residential centres had been some of the most entrenched and problematic users.[35]

But the NTORS evidence is less transparent than it looks. Although alcohol was included in their measure of abstinence, cannabis was not. Nor did it specify whether any of the subsets of the sample were abstinent five years later from prescribed medication. We do not know how a stricter definition of abstinence, including from 'prescribed medication' would have affected the NTORS results and whether the case for 'residential treatment' would have been even stronger.

Interestingly, the recent Drugs Outcome Research in Scotland (DORIS) has sought clarity by explicitly defining abstinence in two ways as either total abstinence from all drugs other than alcohol and tobacco (i.e. including cannabis and prescribed and non prescribed medication) or as abstinence from all drugs other than prescribed substitute medication.

DORIS findings showed an even larger difference in abstinence rates, strongly favouring residential over prescribed methadone treatment which

---

34 The NTORS project examined changes in substance use, health and criminal behaviour at the National Addiction Centre. It longitudinally studied 1,075 drug users recruited from 54 treatment programmes during 1995

35 Ibid

questioned the value of methadone treatment at all.[36] DORIS also investigated clients' aspirations on entering a new treatment cycle. It found 58 per cent hoped for recovery from drug use through abstinence.[37]

The NTORS Five Year Report focused its conclusions on the costs and consequences of drug treatment on limited non aspirational definitions of improved behaviour, rather than on personal recovery. Any treatment interventions which impeded or delayed behaviour, as opposed to fundamentally changing behaviour, were valued as economically beneficial.

> "When we look at who achieves abstinence actually they are predominantly the ones who have had residential rehab. The ones who have had been on the methadone programme, the proportions who have achieved abstinence after three years is not even in double figures in terms of percentages - it is around 7 per cent. The proportion that become abstinent who have had residential treatment approaches 30 per cent. So there is absolutely no comparison as to which of those are most enabling drug users to achieve what overwhelmingly they are saying that they want."
>
> Professor Neil McKeganey, University of Glasgow, Centre for Drug Misuse Research

The study failed to explore the meaningful quality differences in treatment between residential and 'community methadone' settings that led to the different outcomes. It therefore provided the next government with a mandate for 'any' treatment that works, including options with poor long-term results but low short-term costs.

2.1.6 The criminalisation model

Labour's 'crime reduction' treatment landscape: 'treatment works'?[38]

The economic notion that 'treatment works' became the central tenet of Labour's ten year national drug strategy.[39] This challenge was given to the newly established National Treatment Agency to achieve with its dedicated Pooled Treatment Budget.

> "It is a clear anomaly that I can be immediately offered treatment if I am caught shoplifting at Tesco's, but I am not likely to be offered treatment if I am in court with my children, under the Children's Act, for significant harm, (and it is) likely that my children will go into care …"
>
> Member of staff at Bolton's 360 Services

36 Professor Neil Mckeganey in Evidence to Social Justice Policy Group

37 McKeganey, N, Morris, Z., Neale, J., Robertson, M. (2004) "*What are Drug Users Looking for when they Contact Drug services: Abstinence or Harm Reduction*". Drugs: Education Prevention and Policy, Vol 11 No 5: 423-435 October 2004; McKeganey, N., "*Who becomes Abstinent on the Basis of Drug Abuse Treatment In Scotland*":Drug Outcome Research Study In Scotland.

38 For in-depth analysis of Labour's National Drugs Treatment Strategy see Breakdown Britain Interim Report Volume 3

39 NTORS The National Treatment Outcomes Research Study (NTORS) was originally commissioned as part of the review process for the Task Force to Review Services for Drug Misusers 1995, and has since been referred to as the key British research to demonstrate that 'treatment works'

Members of the Addiction Working Group at a hearing with Olga Heaven, Director of Hibiscus Charity

This and the crime implications of drug use have dominated the Government's recent strategic planning – the assumption is that substantial reductions in drug use and associated criminal behaviour can be achieved by treatment. And the justification for the strategy is based on the predictive cost of heroin use for acquisitive crime. The total figure cited in a Cabinet Office Strategy Unit Report was around £16 billion. This thinking was further influenced by Home Office research[40] which sparked the claim that 'every £1 spent on treatment saves £9.50 in criminal justice and health costs'.

The policy shift from health to crime mirrored a shift of policy responsibility from the Cabinet Office to the Home Office in 2003, with a simultaneous focus on the drug user within the criminal justice system, with crime reduction as a key motivation.[41]

The new orders gave courts the power to require an offender to undergo treatment as part of a community sentence in cases where there was a clear link between drug abuse and offending, instead of a prison sentence. The offender had to undergo regular drug testing and undertake a high level of supervised activity (15 hours per week minimum). The treatment requirement typically involved a methadone prescription, with a low level threshold of abstinence required, from opiates and cocaine, for the period of the order alone - not from amphetamines, alcohol or cannabis. In the original phase, 44 per cent of those on orders received substitute prescribing and two thirds counselling.

This constituted the criminal justice route into 'treatment'. It brought additional funding from the Home Office, a budget of £53 million, along with a plethora of complications: overlapping agencies and responsibilities regarding the treatment and monitoring of offenders. By December 2003, 18,414 such orders had been made and both voluntary organisations and probation services were bidding for competitive tenders to supervise them.

Our review of the efficacy of drug interventions in the Criminal Justice System suggested that they were patchy.[42] The pilots showed that after 12 months on a DTTO nearly 70 per cent were still testing positive for opiates. Research has shown that the link between drug use and crime is complex, and that for the majority criminality predates drug use. This view of drug use as a 'sub-set' of criminality is supported by research findings that as few as 7 per cent, and as many as 37 per cent, of individuals under probation supervision are Problematic Drug Users (PDUs). Of these, only 'a minority can be helped and succeed in changing drug use and offending behaviour'.[43]

We discuss in our policy proposals how the criminal justice system can be a highly effective route to recovery and rehabilitation.[44]

---

40 Godfrey, C., Eaton, G., McDougal, C., & Culyer, A. "The economic and social costs of Class A drug use in England and Wales" Home Office Research, Development and Statistics Directorate (2000)

41 *'The Updated Drugs Strategy'* (2002)

42 *Breakdown Britain* Interim Report Volume 3 p141

43 ibid

44 See section 3.3.1

Conclusion

The last ten years of drugs policy under Labour have marked a fundamental shift in objectives. They have seen the introduction of an additional route into treatment, a new target population, and a doubling of the numbers in treatment. However, there has been no parallel shift in what is deemed appropriate and effective treatment. Under Labour, abstinence has been lost in the hierarchy of goals for treatment. Harm education and harm minimisation services, not recovery and rehabilitation, dominate national and local treatment provision.

2.2 'Maintenance' doesn't work – methadone madness

Methadone, the favoured drug for prescribing, is the unquestioned mainstay of the public health response to drugs treatment in general.[46] The evidence base for its efficacy relates to 'stabilisation' measures, to remaining opiate-free for defined periods, and to 'retention in treatment' and ending illicit drug use.

> "Maintenance-oriented treatments in the UK context primarily refer to the pharmacological maintenance of people who are opiate dependent, through the prescription of opiate substitutes (methadone or buprenorphine). This therapy aims to reduce or end their illicit drug use and the consequential harms of such."[45]

Our analysis is not that methadone does not and cannot have a useful and positive role in the treatment of addiction. Its routine and mass prescription is hard to justify on either clinical or ethical grounds and is entrenching rather than solving addiction. The rapid expansion of its prescription appears to be as much an outcome of political pressure and target driven policy as of a dispassionate clinical response to the treatment needs of a particularly vulnerable population. We have found its current mass prescription of methadone to be the cause of deep disquiet amongst drugs workers and addicts alike. Addiction psychiatrists who have run methadone prescribing clinics admit that few of their patients like it – it is not their treatment of choice. Research indicates it is not risk-free and indeed that it is less risk-free than other substitutes. Drugs professionals and experts running methadone programmes in the third sector have said they would refer clients 'on' if there were somewhere to refer them.[47]

2.2.1 The facts

- The number of methadone prescriptions in England doubled from 970,900 in 1995 to 1,810,500 in 2004 – an increase of 86.5 per cent[48], and

45 National Institute for Health and Clinical Excellence (NICE) *Drug Misuse: Psychosocial full guideline draft* January 2007 Page 43 of 264 Draft For Consultation

46 UK Drugs Policy A Critical Overview Part Two: The Governments Supply Reduction Strategy, Breakdown Britain interim report, 2006

47 Martin Blakeborough, CEO Kaleidoscope recommends a 'One Stop Shop' where a person gets their methadone treatment within a rehabilitation service a treatment journey leading to 90% abstinence

48 Summary of the NTA's national prescribing audit

the number of oral prescriptions increased over the same period by 218 per cent[49]

- Three quarters of those prescriptions were methadone maintenance treatment (meaning a continuation of a same dose prescription) and one quarter was methadone reduction treatment, (a prescription in which the dosage is gradually reduced over time)[50]
- The majority of clients (60.2 per cent) had a prescription for longer than six months and 41.7 per cent remained on their current dose for more than six months

> "There are clear medical treatments for opiates users, which is either methadone, buprenorphine (Subutex) or heroin - but less so in terms of stimulant use … there are no pharmacological interventions that effectively reduce cravings or to stop people from using stimulants. The treatment for stimulants users is what is called symptomatic prescribing - i.e. for people who, once they stop using go through a crash. It's giving them either an antidepressant or a new generation of antipsychotic. "
>
> Dr Nadir Omara, Suffolk Mental Health Trust

An analysis of PCA (Prescribing Cost Analysis) data reveals the steep growth in methadone prescriptions particularly since 2001/2. The annual cost of methadone prescribing in England, extrapolated from NTA figures, currently stands at £111,000,000, nearly one third of the dedicated pooled treatment budget of £398 million for 2007/8. The mean annual treatment cost for an individual addict has been calculated at £2020 per person prescribed per annum.[51]

80 per cent of 'substitution' prescriptions are methadone based.[52] Another substitute, less widely used and more expensive in nurse time to prescribe, is buphrenorphine also known as Subutex.[53] A study of buprenorphine treatment (which accounts for approximately 17.5 per cent of substitution treatment) showed that 60 per cent of addicts were on maintenance with 40 per cent on reduction. Fewer buprenorphine prescriptions lasted over six months with only 39.9 per cent of clients remaining on the drug for more than this time.[54] In terms of ultimate abstinence outcomes, buprenorphine looks to be more positive.

Although the 'mainstay' of drugs policy, as a synthetic opiate derivative, methadone is designed for heroin substitution and is not a suitable intervention for those using stimulants, the most widely used of which is crack cocaine. Recent estimates show there are 199,000 crack cocaine users in England for whom it has not been possible to devise a comparable treatment protocol.[55]

---

49 Ibid
50 Ibid
51 NTA correspondence with David Burrowes MP
52 The National Audit Prescribing Report
53 Data from Schering Plough Pharmaceutical Company and Rosemont: One Subutex tablet costs £3.50 per dose in comparison with £3.12 per dose of methadone (60ml average dose) Nurse time for a subuetx dose equates to £4 in comparison to £1.50 for a methadone prescription.
54 Ibid. Calculations based on 6,692 clients surveyed for buprenorphine as a percentage of total clients surveyed
55 Hay et al 2006

We have heard evidence from numerous substance abuse workers who talk of this growing tendency for problematic drug users to use both crack cocaine and heroin, and typically that the drugs are sold together.

2.2.2 Methadone detoxification

As a method of reduction leading to gradual detoxification, the use of methadone can be difficult. Subutex, preferred by many addiction specialists, can be crushed and injected therefore dosage must be supervised adding to its expense.

> "To detoxify someone off methadone is one of the hardest detoxes there is. I would rather take the heroin; it's much easier coming off heroin than coming off methadone."
>
> Dr Neil Brenner, Addiction Pyschiatrisat, The Priory, North London

A number of addiction specialists raised the issue of the difficulties for patients of 'detoxing' off the last 20 or 30 milligrams of methadone especially outside the context of a residential setting or programme.[56] The Clouds detoxification protocol states that:

> *'Many patients attempt very slow 'weanings' with methadone in the community, a process that can go on for months. This undoubtedly works for some people but for many others this slow drawn out process is frequently punctuated with using heroin on top, resulting in the methadone dose going back up again.'*

It sets out a number of alternative client-sensitive detoxification programmes. The full implications of the need for detoxification provision in structured support settings have not been addressed by the NTA despite the widespread dependence on methadone generated by public policy.

> "The NHS has got this belief, well not all of them, but (many) ... that detoxifying someone is a treatment - *no*, it's not: absolute waste of time. If you just bring somebody in, detoxify them and fling them out, quite frankly, you might as well save your money, in my view. It's all about what happens after that."
>
> Dr Neil Brenner, The Priory, North London

There are alternative non-pharmacological approaches to detoxification, the most notable of which is NET, the full trialling of which the medical establishment has not to date undertaken.

2.2.3 Methadone maintenance

The theory

Official claims for methadone maintenance treatment are overwhelmingly

---

56 Dr Ann McCann, Castle Craig

positive: it greatly reduces mortality, illicit drug use, criminal activity and reduces transmission of HIV; it attracts and retains more patients in treatment than other treatments; the children of addicts also benefit. There is no evidence that it increases the overlal length of depndence. That the positive outcomes of methadone maintenance are ony sustained whiklst methadone patients are in treatment

> *The maintenance prescription is a dynamic concept and allows the patient to engage with something other than raising the cash to buy their drugs i.e. re-establishing the essence of a 'normal life' are enabled by stabilisation on methadone or Subutex. Furthermore, it can be achieved in the community, without the expense of a residential setting. However, this process takes a long time. Many of our patients will take literally years to gradually get their lives back together. They may reduce their methadone but they often do not stop altogether and it does not matter because methadone does not inhibit their social functioning nor prevent them from leading a useful and productive life within society.*[57]

'On methadone' – the experience and the practice

But such claims made for methadone were not validated by the evidence we received from witnesses:

> *I overdosed with heroin. When I came out of hospital but I kept using drugs and I got put onto methadone, and that was a joke to me, because they were trying to help me, but I was using the methadone as a way to get drugs, you know what I mean? I would get my weekend's prescription, I'd get home but I'd sell that to get drugs. And any time I did try and really take it serious, I would get put up on my methadone, and it wouldn't help me I couldn't think to myself, 'I'm on methadone, I'm going to go and try and get a job', because every day you still need to go to that chemist, so you feel as if you're still caught up in drugs. So it's just something that gets a grip of your full life, you can't plan anything, first and foremost every day, you've got to think of that.*
>
> Addict in recovery, Maxie Richards Foundation

Numerous addicts reported that they had been prescribed methadone for years, one had been 'on methadone' for twenty years.

The main defence of the failure of methadone treatment in terms of clients 'topping up' is that often prescribing (under 60mls) is too low from the start of treatment for effectiveness.[58]

---

57 A G.P in correspondejce with the SJPG this year

58 The daily mean methadone maintenance dose (regardless of formulation) was 57.6mg but ranged from 6.5mg through to 127mg. On average, services prescribed daily maintenance doses of less than 30mg to 15.5% of clients, while 48% of prescriptions were for 31.60mg of methadone, 27.9% for doses of 61-90mg, 6.6% for doses of 91-120mg, and only 1.9% for doses greater than 121mg. National Prescribing Audit NTA. Summary of the NTAs Prescribing Audit, NTA June 2006

Some protocols produced by DATs, in the context of their shared care agreements, do advocate higher start dosages. One treatment manager told us how important it was to start with a high dose even though clients made be expressing a desire to come off drugs. While this approach may improve proxy success measures such as 'retention in treatment', it also can make 'exit' from treatment for the client all the more difficult.

> *What's happening at the moment, is that people are being prescribed methadone over and above what they need from the off, in order that – the belief is – that they will then be so sort of comatose that they won't need to take other drugs and they won't therefore need to commit crime to take those drugs…And that's what's happening. I see people coming through this court – they're young, you know, early twenties, they've come and they've got a little bit of a habit, and suddenly they're on 100 to 120mls of methadone a day. And, you know, they're being kept on it for months/years and sometimes for a decade at a time.*
>
> Rupert, Drugs Court Adviser

Some experts questioned both the need and the reasons behind higher dose prescribing:

> *There's good evidence from [our analysis of methadone prescriptions] that the carers, the people providing the service, are wanting to keep people 'up there', where the people taking the medication, do actually want to reduce. And they're going against the grain really. So, you know, there's a cultural thing there of control and…professionalism.*
>
> Dr Adrian Bonner-Reader and Director of the Addictive Behaviour Group, Division of Psychiatry, Kent Institute of Medicine and Health Sciences

2.2.4 Problem solving not 'treatment'

'Maintenance' is the most visible and controversial representation of the historical medical bias in addiction treatment and has sparked a vigorous ethical and practical debate about its appropriateness. One addiction psychiatrist said it was about problem solving, giving out methadone and then forgetting about it in order to reduce crime.

The addicts we spoke to were sceptical of methadone maintenance of its ability to deter them from illicit drugs and thought routine prescription meant they were not warned about the reality of their illness.

> *I would say to the doctor, 'I'm using heroin just now', so he would up my dose of methadone...I didn't want to stop at the time…that's the thing there are many people who don't want to stop, and there are many people who wouldn't find out about treatment centres - and, more to the*

point…won't know that they suffer from a disease, of addiction, and they'll die from it.'

Addict in recovery

Those involved in running abstinence recovery programmes were categorical that it is one hundred per cent counter intuitive to treatment needs with no role unless used as a detox in a reduction programme, along with therapuetic treatment. 'If you simply swap their illegal drugs for legal ones you are not treating the person at all.'

Professor Strang, Director of the National Addiction Centre admitted that:

'One of the valid criticisms of some methadone maintenance programmes and buprenorphrine programmes is that they aren't programmes – they are little more than dispensaries. To be properly effective, they should be structured maintenance programmes with important psychosocial active ingredients – just like active prescriptions.'

We found widespread agreement that the best use of methadone is as the carrot to get the drug user into services in the first place, in a programme that is promoting change, ultimately that is moving to abstinence.

Moral disquiet and wasted years

We were confronted by the deep disquiet of those addicts in recovery who had been maintained on this medication for years of their life.

> "It ends up, I think, that that's all you know, and that's all you think is available. There's no options."
>
> Addict in recovery

'I was maintained on methadone for years and years, and not once did the doctor or a drugs worker say, 'well, look, have you ever thought about rehab'?...you're still in your home town, with the same people, with the same drugs, the same everything. And you're very blinkered. Common sense will tell you that you need to get out and break the circle… if you're still in there, on a methadone script, people still use, you've got no chance at all…

When I first came here, I thought 'I need to get off drugs', and that was it. But then I learnt as I went on, that it was about learning life skills which I never learnt from being on heroin and methadone for 22 years…'

Lee, a Graduate of Phoenix Futures Adult Residential Rehabilitation

2.2.5 The 'outcomes' evidence base

The evidence used to support the prescription of methadone as a treatment is based on low threshold 'illicit opiate free' and 'retention in treatment' out-

comes that are routinely referred to as stabilisation, a relative rather than an absolute concept. NTORS had shown that a quarter of methadone patients showed no improvement whatsoever, despite their access to and often extensive input from, drug treatment services. Social problems of methadone treatment including harms to children were not accounted for in this original research.

The most recent outcomes research shows even poorer results - that after three years of methadone use only 3 per cent of addicts had given up drugs.[59]

Conclusion

Our conclusion is that substitute prescribing is a legacy from the 1970's, and since then it has received two massive boosts – one in the early 1990s when politicians were concerned about an HIV epidemic fuelled by intravenous drug users, and the second since 2002/3 with a new crime reduction goal with an attendant target population for 'treatment'.

It is an unplanned treatment policy with a weak evidence base which needs review and reform. Any hope of reducing the ever increasing numbers maintained on methadone by establishing new guidelines for 'treatment outcomes' or 'exits from treatment' is, we suspect, wishful thinking.

The purportedly pragmatic view of the need to 'methadone baby sit' addicts through their 'natural' nine or ten year heroin dependent life span with the dual purpose of reducing crime and preventing mortality, we find to be morally void and economically questionable. Policy makers must address the moral and ethical issue of sustaining dependency for a population of 'patients' whose very dependency condition undermines their ability to make informed choices for themselves or to truly understand their condition. Methadone can condemn them to wasted years.

2.3 Entrenching addiction – the evidence presented to us

Evidence taken from Drug Action Teams, substance misuse workers and third sector providers suggests that far from breaking the cycle of addiction, the national treatment system for many has itself become part of that cycle, helping to entrench addiction.

> "The targets that are being set are driving the services, rather than the services driving the targets."
>
> Andrew Thomson, Chief Officer ADAS, a third sector alcohol and drugs advisory service

59 Professor McKeganey citing recent DORIS findings

Contributing to the process of entrenchment are:

- A bureaucratic, target driven and skewed treatment system which ignores the needs of families and adolescents, sidelines abstinence residential and day programmes, and drives mass substitute prescribing
- An exclusive 'treatment' focus on drugs at the expense of alcohol and a failure to address 'addiction'
- A confusion and conflation of public health, clinical needs and addiction treatment
- Insensitive, bureaucratic and target driven criminal justice interventions, with limited availability of effective treatment for addiction in prison or in the community
- A 'colonisation' of the voluntary sector as the third arm of the state in 'harm reduction' drugs service provision which stifles innovation and holistic services
- Failed and counter-productive harm reduction drugs 'education'

2.3.1 The targets 'numbers game'

Treatment expansion driven by performance targets has resulted in national treatment hegemony[60], in which substitute prescribing and people-processing dominate.

> "I'm not criticising my local Drug and Alcohol Action Team … because they're just going through the standard processes…But within that are enormous targets. If you just look at our reporting mechanisms for this year, there's 38 data fields rising to 78 next year…I'm going to be making frontline (care) staff redundant, to increase the management and administration…to accommodate the new reporting requirements… So the waiting lists will go up….and yet it doesn't improve quality of services, in fact I'd argue it leads to a reduction in quality."
>
> Andrew Thomson, ADAS

This system has marginalised effective abstinence-oriented treatment programmes and practices, whether in residential or community settings, despite the evidence that they give the best recovery outcomes.

Top down performance management and service commissioning in relation to an arbitrary tiered 'models of care' framework is client-insensitive.[61] It stops the local commissioning of services from responding to local needs; it negatively affects voluntary and statutory agencies' potential to help.

60 Andy Horwood Breakdown Britain Vol 3 Addiction op cit

61 The 4 tiered treatment system is highly structured, and does not allow for clients who may require interventions from more than one tier. Commissioning is centred around getting people into 'treatment' within the tier system, rather than looking at what is best for them in terms of outcomes.

Numbers in 'treatment'

In 2005/2006 154,971 individuals started a 'structured drug treatment intervention' in England. Of these, 99,448 of them began a treatment programme that included prescribed medication[63], and many were referred through the criminal justice system.

> "The treatment and the public service agreement target was achieved two years early - that's a remarkable achievement. The Drug Interventions Programme…is on track for a thousand a week into treatment. Over this financial year, DIP has consistently directed over 3000 people into treatment each and every month, and the most recent figures available showing round about 3500, 3600 a month…When I joined the Drug Interventions Programme not all that long ago the figure on a monthly basis was round about 1700, 1800."
>
> Ian Martin, Head of the Drug Strategy Unit, Home Office[62]

There is widespread recognition that the success of the Government's policy lies in the number of people that they have engaged in treatment services. But we found scepticism and dismay regarding targets and 'numbers game' spin:

> *"Government targets are asking me to view my business in a way that's just not capturing the work that we do. It's about getting bodies into a system, head counting and just watching them, it's sheep dipping basically."*

The 'numbers game' has skewed the overall structure of treatment services towards prescribing and harm reduction, and away from the more aspirational and challenging goal of abstinence – for which there is no target.[64] This has a number of mutually reinforcing negative impacts:

> "The targets are about people into treatment. It doesn't tell you what treatment, whether that treatment is any good, all it is, is about numbers…[they] can say, oh, we've got 185,000 people in treatment. To me that's a meaningless statement, what I want to know is how many people have you managed to get drug-free or reduce their level of harmful use by significant levels. That's the only thing that matters, and that hasn't happened…how many people since they started their work have become drug-free?"
>
> Nick Barton, Joint CEO Action on Addiction, former CEO Clouds

Target 'outcomes'

1 Targets have channelled resources away from quality interventions into increased numbers of assessment and referrals – regardless of likely outcomes – and have diverted front line drugs workers into administration

62 Speaking publicly at a 'stakeholder' meeting in London March 2007

63 Answer to written question from David Burrowes MP June 2007

64 Importantly there has been little attempt at meshing other evaluation methods, audit, inspection and a high level strategy for co-ordinating service direction together with the governments KPI targets. Whereas KPI's should have been indicative indicators to feed into a broader strategic level picture they have displaced other key measures distorting the picture acting simultaneously as virtually the only basis for driving / directing policy and the most important 'measure' of its justification.

2 Targets have made The National Treatment Agency a victim of its own success, creating a mass of methadone-dependent clients

> "They...suddenly realised that everyone was stacking up in this cul-de-sac with nowhere to go and they were so worried about how many people (were going in) that they started using this extraordinary phrase about residential treatment being 'an exit from treatment' … Residential is an exit from treatment? I see residential treatment as an exit from dependence."
>
> Nick Barton

Drug action teams have a responsibility to deliver targets as efficiently as possible. Some have found that the most efficient way of achieving targets is through 'shared care agreements' with the local Primary Care Trust. This effectively mainstreams methadone prescribing services within the NHS. This is despite, as one DAT co-ordinator made clear to the Working Group, although many GPs dislike methadone prescribing

3 Evidence collected by the Working Group has shown that targets have spawned a plethora of unaccountable and un-evaluated services – especially in the field of harm minimisation and young people. They have created a bureaucratic system which is unresponsive to needs of clients, and unsupportive of the services that would meet these needs.

4 Targets have also compromised other 'structured' interventions like day programmes which makes them impossible to evaluate.

> "The mix you get in day programmes (here in the UK) doesn't help. We have a rolling programme so one week you can have a therapeutic atmosphere, good retention and engagement - you can see real changes happening for people - then the group dynamic can change, you get some on Drug Rehabilitation Requirements just ticking the box. You don't get engagement, it sabotages it for those who want to get something out of it."
>
> DAT Commissioner

> "I'd like to see more specialist treatment centres. I do think that residential treatment works, and is probably the only treatment intervention with a real weight of evidence to support the work being done"
>
> Darren Worthington CEO SMART

2.3.2 Jeopardised – the Treatment that Does Work

Abstinence Based Residential Rehabilitation

Neither of the two primary goals of initiation of abstinence and prevention of relapse are incorporated into

the NTA's 'models of care'.[65] This is in marked contrast to both Holland and Sweden where 'achieving abstinence' remains a top policy priority.

Money well spent

Abstinence-based residential rehabilitation costs around £500 per week and treatment duration may be up to 9 months or one year. At £26,000 a year it is significantly cheaper than the (conservative) estimate of £37,500 for maintaining someone in prison.[66] the testimonies of addicts in recovery and the 'graduates' of the therapeutic community and 12 step programmes that operate in residential settings, speak for the importance and efficacy of this service:

> *'You've come from a life of chaos, and you come into here and you're thinking, whooah - it's just full of people all asking after you and supporting you, and you're thinking …this isn't right, nobody has cared about me before… How it works here, it's a self-help community… It's about taking responsibilities, actually taking responsibility for your actions, and standing on your own two feet.'*
>
> Lee, Graduate of adult residential centre Phoenix Futures

Addiction Working Group members with staff and clients at 1NE Beulah Road, an abstinence based structured day care service for recovering alcoholics and their families.

Time and again addicts told us how they needed the time in rehabilitation to change and to work on themselves. Yet there is no budget for residential treatment within the pooled treatment budget despite the NTA's own outcome data. This shows that the most effective and most needed programmes are those of 'Tier 4 interventions' – the tier which includes residential rehabilitation.

The complex 'tiered structure' of care 'interventions' neither reflects nor meets referral workers' own assessments of the treatment needs of individuals. One admissions officer noted that 'they've got a huge amount of people in treatment and the NTA rightly tells you that they've met their targets two years early. How? Because the furthest people are getting is into Tier 3.'[67]

Seeking placement funds from community care funds and local social services departments – the only funding streams for this type of intensive treatment - from 149 different DAT areas has become a major administrative task. This is particularly the case with the removal of ring-fencing for 'Supporting People' funds. This crisis in funding, which the Government has failed to address, has compromised the 2441 beds available in the UK for residential rehabilitation, leading to closures and under occupancy of up to 50 per cent.[68]

---

65 Ghodse, 1995, p.114)

66 £37,500.00 p.a, but the cost of sending a criminal to jail could be more than £49,220 a year, a third more expensive than thought, according to a study by the Centre for Crime and Justice Studies and the Institute of Psychiatry at King's College London

67 Tier Three is typically prescribing services. Residential Rehabilitation is Tier 4

68 Case Study: Empty Beds, Breakdown Britain, Volume 3

A last resort

With no 'block booking', underwriting or otherwise 'securing' of this scarce and specialist service it is treated as a 'last resort' to the detriment of the service and the client. Nick Barton, joint CEO of Action on Addiction, informed the Group that 'you are thrown in at the lowest level, cheapest option, if you fail we'll move you up the scale'. Paul Taylor, Central Regional Manager for Phoenix Futures, reiterated this saying that 'the problem has been…it is the last resort…people tend to use all the other routes first, because they don't cost anything like as much.'

This has not only increased financial cost, but also human and social costs. It means wasted years during which the negative impact of successive treatment failure entrenches addiction, leads to family damage, and often imprisonment.

Currently less than 5 per cent of those in 'treatment' get this 'last resort 'opportunity.

Structured Abstinence Day Care - An unsupported and cost effective resource

The majority of day services commissioned by DATs are typically for those on prescriptions and set low aspirations for recovery with minimal appropriate support. Abstinence day services are rarely commissioned.

> "When we write our service specification (for structured day care) it's really, really hard and I have to do this really carefully, because you don't want to exclude people, there will be people who could come through and manage on a small prescription, who might decide to detox 10 years down the line."
>
> Commissioning Coordinator

Client-focused

Structured 'abstinence-based' day care programmes of the innovative type offered by The Living Room and 1NE Beulah Road are the scarcest though potentially most valuable and cost effective treatment resource.[69] These are more than 'just' Structured Day Care as defined by the NTA: they provide peer support, outreach, childcare facilities, and individual counselling.

It is clear that this abstinence based 'structured day care' is a highly appropriate and effective intervention which seamlessly provides continuing care and understands and manages relapse. It allows for flexible programmes that can be extended according to clients needs, with associated reduced costs while engaging clients in a responsible relationship and setting clear boundaries. But only a tiny minority of DATs commission abstinence-oriented structured day care programmes in the community and even then not fully.[70]

---

69 Addressing costs, section 3.2.5

70 Briefing Paper 'Structured Abstinence Day Care: Case Studies-INE &The Living Room' available at www.povertydebate.com

Some seeking treatment need to get away to a safe residential environment and need to find a fresh start in a new area.

But many want or need to get better in their 'home' environment through structured local day care support and treatment.

Our case studies revealed high levels of client approval along with good outcomes, and typically clients found that their illness was addressed for the first time:

> "Structured day…allows addicts to deal with day-to-day problems such as money, work, family and local community relationships, whilst surrounded by services offering practical help. It provides a realistic setting in which addicts find solutions to break the cycle of addiction…; in residential care clients are unable to put into practice the disciplines learnt until they leave. It keeps families together, reducing the need for children to be taken into care as often occurs with clients in residential care. It is a…cost-effective form of treatment. I would like to see it made more available across the country"
>
> Janis Freely, Clinical Director, The Living Room

> *What this place has done for me is actually show me the sort of illness addiction is, if you like…It teaches you about the illness, what your triggers are, how to cope, you know… just living life on normal terms, really.*
>
> Recovering Alcoholic 1NE Beulah Road

These programmes, like most residential rehabilitation centres and many of the third sector agencies, employ counsellors who are recovering addicts themselves and who have subsequently acquired accredited counselling training. Abstinence-based programmes form healing cycles by producing new generations of recovered addicts who – after appropriate counselling training – go on to heal and help their peers still in need. 1NE, for example, estimates that two-thirds to three-quarters of the project's counsellors trained to run programmes for alcohol users are recovering addicts themselves. Practitioners believe the value of this cannot be overestimated.

> "Recovering addicts often help addicts to feel better understood, not patronised by staff, and are often more aware of subtle nuances in an addict's behaviour that a non-addict may be…Counselling allows recovering alcohol users to give something back. Addicts often dislike do-gooders helping them, but they realise that recovering addicts are not like that"
>
> Jo Blackledge Clinical Director 1NE Beulah Road

The goodwill and commitment that drives such enterprises and keeps them alive cannot be underestimated. Small voluntary and charitable services like 1NE must re-apply for core-funding every year; their future is always uncertain.

A recent review of DAT commissioning tenders showed that no abstinence services were being advertised across the country. The rigid nature of the tiered

models of care system currently run by the NTA and local DATs excludes this effective treatment that can break into the cycle of addiction in a meaningful way.

2.3.3 Needs Unmet

Residential Family Services for Substance Abusing Parents

The current treatment system is also unresponsive to key needs. Our interim report identified the numbers of children at risk from parental substance abuse and their vulnerability themselves to addiction. We referred to the government's failure to implement actions flowing from the widely acclaimed Hidden Harm Report which highlighted the needs of such children and their families.

There are only five residential family services left for parents and their children – including those in which children can visit their parents regularly - yet this is a key service for substance misusing parents.

Three of the remaining services provide for couples and their children. Each is equipped to take only a few families at any one time, making the environment feel like an extended family. Some are limited to single sex occupancy and do not accept pregnant women and/or they lack the intense therapeutic programmes required to deal with substance misuse issues. Scotland's one centre, Brenda House, has recently closed. Phoenix Futures run two of the five services, with therapeutic programmes as the core treatment tool.

> *We've got two centres that work with families, in the majority its single mums, but we also work with mums and dads, or single dads, and any number of children up to eleven. We very often take pregnant women, work with them on detox along with our GP and on other health issues to take them to the end of their pregnancy. Then they will come back to us with the baby, stay with us for six months and we'll work with them on family issues and deal with their addiction and so on. That will cost £1200 a week for that period. I don't know what the health economist would say to that, but my guess is, if that is more expensive, it's not much more than taking a child into the looked after system. The independent sector has the majority of the good examples of how that can be dealt with.*
>
> Bill Puddicombe, former CEO Phoenix Futures

The number of such services has more than halved from 13 in recent years[71], yet the positive outcomes and their potential for change are indisputable. The gap between need and provision could not be wider.

Often, the Family Service is used as a last resort: the families have failed to respond to other interventions that have been offered. Some parents have had several children removed from their care previously, and risk the removal of

71 Ibid

their latest child if they do not complete the placement. The Service has historically taken parents who have entrenched substance misuse histories and chaotic life styles. It remains a fact that over 50 per cent of Family Service parents will have children in the care system.[72]Phoenix Futures Sheffield Family Service's completion statistics are high:

	Number of amilies through the programme	Number/% of completions	Number %f of unplanned departures	Number % of planned departures	Number % completions/ planned departures
JAN 06 – PRESENT	22	16 (73%)	2 (9%)	4 (18%)*	20 (91%)
2006 (JAN -DEC)	15	11 (73%)	1 (6.5%)	3 (20%)	14 (93%)
2007 (year to date)	7	5 (71%)	1 (14%)	1 (14%)	6 (86%)

*out of the 4 planned departures 2 had completed 6-months and were in extensions, 1 completed 4 months and 1 completed 3 months.

Part of the organisation's success is due to 'parents [understanding that they] have a lot to lose and many know that if [they] don't make a go of it, they're going to lose their children'.

In the current treatment climate there are no plans for either expanding or replicating this service, despite its success. Paul Taylor told is if they were thinking about commissioning another family service it would probably be deemed too much of a risk.[73]

Finding the requisite funding for those referred to and accepted by the Centre is an ongoing battle and appears highly dependent on very high levels of commitment, persistence and enterprise of dedicated specialist staff.

Community Family Services for substance abusing parents

Substance misusing families and their children continue, five years after Hidden Harm, to fall into a gap between child protection services and adult-oriented community drug teams/substance misuse services. Their needs go unmet. Adults entering treatment are still

> "I'd like to see Adult Drug and Alcohol Workers working as part of a family service, with Children's Services, with Family Support Services, based on family centres and with health professionals, nurses, and health visitors thrown in - encouraging early referrals from antenatal clinics and of people who are perhaps not so drug dependent, but binge drinking, cannabis use, but not yet the severe opiate use that we get in our care proceedings, referred into that service. "
>
> Michael Murphy, University of Salford

72 Trevor Sandford Service Manager Phoenix Futures Sheffield Family Service
73 Paul Taylor, Central Regional Services Manger for Phoenix Futures

not routinely asked whether they have children and what their family responsibilities are.[74]

Across the child care sector there is painful awareness of the lack of any 'incentives' for investment in and provision of, interagency work between child protection, substance abuse and family work. The lack of targets in relation to the crucial groups of children who suffer from parental substance misuse was found odd. Staff at the Bolton 360 project told us that the lack of integrated services leads to family break-up; that substance abusing parents deteriorate and give up on the loss of their children to care and adoption.

Addiction Working Group visit to an adolescent residential rehabilitation service at The Priory, North London

The call for a fully funded and supported flexible, interagency and whole family approach was repeatedly made by organisations involved in family services.

> *We have a high correlation between children we're worried about, on the child protection register and coming into the looked-after system and some of the younger ones, going through to adoption, with chronic substance misusing parents. We'd had an interest in developing whole-family type approaches…the Community Drug and Alcohol Team were working with the adults, and Children's Services were working with the children …we couldn't get a serious commitment from the Community Drug Team to do the work with the adults at the Family Centre…some of it is about their targets for their work and what they have to report on. There is no target that I know of for adult CDATs which is about changing (their clients) into being better parents. There's no performance indicators like reducing the number of children where substance misuse is a major feature in their abuse on the child protection register.*
>
> Staff at Bolton's 360 Services

Local level initiatives like the Safer Families Project in Bolton, developed to provide services for families whose children were assessed to be in need of support, protection or in 'the looked after' system, received just six months of experimental funding – too short a time to test and assess the project. Most parents referred were poly substance abusers.

Even basic crèche support for parents in adult treatment programmes is scarce. The Living Room runs what they believe to be one of only thirteen in the country. Janis Freely, The Clinical Director has seen the damage to children of being taken away from their parents, the damage of separation to the mother as well, damage that could cause relapse even in residential care.[75]

---

74 *Breakdown Britain* Volume 3, 2006

75 The Living Room's structured day care programme is for clients seeking help with a wide range of addictions.

Adolescent Services - A Cause for Concern

Of the 15,999 young people under 18 receiving specialist drug treatment in 2005/06, the age range is from nine to 17, with 77 per cent aged between 15 and 17. Of the total, 10,485 (66 per cent) were male, 5,514 (34 per cent) were female.

The NTA's treatment objectives involve shared and timed targets with the Youth Justice Board. Their overarching target for young people is to increase the number of under 18s in specialist treatment by 50 per cent by 2008, against the 2004 baseline - a target already met. Provisional National DrugsTreatment Monitoring Survey data for 2005/06 has already identified 17,000 young people in specialist treatment, suggesting that this target has been significantly exceeded.[76]

Given the complex nature of substance abusing adolescents' needs, as identified in our interim report[77], such a target driven policy runs the risk of becoming a negative investment. The current approach to these young people appears complacent, seems to lack practical coherence and is not sufficiently robust. Yvonne Lloyd, Senior Communication Officer at the NTA, said 'few of the 15,999 have a severity of drug dependency which would require treatment were they adults.'

> "652 individuals are in treatment as a consequence of heroin use (not all of whom will be dependent), 439 for cocaine use and 179 for crack. Whilst the fact that over 1,000 under 18s are in treatment for their use of the most problematic Class A drugs is disturbing, it would be misleading to assume that all those who are in treatment are dependent Class A drug users… many young people will use substances for only a short time, reflecting the normal pattern of adolescent experimentation. Maintenance based treatments are therefore rarely relevant. Similarly, as most young people have not yet developed dependency, detoxification is not a frequently used treatment option. It is therefore inappropriate to think of young people's treatment as being provided for 'addicts'."
>
> Yvonne Lloyd, Senior Communications Officer NTA

The Addiction Working Group found it worrying that the NTA defines stance misuse treatment for young people in adult 'harm reduction', rather than 'recovery' and prevention terms. We were told in relation to young people that: 'A care planned medical or psycho social intervention aimed at resolving dependence, 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.'[78]

Yet there appears to be no defined strategy to deal with the 54 per cent of young addicts presenting with problems arising from cannabis, or the 29 per cent with problems arising from alcohol. We found no stated objectives in rela-

76 NTA Business Plan 2006/2007
77 Breakdown Britain Vol 3 chapters 3 &4
78 Information supplied by Yvonne Lloyd, Senior Communication Officer, NTA

tion to prevention or reduction of cannabis consumption set out by the NTA in relation to adolescent service guidance.[79] Approximately 40 per cent of referrals come through the criminal justice system. For many of these, alcohol and/or cannabis use will be responded to as part of a pattern of inappropriate behaviour linked to, but not necessarily causing, offending.[80]

Limited expectations and harm reduction ethos

The NTA describe young peoples' substance misuse services as working with a range of young people who are experiencing problems in their lives around family relationships, school attendance or offending, and whose problems will be accompanied or exacerbated, but rarely caused by, their use of alcohol or drugs.[81] They claim that treatment services work closely with children's services, schools and youth offending teams to address the substance misuse component of the young person's problematic behaviour.

However prescribing interventions and 'support into prescribing treatment with adult service' were listed as key interventions in many of the DAT's commissioned services, suggesting a widespread acceptance of 'the inevitability' of adolescent drug use leading to life time problematic drug use.

> *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'm going to be able to do to get them out of it…Some people we can divert, because we will be able to engage with them through that process… the length of time of a sort of typical career is going to be at least 10 years.'*
>
> A DAT Coordinator

This is one example from our evidence collecting of how unreflective services appeared to be with regards to young people, a view shared by Professor Neil McKeganey, a leading expert in drugs misuse: 'The idea of starting someone under 18 on a methadone prescription with an implicit expectation that they may be on that drug for the next ten or more years is appalling. We need services to think beyond the chemical inducement into therapy.'

The services offered vary area by area. The majority are 'tier 3', but some straddle the line between tiers 2/3. There is no residential provision. Some are specifically commissioned for 'tier 2' such as preventative work in schools. Many service sites have provision for prescribing. Some link in with the adult services, some have specialist young people prescribing, some buy in G.P time. Although prescribing is a minority[82] the provision is clearly there. Most are pre-

---

79 For our policy proposals see Part Two Policies

80 Information provided by Yvonne Lloyd, Senior Communications Officer NTA

81 Ibid

82 Similarly, the Early Break Project have a few young people in receipt of specialist prescribing: 'In the one to one work we offer a prescribing service, a young people treatment service in East Lancashire, and in Bury and Rochdale we can support young people into treatment through our advocacy work. Counselling is a low threshold intervention, to prescribing, needle exchange - high threshold interventions, so we offer that range. Substitute medications if needed, so it could be methadone, naltrexone… but we've only got about five . . . six young people in receipt of alternative prescribing'

scribed Subutex - deemed more appropriate 'for younger people who have less entrenched addictions, especially as the young people tend to be smoking rather than injecting at this stage.'[83]

> "I don't think you can stop it, I think you can only reduce the number, because there are some people who are going to be hell-bent on this, and that's just about them and their personalities, and lots of complex things, we make the transition into the adult system as smooth as possible for them."
>
> Adolescent Services Manager

Services in the field range from 'one to one' work, counselling, life skills, acupuncture, sports therapy to Indian Head massage and pregnancy support. Some young people's services appeared to be trapped in the same thinking as adult services, with a sense of inevitability that this is where they are headed, aiming to make the transition into the adult system as soon as possible.

A Planning and Accountability Gap

While delineating specific funding for young people is important, accountability and planning is critical. Those things that are absent in many drug services at the moment include, the lack of training, supervision on a regular basis, and a systemic approach, looking which looks at multiple needs-mental health, educational, and child protection needs across the board.[84]

We found that there are a number of different services, initiatives and providers, each with substantial budget allocations, operating in this field: Connexions, the Youth Justice Board's Youth Inclusion Programmes, local authority youth services in addition to the services commissioned by the DATs, all with an interest in or concern with adolescent substance misuse. This creates a multiplicity of different workers and agencies between which an adolescent may get passed. None seem to be offering either holistic interventions nor robust structures.

> "One of the big problems is that addicted parents are getting their own children on drugs… if I had to prioritise, I would identify all the adults who are addicts who have children. I would put the children of addicts as the number one target."
>
> Camila Batmangheldidj, Kids Company

Cannabis is identified as the main problem – 75 per cent of young people on Crime Concern's Youth Inclusion Programmes have issues with cannabis and other drugs, up to 80 per cent have problems with alcohol.[85] Crime Concern

---

83 Addaction Young People's services

84 Dr Mirza, Hon Senior Lecturer and Consultant Adolescent Psychiatrist, Institute of Psychiatry, London and South London and Maudsley NHS Trust

85 Crime Concern manage targeted youth crime prevention projects in approximately seventy neighbourhoods, working with 'at risk' young people aged from 8 to 25. These projects include Youth Justice Board funded Youth Inclusion Projects, Children's' Trust funded Junior Youth Inclusion Projects and Home Office funded Positive Futures projects.

further reports that many have problems caused by parental substance misuse and by parental acceptance of cannabis use as normal.

Getting a referral to an addiction psychiatrist remains a challenge, and almost impossible for many adolescents with addiction problems. Dr Mirza highlighted the difficulties he encountered when establishing a service in Lambeth. With the new funding available he was only able to get three staff members to create a network of services, with Social Services, with Youth Offending Teams and a number of voluntary agencies like Kid's Company, to form a network of clinicians. The idea was for young people under the age of 18 to walk into any of these services and access help, if they felt that they had a psychiatric problem.

The lack of planning, accountability and robust intervention means that too many adolescents are vulnerable to death and overdose from drug abuse. The current culture of acceptance of drug use by young people leaves parents bewildered, desperate and unsupported. Susan Garner lost her son to drug misuse, and in Luke's Story, describes her powerlessness and the lack of help available

> *I believe cannabis changed my son's personality, Luke became paranoid and his self-esteem plummeted. At 14 Luke suddenly started going round with a different group of friends. He went out and didn't come home at his usual time, he became unpredictable, moody and difficult to talk to…I had him arrested from our home for taking money from me for cannabis. I tried everyone - Social Services, the Police and Health Professionals, as well as my family, nobody seemed to have any answers… January 2001, I received a telephone call, Luke was in Harrogate Hospital, he had overdosed on Heroin – this was the first time I knew that Heroin was involved… one night he did not come home. The following day…I went to work, very concerned. At 9.45 am a colleague came into my office, took me by the hand and led me out of the room, into an empty office – she did not have to say anything: I knew my son was dead.*
>
> Extracts from 'Luke's Story' by kind permission of his mother, Susan Garner

Children in Care

The needs of some of the young people who are most vulnerable to substance abuse – those whose parents are substance misusers and those in 'the looked after' system – remain unmet:

> *Unfortunately there's not been a plan to implement the Hidden Harm Report (which recommended that substance abusing parents should be asked whether they have children when accessing treatment services), and there was no accountability in terms of how you can implement that.*
>
> Dr Mirza, Hon Senior Lecturer and Consultant Adolescent Psychiatrist

Projects like Early Break in Bolton, which has won DAT young people's contracts in three local areas, are still facing a system in which the number of 'accommodated children' in their area, and those in hostels who have left care, is not known. There still seems to be no formal route by which such children can be accessed by adolescent substance workers. Vicky Tatlock from Early Break told the Group that 'in terms of the number of private care homes in this area, I wouldn't know how many there are and neither would social care services… that is a very real issue, in terms of the most vulnerable children in our society'.

Residential Adolescent Provision

When compared to either Sweden or America the near total lack of adolescent residential provision in the UK is startling.

> "If it was a child of your own, that's what you would want."
>
> Barbara Jacks, Early Break

Middlegate

In the UK there is only one small residential rehabilitation centre for young people where places are funded by statutory services. Middlegate has been in existence for 12 years providing 'tier 4' residential care for young people between the ages of 11 and 17 years. They run a 12 week treatment programme which is tailored to the individual. Treatment is in a "domestic" style environment, with well structured and clearly set boundaries providing detoxification and rehabilitation, plus reintroduction into education. Health and social needs are also looked after. They operate zero tolerance to drugs on the premises.

Middlegate is registered as a Children's Home and is therefore subject to the full and rigorous scrutiny of The Commission for Social Care Inspection on a regular basis and was recently described as a 4 star organisation.

Their considerable success is illustrated by recent analysis of a sample of 25 per cent of their residents:

- 100% had failed to follow at least 1 previous "Community" Programme
- 75% had been engaged in theft
- 78% completed the Programme (current figures would suggest that this is now 82%)
- In all cases blood screening showed that the Young Persons health status had improved and/or returned to normal during their stay at Middlegate
- 92% engaged in GSCE or ASDAN work

The young people who go to Middlegate are at the end of the line: it is a last resort once everything has been tried and failed. The young people are in a very poor state of health, usually poly-substance users, and have generally begun

> "Getting them off whatever substance they have been using is generally the easy bit. It is once you get to this stage and start to uncover the reasons for their addiction that the real work starts. A lot of them are abused children, either sexually, physically or emotionally, really very sad. Treatment within their own communities is not necessarily the best option - you would not consider leaving a sexually abused young person in their own environment, why should this not apply to all abused children."
>
> Fred Henry, Liaison Director, Middlegate Lodge

their substance abusing careers with alcohol.[86] Their self professed reasons for taking drugs ranged from abuse, being bullied, disliking themselves, strained family relationships, being excluded from school and lack of parental control. In terms of follow-up the adolescents are handed back over to their local social services, 'who generally don't want Middlegate to follow them up in the community'.

Its reputation within the sector is good, with one Early Break worker commenting that 'Middlegate would work with sixteen and seventeen and under if needs be, and have done so very successfully, but it's tripartite of course. It's social care, education, and health… It's twenty-four hour care…it's intensive care, it's high staff ratios and so on'.

Despite its record of success, lack of secured funding has resulted in the temporary closure of half of this rare and important facility. It would seem that those involved in Commissioning services for Young People with addiction problems are often managers without a real knowledge or understanding of either the needs or the services available.

The very few other adolescent addiction residential services operate entirely in the private sector. One of these at The Priory in Enfield has introduced an innovative programme for adolescent abstinence programmes with family engagement. Unlike statutory young people's services The Priory is confronting growth of cannabis use and associated mental health problems head on and regards it as urgent It runs an adolescent mental health/psychiatric unit which operates almost exclusively on NHS and local PCT contracts but its more recent residential adolescent addiction unit does not.

> *It's a new venture for us, so we're just doing it very slowly. Our model is very simple: all patients, the moment they come in, are quickly assessed. We decide whether we need them to have a detox or not and at the same time they are put into group process, because one of the most important curative factors in my view is the bonding with their peer group… it's an open group, so there are people who are coming to the end of their treat-*

86 58% had family members with problem alcohol use, 79% with drug use, 58% had used heroin, 83% had used cannabis, and 40% crack. In age they ranged from 14-17, and 84% had been excluded from or did not attend school

ment and people who are starting their first day, all in the same group. After they've finished their day care, they then will do one to one work. Then we have aftercare for a year, one evening a week, which is free. They come to that, and that is all part of the package.

Dr Neil Brenner, The Priory, North London

Robust interventions as provided by Middlegate Lodge and The Priory – routine at an early stage in Sweden where drug and alcohol abuse rates amongst adolescents are significantly lower – are scarce and largely unfunded in Britain. That adolescents are being failed is clear.

Alcohol – The Ignored Addiction

The distinction drawn between alcohol and other addictions is a curious feature of UK practice. Sweden and Holland, the two countries most often invoked as providing preferable or more effective drugs policies than the UK, embrace all addictions and do not compartmentalise drugs and alcohol. The UK effectively excludes 'alcoholics' from treatment.[87]

> "The amount of independent policy work that is being done around alcohol at the moment is pitifully low. Given that maybe ten per cent of the population are in some way affected by it, maybe more than that, we're concentrating on drugs, drugs, drugs, which seriously affects, what maybe one sixth of the number of people that alcohol is seriously harming, and yet, there are less organisations, attention, and policy funded, working on the issues on alcohol."
>
> NHS Addiction Psychiatrist

In 2004/05, there were around 35,600 NHS hospital admissions with a primary diagnosis of mental and behavioural disorders due to alcohol. Around two thirds (68 per cent) of NHS admissions with this primary diagnosis were men.

Yet in 2004 it was estimated that only one in eighteen people with alcohol problems in England gets help.[88]

The evidence we received from various specialists working in this field is that the order of the problems associated with alcohol misuse is not being acknowledged or responded to by either central government or local statutory services.

In contrast to the information collected for Supporting People funding which indicates that 10 per cent of people being admitted to Salvation Army homeless centres have significant alcohol problems, the real numbers are like 80 per cent, and 30-50 per cent with mental health

87 The voluntary residential sector has, historically, responded to all addictions and addiction psychiatrists treat multiple addictions

88 ANARPS

problems. There is a very strong link between alcohol and mental health…to date we have very limited information as to the extent of severe and enduring mental health conditions including psychosis and personality disorders. There's a major reporting problem here in the way the data is collected, again it's not the real picture being presented to government for funding purposes. The relationships between alcohol and mental health, alcohol and cognitive function present a worrying trend - increasing levels of enduring mental health problems in the socially excluded population, and link with alcohol in particular.

Dr Adrian Bonner, Reader and Director of the Addictive Behaviour Group, Division of Psychiatry, Kent Institute of Medicine and Health Sciences

All addiction specialists we spoke to expressed grave concern about the widespread lack of awareness of the negative health and mental health implications of alcohol abuse.

'There is irrefutable evidence that alcohol and nutritional deficits, in particular Vitamin B1, are a very strong marker for secondary brain damage. Professor Chris Cook and Dr Alan Thompson have developed the guidelines, adopted by the BMA people with alcohol problems being admitted to hospital A&E departments. This is aimed at protecting the brain from alcohol related damaged by IV injections of vitamin B1 (Thiamine). In addition to long term alcoholics there is increasing numbers of "at-risk" people, including young people (in their twenties) who are at risk for liver damage and potentially brain damage due to their drinking behaviour. The nutritional status of these vulnerable groups need to be properly assessed with a view to addressing deficiencies in Vitamin B1. We're trying to move this work from a hospital setting to the community, for instance by considering the 30,000 people in Salvation Army homeless centres, with the possibility of pre-clinical interventions, and early and interventions to arrest further potential decline in brain function.

Dr Adrian Bonner

Further concern that spiralling alcohol-induced harms and costs have been met with service closure – both inpatient detox beds throughout the NHS and community services – was expressed to us.

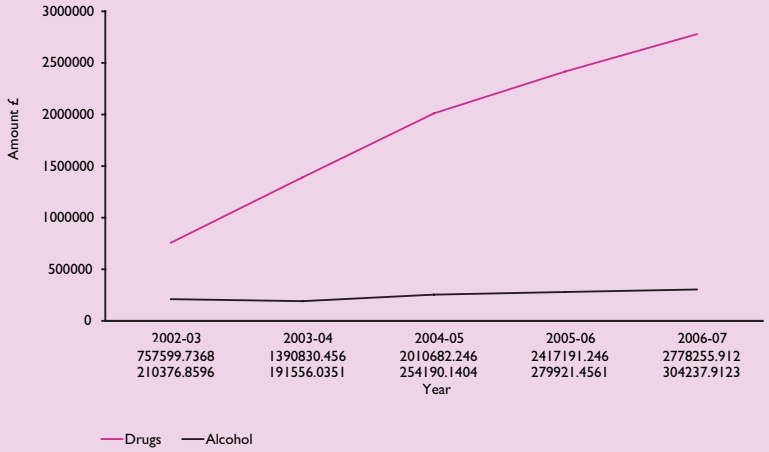
In response to this the Deputy Chair of the Addictions Working Group, David Burrowes MP, wrote to all Primary Care Trusts to request information on their total expenditure on drug and alcohol treatment as a freedom of information request. They were asked to provide expenditure figures for the three items below:

1 Total Annual Spending on drug and alcohol treatment for each of the past 5 years.

2 Spending on drug and alcohol treatment as a percentage of the total annual budget for each of the past 5 years.
3 Breakdown of the amount of spending on Tier 1, Tier 2, Tier 3, Tier 4 drug and alcohol treatment for each of the past 5 years.

The results computed in Chart A indicate that whilst average spending on drug treatment has risen steadily over the past 5 years, in comparison spending on alcohol treatment shows very modest growth and is but a tiny fraction of drugs spending.

Chart A
Comparison between average PCT spend on drug and alcohol treatment for the past 5 years.
Average PCT spending on drug and alcohol treatment



Only 'creative' Drug Action Team Coordinators are finding ways to purchase alcohol treatment at all.

> *You've got the structured day care and counselling services, I would say by and large across the county – funded through drugs finance, which is very explicit around drugs, and can only be used for alcohol where it's a secondary drug problem. So essentially they are very, very tightly monitored by the NTA, quite appropriately, and so you've got to find quite ingenious ways of helping them to provide an alcohol service. Now, the way that we've been able to manage to do that is to shift over, on paper, PCT core finance… which allows them to provide a drug and alcohol service, albeit for the alcohol users it's more of a self-help route, and it's a pathway that is very, very limited, basically, support groups more than anything for alcohol.*
>
> DAT Coordinator

Exceptional DAT areas are pro-active in raising funds to support new initiatives and intervention but this is against a background of cuts in statutory serv-

ices and third sector alcohol services struggling for survival under the current 'drugs' commissioning system.

As mentioned earlier, 1NE Beulah Road, which runs a rare but successful and cost effective abstinence structured day care programme for alcohol, only manages to secure short term and partial funding because of a highly 'enlightened' local DAT commissioner. A significant proportion of those using the service are referred from the statutory sector after inpatient detoxification.[89]

Poly-Substance Abuse – A Disregarded Fact and 'unintended outcome'

The national treatment hegemony is unresponsive to the reality of complex addiction profiles and to co-morbidity in the population. It is also adding to this problem through widespread substitute prescribing as one local drugs counselor told us:

> "The way I think of an addict is like an umbrella. There are lots of segments in an umbrella, and they can be for drug, alcohol, sex, gambling, food, shopping, and relationships and if you just treat one segment of the umbrella, they just move round to another segment. . . and that's called cross-addiction. It's something that's very often missed - that you have to treat the whole addiction process... The other problems with addiction are co-morbidity, where they have other illnesses attached, such as depression, schizophrenia, manic depression and vast amount of people with major mental illness problems who are then starting to use drugs and alcohol."
>
> Dr Neil Brenner, The Priory, North London

"The problem of alcohol and crack use amongst methadone patients is becoming a major problem within Stockton with negative effects on the local community, family life, treatment services and society as a whole. Patients become aggressive, unpredictable, temperamental and unreliable. Although heroin related crime has mainly lowered there has been in increase in the crimes associated with alcohol and crack use which is violent crime and anti-social behaviour… it is becoming increasingly difficult to work with these poly-drug use clients. We have had acts of aggression and violence never seen before. These clients often want to get off drugs but are not being an offered an effective way out. A client recently commented how she had breached her probation more than 40 times in the hope that that she could go to prison to have a break from her drug and alcohol use and the associated devastating life that accompanies that use."

Harm reduction strategies appear to be contributing to poly-substance abuse and the NTA's tiered intervention system of care is ill equipped to deal with the

89 INE Beulah Road, A Case Study in effective and cost effective abstinence day care.

reality.A patient who is severely addicted to opiates and stimulants may require a community prescription for substitute prescription (such as methadone or Subutex) which is a Tier 3 intervention, but the services for stimulant users comes under Tier 2 services, thus there is a possibility that the same patient may have to receive one part of his/her treatment from a Tier 3 service whilst the Tier 2 service is provided by another. The interface between two different providers can cause difficulties, and make collaborative work difficult.[90] Many patients with complex poly-substance, addiction and mental health problems end up as long term hospital inpatients with nowhere else to go; others may 'present' for the first time through NHS Accident and Emergency Units:

> *In A&E there is frequently a queue of people who have taken an overdose the night before. One example is a 36 year old professional who had taken an overdose following feeling "really, really anxious". He had been finding work extremely difficult to cope with over the last few weeks, and described feeling anxious, pacing and not being able to concentrate. His alcohol intake had increased and he was using alcohol to self-medicate feelings of anxiety, which had been made worse with cocaine abuse. He had no insight into the fact that cocaine may cause anxiety symptoms to worsen, nor the fact that cocaine had contributed to his financial difficulties. He thought cocaine was something everybody does and it is freely available.*
>
> Dr Michelle Tempest Cambridgeshire and Peterborough Mental Health Trust

The day to day contradictions a referring psychiatrist confronts in the current system when dealing with poly-substance abuse are that:

- A patient may be addicted to both illicit substances and alcohol, yet there is a division between the illicit substance services and alcohol services. For example, one service may not treat illicit drug abuse until the patient is detoxed from alcohol; yet the alcohol services may not detox the patient whilst addicted to illicit drugs. Hence, the patient does not get access to appropriate treatment.
- In patient detox beds have been closed. Within all detox programmes there are wide variations between 'best practise'.
- The centrally controlled opiate abuse targets have meant that more money has been available for opiate users – that is a good thing. However, the services for other illicit drug abuse, such as cocaine, amphetamines etc, have suffered as a consequence. In some areas funding has been solely used for opiate abuse services, to the exclusion of services for other illicit drugs. This is counter intuitive as latest drug trends illustrates that opiate use has stabilised, but there is an increasing and unmet need for other illicit drug abuse services.

---

90 Dr Michelle Tempest

- Money for start up programmes is often at the expense of long term stabilisation. Addicts need more than just a short sharp fix; long term support needs to be provided. For example, in some areas alcohol day services (such as group therapy or community groups) have been forced to close. This lack of long term holistic care has meant that rates of relapse have increased.
- The long term consequences of drugs and alcohol, such as brain damage, are often overlooked. Patients who unfortunately suffer brain damage face long hospital admissions and Social Services struggle to find suitable community placements and struggle to allocate a funding body. These patients fall at the interface of NHS Hospital Trusts, Mental Health Trusts, DATs, PCTs and SS.[91]

2.3.4 Public health harm reduction?

Harm reduction services are classified as drugs treatment by the National Treatment Agency and by the Drug Action Teams that commission them. More accurately they would be described as public health and clinical interventions to mitigate or manage a range of problems caused by drug use to society and the individual user.

A lack of transparency about what constitutes treatment is a key dimension of drugs policy failure. There has been inadequate open discussion of the correct balance of investment in services to address different orders of problems – public health and clinical issues associated with drug use on the one hand and addiction treatment (with a view to becoming drugs free) on the other. To date 'harm reduction' has dominated the drugs budget and the drugs services available, regardless of the goals and aspirations of drug users. It has served to entrench addiction by making drug use so viable.

Provision is well developed though of poor quality. 97 per cent of all DAT areas now have harm reduction services (harm minimisation and outreach services) and 87 per cent give access to drug prescribing services. This contrasts with the marked absence of recovery service in the community or in residential settings.

An analysis of the balance of treatment as deduced from the Treatment Plans for all DATs in the South East region shows that routinely over 10 times more Tier Three 'harm reduction' treatment is commissioned per client than Tier 4 (the tier that includes residential and abstinence treatment).

Differentiating between interventions on the basis described above serves to illustrate the public health emphasis of the 'treatment system'. Such an analysis is not to dismiss the importance of reducing public health risk; this should be one of the key aims of an effective drug strategy.[92] However, there is an imbalance of investment arising from a lack of evaluation and a lack of emphasis on

91 Evidence from Dr Michelle Tempest and Dr Nadir Omara
92 NTA, Business Plan 2005/06, 2005, p.18

a holistic concept of recovery, from which both public health and crime reduction outcomes could be effectively derived.

Harm reduction in practice

Harm reduction services were originally designed with the purpose of comprehensively reducing health harms and the spread of BBV (blood borne viruses) problems associated with drug use. Many services are failing to do this and may in fact be contributing to greater public health problems. We detailed the significant failings in our interim report.[93] In addition the NTA's Prescribing Audit report found:

> "When we look at needle syringe exchange there has been a virtual collapse in the services emphasising the health risks associated with injecting use and an encouragement to get into treatment. The pharmacy led services have allowed a greater access to clean needles but have been at a cost of losing the public health issues."
>
> Martin Blakebrough CEO Kaleidoscope

- Overdose prevention measures were lacking. A substantial number of injectors appear to have had no support or risk assessment in terms of injecting practices, hygiene or techniques.
- In many areas, needle exchanges simply work to distribute and return needles without any of the harm reduction measures such a scheme is designed to take advantage of.
- Estimations suggest one syringe was given to clients every two days which clearly is not enough to prevent exchange or clean injections, especially when the injecting behaviour of some users will include the regular use of stimulants.[94]

Both the localised commissioning of prescribing and harm minimisation services by DATs and the spread of responsibility for public health and clinical services between the statutory national health sector, the third sector and the private sector (pharmacies) may have undermined effective and efficient management.

In Suffolk, the community prescribing is undertaken by the Community Drug Team which is part of the Mental Health Trust, but the services for Blood-borne Viruses is undertaken by the Blood-borne Virus Project which is part of the Primary Care Trust. The patient has to be referred to the BBV in order to receive their blood checks. In turn this creates anoth-

93 Injectors in half of all DAT's were denied access to viral testing on site in needle exchange services and 40 per cent of DAT's had no immunisation on site. Approximately 40 per cent of needle exchanges failed to address Hepatitis B immunisation and testing for BBV's when assessing new clients. One third did not discuss injecting hygiene and safer injecting techniques.

94 Findings of a survey of needle exchanges in England, NTA, May 2006

er difficulty. Whilst the HMP undertakes the blood tests for liver and hepatitis serology, the BBV declines to undertake the blood tests for other tests such full blood count and thyroid function. These tests require the same blood bottle and nothing further. The reason for their refusal is because the BBV is not funded for any other test!

Dr Nadir Omara Suffolk NHS Mental Trust

National Hepatitis C and drugs related deaths trends suggest more fundamental flaws in the harm reduction philosophy.By the end of 2003 a total of 38,352 cases of Hepatitis C had been diagnosed in England, over 90 per cent of which are thought to have been acquired as a result of injecting drug use (HPA 2004). In Scotland similarly 90 per cent were known to have injected drugs (HPA 2004). Bloor and colleagues have recently reported that as many as 60 per cent of injecting drug users in contact with drug treatment services in Glasgow may be HCV positive (Bloor et al 2006), all the more striking when one considers that for much of the nineties to the present day Glasgow has had a well supported, city wide, network of needle and syringe exchange schemes (EIU 2003).[95]

Drugs related deaths statistics similarly suggest that harm reduction in public health terms is failing. The decline in the number of drug related deaths in England and Wales, with the number of heroin and morphine related deaths falling from 926 in 2000 to 744 in 2004 is hardly commensurate with a successful harm reduction campaign that still leaves hundreds of drug users dying prematurely each year (ONS: 2006). Indeed, for the period 1993 to 2000 (a key period in the impact of harm reduction ideas within the U.K.) deaths from heroin and morphine in England and Wales actually increased from 187 in 1993 to 926 in 2000 (ONS: 2002).[96]

The harm reduction approach assumes rational and responsible behaviour but everything about drug lifestyles and addiction suggests that the line between harm reduction and promoting drug use is a fine one. Former addicts have given us their view of needle exchanges:

The problem of seeing the needle is the anticipation for the drug clicks the brain on immediately and the longing for the drug is immediately there. If you go to snort cocaine you start getting excited and you start having the cocaine rush the minute the mirror is brought out – it's the Pavlovian response – the minute the bell is rung you salivate. That is what happens when you see the needle, to the point where you could probably just stick the needle in you and that would work for the first half hour. If you have a needle exchange the effect is that it will import the dealers outside – the customer is at his most needy as soon as he has got his new needle – you

95 Neil McKeganey, The Lure and Loss of Harm Reduction, op cit
96 ibid

get a new needle in order to inject - the anticipation of the drug is so intense that if the drug isn't there for you what is the point of having the new needle?

Former drug addict

Addiction Working Group trip to the Netherlands

Harm reduction is the central plank of this government's drugs strategy and dominates the use of the pooled treatment budget but the implications for its effective management especially when dealing with a chaotic clientele appears not to have been fully thought through. Services have been 'rolled out' nationwide through local commissioning without proper testing, monitoring, evaluation or accountability, sustaining drug use but not effectively minimising health harms. Policy and funding preference for these services leaves the addict who aspires to recovery with little support and even less choice.[97]

2.3.5 Negative criminal justice interventions

The approach of focusing policy on crime reduction as opposed to recovery creates the perception (if not the reality) of unfairly demoting those who seek treatment voluntarily:

The potential value of using the criminal justice system as a route to treatment and a constructive alternative to prison is not in dispute. How this policy has been carried out by this Government's Drugs Intervention Programmes is. Coercive but misconceived treatment interventions, along with the failure to treat and rehabilitate prisoners (who constitute the most concentrated population of 'problem' alcohol and drug users) is entrenching addiction further.

Drugs Intervention Programmes

The 'roll out' of Drugs Intervention Programmes and Drugs Rehabilitation Requirements has continued despite the poor evidence base on re-offending[98]. A systematic reviewof treatment evaluations commissioned by the Home Office concluded that there is strong evidence that the most effective interventions to reduce drug-related crime are therapeutic communities and drug courts. The critical factor is therefore not 'treatment' per se, but a particular type of treatment.A full analysis and critical perspective on these policy initiatives was published in our interim report.

However, under Labour targets rather than the 'type of treatment' have dictated Drugs Intervention Programmes. We found that 'spin' about their success has left arrest referral workers disillusioned:

97 Briefing: 'A Perspective on the Commissioning of Recovery', Available at www.povertydebate.com (reproduced by kind permission of the Centre for Policy Studies)

98 Holloway, K., Bennett, T. and Farrington, D., The effectiveness of criminal justice and treatment programmes in reducing drug-related crime: a systematic review, Home Office, 2005, available at http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr2605.pdf

We're being told constantly that DIP is succeeding - I'm not really seeing the evidence to suggest that what's happening today was better than the previous model. Custody is a great place for accessing people because the consequences of their actions are all too real for them at that point. I mean, 65 per cent of the people we used to assess would go on to have a treatment intervention, a long-term treatment intervention in some cases. All I see now is people coming back to the service, because treatment has failed, or the treatment they were told to go into had failed. This is the first criticism of DIP.

Arrest referral worker

The high levels of re-offending rates and revocations of orders detailed in our interim report are not surprising in light of evidence of such cynicism, alongside the inherent limitations of methadone maintenance already detailed.[99]

DIP and DRR workers can be wasting time and resources by not being allowed to judge on the basis of their own experience which drug users would be motivated at this point to be able to take advantage of treatment.

The processing of arrestees takes precedence over any analysis of their problems, their individual circumstances and treatment needs:

We assess probably about 60 new clients every month. And then we've got ongoing caseloads, each staff member has anywhere between eight and twelve, so there'll be case managing these people through their treatment process… getting them into structured tier treatment, but they'll also be picking new clients up, so it's a bit of a rolling programme…And with the rapid prescribing - because we've got the nurses as part of a team, if they think they're going to get a prescription, they are much less likely to turn it down.

Arrest Referral Worker

The complaint from our witnesses is that too many resources are going into achieving targets rather than being spent on quality interventions and that a more sensible balance needs to be struck across the system.

I've got a team of 19 workers in one location and 14 or 15 of those have the main responsibility of sitting in a custody suite processing people that have been tested positive through the DIP programme. That's 14 or 15 trained workers focussing their time on meeting one key government target. That's 14 or 15 trained people…losing motivation and skills because we have to satisfy that one target above all others. I'd prefer to use those bodies more creatively … but the persistent threat of not meeting that golden 'compact' forces my hand in a way that doesn't add up whichever

99 Breakdown Britain Volume 3 (Addiction) 2006, pp41-147

way you cut it. Effective drug work is not just assessing and making a referral into treatment, these people need to be closely managed by workers who use their skills to optimise the outcomes without the sword of Damocles hanging over them.

Darren Worthington CEO SMART

At the moment, processing and bureaucracy takes precedence over the development of any ongoing therapeutic relationship:

The paperwork must take up 30 per cent of people's time. A twenty-one page DIR form, a seventeen page triage document, a risk assessment, and then you've got a referral document. And that's just from picking up one client in custody, you may well have to complete maybe fifty, sixty, pieces of paper …

DIP Contract CEO

The quality of the intervention and the potential skills of the drugs worker have been sacrificed on the alter of targets:

I would create a system that's got more emphasis on the quality of intervention, you know, the real meaty stuff that matters - not just assessing and making a referral into treatment. If you're pulling somebody out of chaos, you know, you need to settle that person down for a while. People strike up a relationship with a drugs worker, that is a big ask of any individual, to trust somebody. So they meet the worker, they trust that person, it takes some time, they have established a rapport, established a relationship, and then it's: 'well, I've got to pass you on to another drugs worker now'.

Darren Worthington CEO SMART

We were given evidence of some Drugs Intervention Programmes in some areas abusing the target system:

It was a required target that DIP's engage with a certain number of clients. My local DIP were achieving 100 per cent. When a neighbouring DAT asked how they were getting such good statistics they said that any client registered with the project was given a care plan form on which they wrote the persons name and wrote within the plan (section of the form) "made a referral to DIP team". They then got the client to sign the form and this was the completed care plan. From the outside, it looked as though this DIP team were performing brilliantly and after all, they were achieving 100 per cent of their care plan target. Obviously this had no impact at all, upon the person's drug use or any other aspect of their life.

Jessie Jacobs, Head of a Christain Addiction Support Project

Drugs Courts

The Government has introduced two experimental drug courts – one in Leeds and one in West London.[100] They indicate significant potential for success, not least because of the leadership and commitment of the judge involved.[101]

> *The crucial thing was the very informal environment of the drugs court although it's still a very nerve wracking experience, because he's still a judge and he can still send you to prison… There was this, 'look, you're on a review, we want you to get drug-free,' and they start talking to you, and Judge Justin, in my case, was saying, 'come on, you've got to give some negative tests', and there was encouragement, which is such a different way of interacting with someone in authority, it was a bit disconcerting in a sort of nice way… not what you expect. And then you start to think that they actually cared about you as a person, not a criminal . . . you know, they saw beyond, behind the very unpleasant exterior, and that really sort of resonated. It wasn't until I was sentenced to detox that I became drug free. This is when the drug court really kicked in, because then you're coming back and you're supplying, for the first time in a year, negative tests.*
>
> Former addict and repeat offender

A number of randomised and controlled experimental studies published in peer reviewed journals have found that drug court graduates have significantly lower re-arrest rates - lasting more than 2 years beyond graduation - than those who do not participate in the programme.[102]

Certain 'key ingredients' of the success of Judge Phillips's West London court were evident. They were: personal and sustained interest and caring on the part of the judge (without doubt a 'therapeutic relationship'); and the use of detoxification orders (in the particular case above, an order on to an abstinence day care treatment programme, plus the requirement to continue to provide negative opiate tests). This particular court has employed 'court helpers' who are themselves in long term abstinence recovery and were former offenders. Abstinence guidance and support under the enlightened guidance of Judge Philips is given through a Narcotics Anonymous West London network although this is not a requirement of the court.

---

100 Drug Courts Decrease Criminal Recidivism: National Research. According to a study released by the National Institute of Justice (NIJ) in 2003 from a sample of 17,000 drug court graduates nationwide, within one year of programme graduation, only 16.4 percent had been rearrested and charged with a felony offence (Roman, Townsend, & Bhati, 2003). A 2000 Vera Institute of Justice report concluded that "the body of literature on recidivism is now strong enough, despite lingering methodological weaknesses, to conclude that completing a drug court program reduces the likelihood of future arrest" (Fluellen & Trone, 2000).

101 Judge Justin Philips

102 Painting The Current Picture: A National Report Card On Drug Courts And Other Problem Solving Court Programs In The United States, May 2004. Researchers are beginning to isolate the effects of the various "key components" of drug courts in order to establish their efficacy. The National Institute of Justice has funded a multi-site evaluation of adult drug courts that builds on previous studies. The evaluation is measuring the impact of drug courts in rural, suburban, and urban sites using a novel research design that factors in the characteristics of the community, the court, and the offender. The researchers are examining the influence of court programmes on recidivism, use of treatment and ancillary services, use of drugs and alcohol, and other behaviour changes such as employment

Equally evident were the limitations of the court created by the low threshold of treatment and testing, allowing cannabis and alcohol and amphetamine use and by the fact that treatment orders have to be in the main based on prescribing and counselling with no scope for residential placements.

Treatment in prisons

More numbers games - the Integrated Drug Treatment Strategy (IDTS)

The number of prisoners with drug and alcohol dependency problems is disproportionately higher than in the general population. Treatment provision of any sort is disproportionately lower. The numbers of problem drug using prisoners accessing any form of treatment in prison remains very small. Even smaller is the number who access an abstinence programme in any one year. Published data –like that from the Criminality Survey and Office for National Statistics – show between 40 per cent and 55 per cent of new receptions to be Problem Drug Misusers. Indicative feedback shows some prisons reporting up to 80 per cent testing positive for opiates on reception. …The Service has the greatest concentration – assessed to be as high as 60 per cent - of PDMs present in one place at one time either in the healthcare or criminal justice systems.[103]

Addiction Working Group visit to HMP Holloway

HMCIP (Her Majesty's Chief Inspector of Prisons) made clear the extent of the problem in the prisons in her 2005-06 annual report:

> *Inspections find that it is rare for prisons to have, or to use, needs analyses of their population to ensure that the right services are being provided. Those that did were able to target services much more effectively. …An indicative target HMP has set itself is 18,000 drug misusers who could benefit from treatment. Given the ranges between high and low estimates this could be thousands off the real numbers in need of treatment. The only recognised certainty as ever is that "need outstrips supply".* [104]

Prison drug treatment services are subject to performance management and service evaluation – but this focuses (as in the community) on processing and meeting targets. The prime aim of the Integrated Drug Treatment Strategy (IDTS) is to improve clinical management with greater use of maintenance prescriptions and expand the number of treatment/stabilisation programmes. But this system will push more prisoners into methadone substitution and add to the maintenance cul de sacs both within the prison system and within the community. This can only serve to entrench addiction.

---

103 The prison service drug strategy: General briefing note, 2003

104 The prison service drug strategy: General briefing note, 2003

The five other aims set out in the Integrated Drug Treatment Strategy make no mention of expanding abstinence base or therapeutic community programmes. Since 'retention in treatment' should not be an issue in the confines of a prison setting and given the proven success of RAPT programmes, one would have hoped to see aspirations for the expansion of rehabilitative programmes to meet the gap between demand and provision.[105]

The need to identify need

Plans for the expansion of treatment services should be based on need. But here, too, existing systems are inadequate as only 40 per cent of prisoners access the basic assessment service provided by CARAT. Further, the data produced by CARAT fails to give much insight into the 'latent' groups it is failing to engage.[106] Research also points to the lack of services to address the high need correlations around heroin, crack and alcohol.

Abstinence provision

> "The key issue is the balance between abstinence-based treatment and other forms of treatment."
>
> A former prison drugs counsellor

Across the entire prison estate, there are just four of the therapeutic communities that Home Office research itself has shown be the most effective treatment system.[107] Treatment length is between 18 months and three years. Only 366 prisoners entered such programmes in 2005/6.

In addition to the therapeutic communities run by Phoenix are ten '12 step programmes'in dedicated wings run by RAPT, the main abstinence based provider. RAPT also runs an alcohol specific programme in HMP Bullingdon which is self-funded as there is no money for alcohol initiatives:

> *Hundreds, even now thousands, have come through RAPT programmes so we know it works. The Government pays for it as we have convinced them that it has a positive result on crime. It has results, as recovery and being drug –free means people can rebuild their contribution to society, including work, building family relationships etc. This means it is fundamentally right on a human level. … Rapt does not defend what people have done, but we do promote their right to choose a different path. 60 per cent of people graduate our programmes, which are tough. They have to be 20 weeks, with daily programmes, urine tested etc….Research shows*

105 See section 3.3.3

106 Briefing: 'Drug Treatment Services in Prisons,' Available at www.povertydebate.com (reproduced by kind permission of the Centre for Policy Studies)

107 Abstinence based lasting one year

that those who graduate commit offences at 1/3 of the rate of others that have not participated in the programme.[108]

Mike Trace CEO Rapt, speaking at Wandsworth Rapt 'open day'

There are also five 12 step programmes run by other providers.[109] In total these reach a tiny minority of prisoners, 977 in 2005/6, but are highly effective:

The treatment takes place down here in the wing, it's a community, an environment of safety in a difficult prison. The treatment is based on the 12 step philosophy, Rapt do the first 5 steps in the pri`mary programme. It involves motivational therapy, engaging in group structures, it's very demanding-definitely not a soft option, but very intense. We link in with the 12 step-the AA and NA, b having guest speakers come in who are generally graduates of the Rapt programme, as this helps to engender hope. We have central peer supporters who have completed the Rapt programme and have been selected to work with the counsellors as part of the team, to help those that come onto the programme, as it is important they are supported.

Manager, Rapt wing Wandsworth Prison

"For me prison was a saviour. Within six weeks of being sentenced I was on the Rapt programme…I graduated the programme in July 2005, I've been on the programme 26 months. I've learned to accept life on life's terms. I had not accepted responsibility before. Prison gave me freedom, I smile and am happy when I get up in the mornings, I've had the opportunity to understand myself. We all have goodness in us, but don't know how to use it, or are scared. Through Rapt I realise I could make good with my life, and prison is a great place to out this into practise - you have to learn tolerance. I've now got an NVQ and can help others. Being in this field, helping others and seeing the changes, seeing that I don't just help one person, but whole families because it has a knock on effect, it's like spending a penny today and getting a pound tomorrow - it benefits all of society."

A Rapt graduate, former addict and repeat offender

Of the total prison population the breakdown shows 4000 entered cognitive behaviour therapy (for those on longer sentences) and 5300 shorter duration CBT programmes which focus on harm minimisation and are made up of 20 daily sessions to be completed within 4 weeks.[110] There is also a dearth of proper evaluation of any of these programmes or of any outcomes monitoring comparable to that performed on the RAPT programmes.[111]

---

108 Two research studies, the first Martin and Player (2000) involved interviews and reconviction data on 95 graduates and the second Liriano (2002) involved reconviction analysis of 274 graduates.

109 Prison Partnerships

110 Cognitive Behavioural Therapy

111 Briefing: 'Drug Treatment Services in Prisons,' Available at www.povertydebate.com (Research reproduced by kind permission of the Centre for Policy Studies).

But the reality for the majority of those going into local and remand prisons is not the possibility of a RAPT programme, or even CBT, but 'clinical services' to manage substance misuse. These comprise detoxification and maintenance prescribing programmes which are meant to be a prelude to broader based drug treatment interventions. In the main they are not. NHS research suggests that detoxification of a pre set duration remains the option in the majority of local prisons of 14 to 21 days.[112] The proportional split in treatment received by the 53,773 prisoners who entered prison detoxification and drug maintenance programmes in 2005/06 is unknown. The aggregated figures will be reported separately from April 2007.[113]

There is also a total underdevelopment of alcohol provision and crack services. The 2004 Alcohol Strategy is completely inadequate; its total lack of earmarked funding or resources has left prisoners with an alcohol addiction effectively excluded from treatment.

Coming out of prison

After care is essential following release. This is an accepted fact across the entire substance misuse professional field. Addaction has recently set up an immediate service outside Manchester Prison into which newly released prisoners can walk straight into on release preventing the type of problem described above. It is arguable that there is a need for such a service outside every prison.

Resettlement is vital. But such services and accommodation provision are negligible. A pathfinder project found that of 526 released prisoners with significant drugs problems only 40 were known to have attended drugs services subsequently.[114]

We found in the course of our investigation that few of the hostels for the homeless whether run by the Salvation Army or by other charities such as St Mungo's, are 'dry houses' or offer drugs and alcohol free havens. We did find a few rare third sector examples of the type provision for secondary residential abstinence programmes appropriate for ex prisoners in recovery.

2.3.6 The state colonisation of the third sector

The massive expansion in the provision of drug related services funded by the government has been matched by a growth of third sector involvement in providing them. Delivering services in accordance with the performance management criteria defined by the government has effectively entrapped once independent voluntary organisations into operating in terms of government criteria and values.

---

112 Clinical management of drug dependence in an adult prisoner setting, November 2006, NHS
113 Rosie Winterton MP, Minister of State (Health Services), Department of Health
114 Russell White op cit

The resulting '**statutory colonisation**' of the voluntary treatment sector has marginalised much needed:

- Dedicated abstinence/recovery treatment programmes,
- Small charities providing faith and community based 'recovery' programmes

> "There's a dilution of ethos, almost, because we've had to sacrifice a couple of our beliefs, you know. You are never forced to do anything, for sure, but…you reach a compromise. I'm trying to develop an organisation that I know has a place in delivering services. And if government money is the only way I can do that for the time being, it's really sad, I struggle to live with myself sometimes, because of decisions I have to make, you know."
>
> Voluntary Sector CEO

It has also threatened the existence of those third sector organisations who wish to be guided by their own aims and objectives and values rather than by those of the government.

The new commissioning environment has focussed funding into desired fields – the tiered models of care - which include 'assessment', 'care planning', 'care co-ordination', 'structured psychosocial interventions' as well as harm reduction services and DRRs. This environment has encouraged organisations such as Phoenix Futures to diversify from their core or original mission - in this case, a unique expertise in the holistic treatment of addiction. All the large third sector providers, such as Turning Point, Addaction and Phoenix Futures[115] have grown dramatically and have expanded their remit to take on the range of services tendered – from treatment orders to young people's services to needle exchange and counselling. Addaction is 95 per cent funded by government contracts. Inevitably, in the process, they have become ever more government dependent, carrying large staffs to both bid for and meet their varying administrative contract requirements while expending resources to compete with each other for the same tenders and for reapplication for tenders currently held. Sometimes these are for disparate services of limited value.

We found that charities set up to respond to needs in the local community dependent on statutory funding feel they have lost the independence they once had.

> *I think that's a pertinent issue, and if we look back from an historical perspective, the funding was always predominantly state-based, but we did have an awful lot more independence, and that goes back to another issue I made reference to re the contracts. Our original contract was one page,*

115 Phoenix Futures has a staff of between 400 and 450 and a clientele of around 9000. It began as one residential abstinence rehabilitation house in 1970

it increased when I started there in 1995 to three pages, and now we're on over a hundred page contract.

Andrew Thomson ADAS

In this environment the third sector is now less free to challenge the basic tenets of policy, and their expertise is not being fully brought to bear on either treatment goals or commissioning decisions.

What commissioners purchase from the voluntary sector is the culture, the ethos; it's the commitment to the work, the 'can do' and flexible attitude. We're dynamic organisations because we've lived hand to mouth and have had to respond to the continual changes imposed upon us. But Government programmes came along and stifled those qualities and - more importantly - innovation, because it was telling people, 'this is the way you do it from now on, you go from A to B to C.' As a VSO we started to resemble the statutory bodies in how we viewed our work. . Now we are all satisfying the government's agenda without asking if it actually works.

Darren Worthington CEO SMART

Several small drugs charities have complained that commissioners often offer only short term contracts with unrealistic budgets which means that the winning bidder is forced to subsidise service from its own resources:

This highlights the problem throughout the country whereby drugs or alcohol services are taken over by the "Big Players" such as Addaction or Action on Addiction who have reserves and resources to subsidise treatment, pushing out the smaller agencies that have local knowledge and expertise. This also results in organisations that are trying to innovate service delivery often lose out. For example recent proposals by Drugsline for a unique Jewish/Muslim partnership bid which would have resulted in cross community work to improve drug treatment have been left unsupported.

The biggest local provider in Redbridge is Statutory Services who are well supported by the DAT. However many of our clients are unwilling to approach Statutory Services for a variety of reasons including its emphasis on harm minimisation.

Christina Ball, Operations Manager, Drugsline

Once a large operator is appointed by a DAT to take over all the areas drugs services – as is the case with Turning Point in Hertfordshire, then smaller voluntary agencies like the Living Room get pushed out all together.[116] The statu-

116 Janis Freely, Clinical Director, The Living Room

tory colonisination of the third sector has not been conducive to investment in or expansion of the much needed day and residential abstinence based programmes which struggle to find funding from independent sources.

Employment of addicts in recovery

Standardisation of services and a commissioning hegemony that favours prescription marginalises 'abstinence oriented' charities and also, by definition, their ability to employ and expand employment recovering addicts as counsellors and therapists.

The current system doubly loses out on the potential of the addicts in recovery who have benefited from abstinence programmes and want 'to put back' - an opportunity to invest in this 'healing cycle' has been wasted over the last ten years

> "I will only employ therapists who are addicts in recovery."
>
> Dr Neil Brenner, The Priory, North London

> "It is essential to employ people who are in recovery themselves. It is the only way to have empathy with the clients, to see through their denial and to be able to give tough love."
>
> Janis Freely, Clinical Director, The Living Room

2.3.7 Drugs education - a mixed blessing

The Every Child Matters Agenda sets out the need for: 'ensuring provision is built around the needs of vulnerable children and young people; more focus on prevention and early intervention with those most at risk…' This is an important ambition, given the particular vulnerability of the already most vulnerable children to drug and alcohol use. But the recent history of drugs education has not lived up to the ambition to focus on prevention and intervention; instead, like so many other parts of the Government's strategy, it has progressively focussed on harm reduction.

A Brief History of British School Drugs Education

John Major's Government set out a clear policy of 'primary prevention' in relation to children and young people's drug use:

> *The government starts from the basis that the ultimate goal of its drug policies must be to ensure that people do not take drugs in the first place, but if they do, they should be helped to become and remain drug free.*
>
> Tackling Drugs Together – A strategy for England 1995-8, 1995

Information and facilities aimed at reducing the risks for those who do misuse use drugs for whatever reason should be provided because this may save lives, but it was stated that this information must be coupled with the

unambiguous message that abstinence from drugs is the only risk-free option.

Curriculum guidance was set out in May 1995 for knowledge, understanding, skills and attitudes. *Tackling Drugs to Build a Better Britain* – the Conservatives' second national plan for 1998-2002 kept the key aim of prevention. With the arrival of a new Labour Government came a change of philosophy and a change of message.

The Government's drug education guidelines and advice since 2003 have omitted mention of prevention, instead focussing on informed choice[117] - reflecting early thinking set out by SCODA:

> *"The reality (is) that many young people use both legal and illegal substances…. Those who advocate this approach acknowledge the importance of young drug users being aware of the risks associated with drug use, and aim to equip them with the knowledge and understanding that seeks to minimise them. "*
>
> The Right Choice, SCODA 1998[118]

The United Kingdom's Anti-drugs Coordinator's Annual Report 2000/2001 stated with some confidence that: 'educating children about the risks associated with drugs can delay or avoid the start of experimentation'. This mixed message – conflating 'delay' of drug-taking with the avoidance of drugs – has driven the expansion of drugs education in the school system and has caused confusion.

> *Preventing drug use and reducing drug use are two different things, and there is a muddle and confusion here that needs to be resolved. Either you try to stop children from ever starting to use drugs, or you surrender to what you think is inevitable, i.e. that they will use anyway, and so do a damage-limitation exercise. Prevention is better than cure and cheaper and always has been. And it's what the parents want for their children.*
>
> Mary Brett[119]

Current Education– more harm than good?

A major submission presented to us by Mary Brett sets out a series of criticisms of current school drugs education and advice. The most recent official Drugs Education pack for schools[120] is criticised for failing to deliver adequate information about the serious risks of cannabis:

---

117 DfES Drugs - Guidance for Schools Feb 2004

118 SCODA later was to be merged into DRUGSCOPE

119 Mary Brett: 'Drug Education A Systematic Review, - Preliminary Notes, A Submission to the Social Justice Policy Group' Available at www.povertydebate.com

120 Understanding Drugs: Drug Education pack for schools(Key Stage 3) DfES and Home Office 2006

> *The pupils booklet gives no warning that cannabis can and may cause psychosis and refers only to paranoia to which it gives equal weight alongside other cannabis effects including 'you might feel happy and relaxed'.*
>
> Mary Brett

Similar criticism is directed at the Government's key drugs education vehicle FRANK, a multi media information service about drugs (which receives about 10,000 calls a month about cannabis) which should be irreproachable, detailed, scientific, unexaggerated and true.

> *Information about strength is inaccurate. It says that herbal cannabis has a THC content of 1 to 5 per cent and some is grown in the UK. Actually most of the cannabis grown here, 60 per cent, is of the much stronger "skunk" variety with a THC content of anything between 9 and 29 per cent (Forensic Science Labs). The FRANK figures for "Skunk" THC strength are 8-20per cent. The opportunity is missed to get a strong message out about cannabis and mental illness. Cancers, heart problems, effects on the immune and reproductive systems, addiction, long-term persistence in the brain, possibility of a gateway to other drugs, all of these are ignored.*
>
> Mary Brett

The Government's approach to teacher guidance is also criticised for lacking depth and established scientific fact.

> *To be called an information book and have so few facts and so much empty space is a travesty of the use of taxpayers' money. Teachers should not need to be "bribed" by an attractive layout, nor do they need to be "patronised" in this way…*
>
> Mary Brett

Much government generated advice has been condemned as patronising, pointless and even as encouraging drug use in attempts to be 'non judgemental' and to key into perceptions of youth culture and values. We have had our attention drawn to material designed for young people, put out by charities in receipt of government contracts, which seems quite irresponsible.[121]

One of the very few reviews of drugs education in practice in nine secondary schools in Scotland revealed it to be in a chaotic state and with a lack of clear guidance. One of the biggest problems was the unacceptability of harm reduction as a concept for the teachers of drugs education themselves.[122]

---

121 Lifeline's The Big Blue Book of Drugs
122 Niamh Fitzgerald PHD thesis

The limitations of harm reduction as an education philosophy

There is extremely limited evidence of long term impact on reducing drug use as a result of any type of drugs education in schools. The harm reduction drugs education that now predominates in the UK has no foundation in evidence. This form of drugs education may be as damaging as it is helpful.

> "A significant problem with harm reduction is that in some cases the policy has become diluted by the "mixed message" that it transmits, particularly to young people, when those in authority appear to condone an inherently dangerous and criminal activity. In the case of some teachers, they have taken the line of least resistance by trying not to be "judgemental" in their teaching by informing pupils about drugs and the safest ways of using them, leaving the pupils to make "informed choices". …. This type of liberal and "politically correct" attitude can create greater harm than it is supposed to prevent and it has been exploited by those who use the message of harm reduction as a way of breaking down resistance to drug experimentation."
>
> Dr Ian Oliver, fromer Chief Constable

The education harm reduction message has not been one of abstention or indeed one of encouraging abstinence but of encouraging children to be safer than they might be.[123] This is not 'value free'. It is based on an ideology of freedom of choice applying to children which assumes that given the correct information children and adolescents are free individuals who can make further free (and sensible) behavioural choices. All the evidence suggests that many of them cannot.

> *The pragmatic harm reduction proponent holds that we cannot keep people from using drugs, so we should help them to use them safely. The libertarian believes that drug use is no-one else's business but the users, and/or that drug use is simply a lifestyle option – even a human right. The latter includes activists who strive to change or eliminate drug laws, and the lines between policy makers and activists often become blurred.*
>
> Professor Neil McKeganey

The ethos such drugs education reflects in relation to children is worrying. It leaves those children whose parents are neither establishing boundaries, nor supervising them, particularly vulnerable and especially to peer pressure. It assumes equal resilience amongst children – but this of course is not the case.

The official approach to schools drugs education seems to be particularly out of step with revised 'non negotiable' education approaches to the most problematic children. It appears also to be out of step with the concerns of scientific experts about cannabis.

---

123 This goes counter to the insistence of many parents that their children are drug free and counter to 'family rule' about the unacceptability and damage of drug use.

There's no doubt that cannabis consumption has increased between the 1990s and 2005 across the whole of Europe. Over the past two years the overall consumption of cannabis has plateued and in some cases has gone down, the consumption amongst the younger population (15-16 years old) is increasing. Evidence from the 2002 UN reports and from the England and Wales Crime Report 2006 also indicate that the overall strength of available cannabis is increasing. Along with the traditional cannabis with 2 or 4 per cent THC in it, it is becoming much easier now to get skunk varieties with up to 4 times higher concentration of THC. The average age (of initiation) is falling. In South London our problem is very much in young adolescents starting taking cannabis. And of course, one of the problems is they or their parents are not aware of its potential harmful effect and they do consider it as an "illicit drug". So, when you take a drug history from adolescents or young patients, and you say, "do you take any illicit drugs?" "no, no, don't take drugs". "What about cannabis?"- "oh, that is not a drug it is just a natural erb".[124]

Professor Robin Murray

Because of the strength of the active ingredient it is thought that the current proportion of schizophrenia caused by cannabis - which is estimated between 10 and 15 per cent - is likely to increase in the future. This is considerable cause for concern for the Afro-Caribbean population where the rates of schizophrenia are already nine times higher than in the white population.

The government has yet to take an uncompromising line in light of this evidence repeating claims in their literature of a 24 per cent drop in use – somewhat misleadingly as this figure refers to the percentage of a percentage drop.

Others in authority argue that no other line can be taken:

This strong line might seem heartless, but it has saved many more pupils than it has damaged. Random drug testing and sniffer dogs are other devices. Nothing is ruled out in the interests of protecting those in my charge. By far the best method, however, is to teach young people how to live. The "well-being" lessons which we have introduced at Wellington, and which are now spreading across the country, are designed to help young people realise that if they look after their bodies properly, they do not need to resort to drugs…Drugs are not intelligent living. Alcohol is part of intelligent life for many, and with older school children the art is to help them to realise that drink, properly used, can be a significant enhancement to life. With drugs, there is no half-way position. Everyone - government, the media and schools - needs to give the same message: "No."

Anthony Seldon, Headmaster, Wellington College[125]

---

124 Robin Murray, Professor of Psychiatry and Psychological Medicine, Institute of Psychiatry, Kings College London

125 Article extracts, Independent 15 April 2007

Ineffective or inconclusive?

We do not know whether schools education programmes can make a difference if geared in the right way. Education programmes are so variable – ideologically as well as practically - and so variably delivered with so may factors affecting outcomes (interactivity, peer leaders, quality of implementation, multi or single substance focus) that they have been impossible to compare, let alone measure for impact. But we do not know whether we are dealing with 'absence of evidence' or 'evidence of absence' effectively.[126]

One 'meta- analysis' of research findings concluded that there is a small but measurable effect of school prevention programmes rather than firm evidence of absence. This suggests that even if the effect of school based alcohol and drug prevention is small it might be a cost effective intervention and therefore desirable.[127]

The lesson from this is clear – there is a need for carefully trialled and tested methodologically sound schools drug and alcohol education prevention programmes before wider implementation. In short, we need to start from square one.

127 Caulkins JP, et al School based drug prevention: what kind of drug use does it prevent? Santa Monica, CA:RAND;2002

Section 3
Policies

TOWARDS RECOVERY

The conclusion of our 18 month inquiry into 'addiction' is that drug policy – both historically and currently – is antagonistic towards recovery. This has had a doubly negative effect. Attitudes have been coloured by addicts' 'failure' to recover, and by the apparent intractability of the problem. There has been little awareness at the level of policy making that it is the system and even 'professionalism' that is feeding failure. The voices of hope have been neither heard nor listened to. Perversely, those organisations that 'deliver' genuine recovery are the least supported and the most jeopardised.

> "The greatest failure of government in this debate is to forget that treatment is more than reducing crime and to forget that drugs are a symptom of profound disillusionment. We have seen a dramatic cut in therapeutic rehabilitation services. We have seen that the agenda for helping drug users make meaningful changes in their lives reduced to little more than stabilising a person and hoping that in their drug induced state they will no longer commit acts of anti social behaviour. The reality of the situation is that if you vaccinated the population against cocaine people would turn in greater numbers to methamphetamine and if you eradicated heroin they would turn to equally damaging pharmaceutical drugs because they are deeply unhappy with what life has to offer them."
>
> Martin Blakebrough CEO Kaleidoscope

A significant number of addicts do, however, recover and their ability to do so must now govern thinking and be the focus of attention. There is a need for a major shift in attitude by policy makers and practitioners from negative to positive, matched by a shift in investment.

We can but pay tribute to the dedication of those working with addicts, many of them recovered addicts themselves who, against the odds and in increasingly difficult circumstances, are persisting in helping others into recovery using the methods that they know work. Policy makers should look to them for guidance.

The ingredients for success – for breaking cycles of addiction – and for restoring to people their humanity and their potential and the principles on which they are based - already exist. They are to be found at *Phoenix Futures*

Family Centre, the trialled '*Safer Families Project*', the adolescent treatment centre, Middlegate Lodge, '*Kids Company*' safe havens, *The Living Room* and the *SMART* arrest referral team, to name but some.

Principles of Policy

The policy proposals we suggest are derived from what we learnt from the many centres we visited and the people who talked to us. They are based on the following three principles:

1. Reforming treatment – breaking the cycle of addiction and devolving responsibility

The ultimate goal of treatment should be recovery and rehabilitation through abstinence. Such treatment is labour intensive, time intensive and commitment intensive but highly cost effective. Alongside this strategic direction and oversight, the principle is one of devolution of responsibility for recovery to a local level. Local projects that deliver 'recovery' should be supported and given incentives to expand and replicate.

2. Preventing harm - promoting public health and social order

The most effective way to reduce harm is to set out to prevent it. Fundamental to prevention is cutting consumption in the first place – the more consumption is cut the less damage, the less cost and the less enforcement and ultimately the less treatment is required. Harm prevention also requires higher expectations of social and personal responsibility and requires local level initiatives.

3. Protecting children – facing parental substance misuse and confronting cannabis

Children have been the most compromised and abused by the harm reduction philosophy – they have been left exposed and unprotected and the best offer that is made for them under the current system is to help them build their resilience. That is not good enough for us as a society. Parents must be supported to meet their children's needs for love and security, praise and recognition, responsibility and new experiences – all their emotional, social, intellectual and educational needs. Where this is impossible society must provide safe havens.

3.1 Breaking the cycle 1: Structural Reform

There are vested, albeit unconscious, interests in sustaining rather than breaking cycles of addiction and dependency. These have to be reversed to ensure that interests become focussed on recovery. To this end, it is important not to dismantle the structures that have been established but to redefine the goals they operate to, to direct them and to improve their efficiency and effectiveness. Such changes depend upon creating different incentives and redirecting funding streams.

The pre-requisite of investment in recovery is an understanding of addiction. This means understanding cross-addiction, poly-substance abuse, addiction as a family illness with family repercussions and the fact that alcohol addiction is part of the pattern. It means focussing on the fact that children are damaged by parental addiction. It means accepting that addiction is widespread in our society and affects most of us one way or another.

In practical terms investment in recovery means that dedicated treatment money must be spent on abstinence-based or abstinence-goaled programmes and services if taxpayer's money is not to be wasted.

The launch of 'Joining The Loop', a partnership between the Jewish and Muslim communities of Redbridge, Drugsline, the QALB Centre and the League of British Muslims.

Policy Proposals

3.1.1 An integrated 'addiction' policy

The focus of policy should be redefined in terms of addiction embracing both alcohol and drugs, as alcohol remains the largest addiction in the country. As a 'chronic' problem in itself, and as a 'portal' to other substance abuse – especially for children and adolescents - and as a fast intoxicant, alongside other drugs, alcohol is a key ingredient of the problem. Its inclusion and integration is imperative. The lack of 'joined up policies' for alcohol and drugs along with a misguided policy focus on 'the primary drug' are the lead criticisms of current policy.

Cabinet Office Strategic Lead - 'A Second Chance Unit'

An integrated addiction policy, replacing the separate drugs and alcohol strategies, would enable policy to move away from the traditional battleground between the public health and crime lobbies. Calls to return to a narrow public health perspective avoid the central issue of the problem of addiction.[128] Similarly, a structural relocation of policy in isolation provides no answer.

A fundamental shift of focus from negative management and maintenance to a positive 'recovery oriented' policy requires a combination of independence from existing departmental interests and a high level of commitment. Any new structure needs to focus on the notion of 'a second chance', replacing despair with hope. A 'Second Chance Unit' within the Cabinet Office could provide the strategic lead.

3.1.2 National Addiction Trust (NAT)

To emphasise this shift of direction we propose a National Addiction Trust responsible to the Second Chance Unit to replace the existing National Treatment Agency.

It would have responsibility for:

128 Transform Drugs Policy Foundation and the Harm Reduction Alliance for example

- Managing a Treatment Trust Fund to deliver recovery through a Treatment Voucher System, following the client and rewarding recovery. The NAT should have a streamlined staff (following a staff audit) with a smaller administrative budget to match
- Establishing a balanced Board of Trustees representing alcohol and drugs expertise, voluntary treatment providers, (large, small and faith based), child protection specialists, adolescent and adult addiction psychiatrists and representatives from Alcoholics Anonymous, Narcotics Anonymous and the Regional Addiction Action Centre leads
- Responding to and meeting known need for the treatment of addiction, abandoning the discredited treatment targets and 'Models of Care' tiered structure for commissioning
- Monitoring treatment 'success' in relation to independently defined and sensitive outcomes measurements
- Promoting a treatment philosophy which recognises there is no 'one size fits all' route through treatment, which devolves responsibility, supports small but committed third sector and faith based projects as well as the large providers and which is sensitive to different (traditional) cultural attitudes around drugs and alcohol misuse
- Managing a dedicated Research Budget liaising with the Home Office and Department of Health, guided by an academic advisory council
- Working with an academic advisory council/board[129] to:
    - Keep needs assessments updated (including alcohol)
    - Commission treatment outcomes monitoring from reputable and proven university departments such as the Centre for Research into Drug Misuse at Glasgow University
- Underwriting 'trustmarked' residential treatment centres to secure their service[130]
- Supporting the expansion of residential and day care abstinence based programmes, prioritising families and adolescents through Treatment Vouchers (removing treatment of dependency 'Supporting Peoples' funding streams).[131]
- Holding a centralised treatment voucher register fed from local Addiction Action Treatment Centre Coordinators

We would further propose that the NAT be headed by an individual with life time experience in abstinence based treatment of addiction.

---

129 Taking over some of the functions of the Home Office's Advisory Council on the Misuse of Drugs
130 For details of trustmarking and accountability see Volume 6, Section 3.1.2
131 Ibid, Section 3.3.7

3.1.3 Alcohol and Drugs directorate at the Home Office

A combined Alcohol and Drugs Directorate at the Home Office would retain responsibilities for the enforcement of drugs laws and alcohol licensing laws, interdiction of drugs supplies and asset seizure. It will also have the responsibility to provide a strategic lead on harm prevention. This would be both through local drugs law enforcement, but also in pro-active ventures in cooperation with local Addiction Action Centres coordinating and working with local communities:

> *One of the real problems that I've had is trying to get something done locally around understanding how drug markets work, and how you link that into the work that Drug and Alcohol Action Teams try to do . . . there being a mismatch between what the policing targets are and what our interest is, and trying to get any intelligence geared towards looking at how the drug markets work. It seems you're [the Home Office and the Police] are not really joining up these things very effectively. If you're going to have a strategy and if you really don't know about the intelligence around how it works, it makes it very hard to do anything at a community-based level to tackle those drug markets.*
>
> Islington Drug and Alcohol Team Coordinator [132]

3.1.4 Reform of Drugs Legislation

A review of the Misuse of Drugs Act and associated penalties is proposed. It would be undertaken by a reconstituted Addiction Advisory Council. There is a growing consensus that the ABC classification system is not fit for purpose. We share the House of Commons Science and Technology Select Committee's conclusion that there is a 'regrettable lack of consistency in the rationale used to make classification decisions.[133]' We have been impressed by the simpler and more effective Dutch and Swedish legislative frameworks.[134] In both these countries it is abundantly clear that drugs are illegal, and that possession of them carries certain penalties. This is supported by enforcement agencies which are rigorous in their application of the law. The structure of these systems is also such that enforcement acts as a route into rehabilitation, focussed on getting people drugs-free.

Contrary to popular belief about a more liberal framework in Holland, all drugs are illegal. Indeed, whilst visiting the Netherlands, the Addiction Working Group discovered that the Dutch were surprised to learn that the UK considered their drugs policy to be liberal in nature.

The range of schedules and penalties available through legislation in both Dutch and Swedish law, appear to be well understood by their public, to be

---

132 Speaking publicly at a 'stakeholders' meeting run by Drug Strategy Unit at the Home Office in London, 13th March 2007

133 Science and Technology Select Committee's Fifth Report of 2005-2006 session, 'Making a Hash of it',18th July 2006

134 See section 4 Briefing A Perspective on Comparative Drugs Policies and Implementation in the Netherlands, Sweden and the UK,

consistently and transparently applied in practice, and supported through the funding emphasis of the national strategy. This cannot currently be argued to be the case in the UK.

Penalties must provide a route out of addiction through provision of appropriate drugs programmes for those who are caught up in the criminal justice system. This can be achieved through use of dedicated drugs courts as detailed in Breaking the Cycle 3. Although the UK spends more on 'treatment' than its neighbours, it has been less effective owing to lack of recovery oriented treatment.

	Netherlands	Sweden	UK
Prevention/Young people	2%	1%	12%
Law enforcement/Supply	75%	54%	28%
Harm Reduction/Social Care/Communities	10%	23%	22%
Treatment	13%	22%	38%
Totals	€2,186m	€1,200m	€2,000m

"Since the implementation of the Misuse of Drugs Act 1971 the UK has operated a 3-tiered system of criminal sanctions, dependent on levels of perceived harm. Harm is adjudged as attributable to the drug itself. Whilst this approach may appear to reflect legislation in the Netherlands and Sweden, in practice the idea of 'relative harm' has served to 'de-sensitise' the issue of illegal drug use. For example, the re-classification of cannabis in January 2004 was seen as a 'green light' for its use, especially amongst younger populations. The popular conception has become that there are no longer legal sanctions applied for cannabis use. This conception then undermines the overall framework of 'relative harm', wherein, if cannabis is perceived as relatively harmless, then how harmful can drug use be per se?"

Andy Horwood[135]

We therefore recommend a revision of the Act based on the relative seriousness of the crime of selling incurring a given sentence, as a more straightforward and less disputable concept than the notion of relative harms. We reject moves to add alcohol to the list of harms; to try to develop a broader and more social notion of harm into the index, would be to confuse rather than clarify the issue and we believe is going in the wrong direction.

We concur with another of the Science and Technology Committee's conclusions that the 'weakness of the evidence base on addiction and drug abuse is a severe hindrance to effective policy making'. We would wish the reconstituted Addiction

135 Ibid

Advisory Council to undertake a technical evidence-based review of the appropriate schedules of a revised Misuse of Drugs Act and its associated penalties. Legal and international legal advice on revision of the law would be seconded.

An Advisory Council on Addiction

An integrated addiction policy necessarily means replacing the existing Advisory Council on the Misuse of Drugs with a new Advisory Council on Addiction. We found widespread criticism of the ACMD, of the imbalance of it membership towards pharmacological interests and the lack of representation on it from the 'abstinence' tradition of treatment. We suggest a completely new look is taken at its membership to include social scientists, child psychologists, psychiatrists, treatment practitioners with expertise in the 'common' addictions of alcohol, cannabis and cocaine as well as in the 'minority' opiate addiction field. The new council would advise the National Addiction Trust and the Home Office Alcohol and Drugs Strategy Directorate

3.1.5 Addiction Action Centres

Addiction Action Centres should, in our view, replace Drug Action Teams which are cumbersome and variable in practice. Staffed in proportion to *local known needs* based on estimates of problem drug and alcohol users in the area, they should be led by an **Addiction Action Coordinator**, a former residential or day care drugs CEO/counsellor or addiction psychiatrist. His or her responsibilities would be to:

- Coordinate with local statutory health services, child protection and family services, police , schools and voluntary addiction services;
- Assess local treatment needs, including alcohol, with local input – as above.
- Maintain a full record of all local voluntary drugs and alcohol and addiction agencies and services.
- Administer abstinence goaled treatment vouchers with the aim of beginning rehabilitation at the start of treatment – not years down the line.
- Commission '**One Stop Shops**' for 'accident and emergency', referral to treatment and management of care plans, if possible to be located in AAC shared premises.
- Work in cooperative regional groupings and appoint a regional lead.

The new Addiction Action Centres would be set a recommended limit to 'management costs' in line with best practice in the third sector. For example, no more than 10 per cent of budgets to be spent on management and overhead costs – to be monitored by the NAT.

3.1.6 Abstinence based treatment vouchers

As indicated in section 2.1.2, we propose funding of all treatment vouchers from a National Treatment Trust Fund. The rationale is to provide the vehicle

for the addict's road to recovery. All too often the addict seeking recovery will find the road leading to abstinence only after many road blocks put in his way by the state. The exceptions who make it onto the road generally find it having 'failed' at every other route offered by the criminal justice system or only after the persistence of enlightened drugs workers or relatives.

Treatment Vouchers will help the exception become the norm. The vouchers will incentivise both the addict and his local addiction action coordinator to move to recovery with a guarantee of funding if he continues on the road. They will also provide the dynamic to fill and increase the supply of abstinence based day and residential care centres. The demand for recovery will be matched with funding which will go with the addict. This system of funding will help remove the tragic waste of an addict motivated to rehabilitation and recovery but not receiving assistance due to lack of funding.

3.1.7 One Stop Shops

One Stop Shops and GPs, whom many addicts initially access for help, provide both the start and continuity through the treatment journey. Their purpose is to end the tortuous process of chaotic drugs users going backwards and forwards between their GP and community drugs services, never being regarded 'as ready for treatment', and to get the addict a foot on the ladder of meaningful treatment and care. They will assess, refer and maintain responsibility for the treatment journey.

Commissioning these shops will be the one such task of Addiction Action Centres - one in each major city or town according to known need, ideally sharing premises funded from the Treatment Trust budget. Bids would be invited from existing proven and trust marked drugs and alcohol agencies.

Their remit would be:

- To be led by drugs and alcohol addiction counsellors with proven experience in abstinence based recovery
- To be responsible for assigning a key counsellor to each client to discuss all aspects of his or her situation and coordinate with other services accordingly (child protection and housing for example)
- To be responsible for guiding and monitoring the client in his or her use of their treatment voucher – for motivational interviewing and structured group work within a positive environment, for moving clients to detoxification and abstinence programmes and for developing strategies for management of change
- To provide 'stepping stone' substitute prescribing through a prescribing nurse on site or though a GP associate as a bridging mechanism to detoxification and rehabilitation treatment
- To coordinate clinical and medical interventions, Hepatitis C and Aids testing
- Have direct links with family and adolescent rehabilitation services and

voluntary peer support groups such as NA and AA, referring clients to them, and hosting meetings

One stop-shop services would be more cost effective because of shared premises and no duplication of staff roles (a saving being **one** assessment for clients rather than at present each service wanting its own assessment service). They would provide a more effective assessment and referral process, more time with the client and more engagement in motivation.

Preparation for treatment determines its success as does the attitudinal change towards addicts' potential for recovery. This is the considered view of one of the most able abstinence treatment providers.[136] These would be integral to the One Stop Shop idea.

A number of existing providers could provide this service in different geographic areas including *Kaleidoscope*, *Turning Point*, *Smart*, *Addaction*, *Phoenix Futures*, *Action on Addiction* etc. Important input from some of the smaller third sector providers here, like the Living Room and 1NE Beulah Road would be guaranteed – a minimum of 25 percentage of tenders.

3.2 Breaking the Cycle 2: Treatment Reform

3.2.1 Redressing the balance

Our key aim in relation to treatment itself is to redress the current gross imbalance between harm reduction services and abstinence based treatment, and to recognise that the effectiveness and success of any project/programme is dependent upon the type of care given and is often driven by the leader's (and staff's) own:

> "Confusion arises as harm reduction has come to be viewed as synonymous with treatment. *Treatment* however, at least in the tradition in which I work, and which I believe is how the word is popularly perceived - is about enabling those addicted to drugs or alcohol to stop using and to remain abstinent from the object(s) of their addiction."
>
> Janis Freely, Clinical Director, The Living Room

- Personal experience
- A 'Calling'
- Training

Typically inadequate leadership is the 'missing ingredient' in the many diverse services between which clients are currently moved in great numbers.

136 Jeremy Booker, Service Manager, Phoenix Futures

Abandoning targets and 'models of care'

Redressing the balance in treatment requires abandoning centralised targets and the tiered models of care and moving towards a needs-led system, monitored and measured in terms of real outcomes – including abstinence or reduction of substance use, improved mental health and social functioning and motivation.

Replacing commissioning and performance management with outcome monitoring

We propose a reduced role for commissioning by competitive tender under the treatment voucher system, with vouchers to be used to purchase treatment whether for residential or structured day care. Providers would be held accountable for the quality of service they provide their client.[137] Recovery is time intensive; therefore providers, including one stop shops, should be subject to ongoing inspection but not have to re-tender – thus reducing administration and cost on both sides.

Treatment services should be judged in terms of independent outcomes assessment and monitoring – not by their ability to deliver 'targets'. Treatment voucher money would follow successful delivery of recovery.

> "At the moment to be "effective" is all about waiting times, interventions offered, number of clients seen, numbers in treatment etc. It is very much output driven. Effectiveness at present does not seem to include essential outcomes such as whether a treatment intervention actually makes a difference to an individuals life. Whether an individual reduces their drug use, have their living circumstances improved? What is their mental health like? What is their desire to change? None of the services that are delivered or commissioned through the DAT have any targets around these outcomes. There is not a requirement from central government for any of this data so it is therefore not recorded or collected. An outcome focussed treatment plan is not a quick fix labour spin solution, it will take time, determination and commitment to deliver and statistics could get worse before they get better, but this fundamental and foundation change would make the biggest and most lasting impact within society."
>
> Jessie Jacobs, head of a local Christian support group

3.2.2 Structured abstinence day care expansion

The treatment service that is key to redressing the balance is abstinence based structured day care. We propose a major expansion and roll out of such services.

Current reluctance to commission abstinence-based day programmes is an outcome of rigid performance management as well as of pre-conceived, but largely incorrect ideas, about their inflexibility and intolerance. Our research

137 See also Volume 6 (Third Sector), Section 3.3.7

revealed that while such programmes necessarily had to abide by clear rules of behaviour regarding on-site drinking or drug taking or arrival in intoxicated states, they were not rigid. Clients on prescriptions were taken onto programmes at The Living Room and supported to come off. There was also an understanding of and support for relapse.[138]

An ideal SADC service would not only assist their client in finding a next stage of treatment but ensure that, when they came back into the community, they were there to continue support/treatment – as is the case of The Living Room.[139] It may be that asking all SADC facilities to have this longer term 'mentoring' role is unrealistic and this should not preclude them from receiving clients with treatment vouchers. However it is our view that such a role, where someone was available to help when there is any form of relapse, would not only result in improved recovery outcomes but would be cost effective in the longer term and is therefore preferable.

The expansion of SADC should be supported by treatment vouchers in each AAT area in relation to need. These services would no longer be subject to commissioning vagaries but to their own outcome success. The more successful would be trust marked and attract more treatment vouchers. We would expect to see the larger third sector agencies such as Addaction and Turning Point supporting the smaller agencies to replicate their existing successful services in new Addiction Action Areas.

3.2.3. Residential rehabilitation expansion

We have become strong advocates for the residential rehabilitation centres we have visited in the course of our enquiries. Their relevance is as a part of a range of services, preferably to be considered after SADC, where that service is available. However residential rehabilitation does have many advantages over SADC for some, though not all, clients, and demand for this treatment has barely been tapped. We propose an expansion of the current 2,400 beds to 10,000.

> "Experience has shown that breaking free from a life controlling problem is a process which can often take a number of years. The problem with this is that funders look for maximum results with limited expenditure. Looking back to rehab in the late 1980's/early 90's residents could stay as long as they 'needed' to; bearing in mind that everyone worked hard to avoid 'institutionalisation'. Because the time in rehab was longer (involving different phases of treatment and resulting in much stronger, supervised re-entry and after care) resident's recovery was much more 'in-depth'. The problem with the subsequent finance driven, shorter rehab programmes is that a client's deeper issues do not get fully dealt with."
>
> David Partington, CEO International Substance Abuse and Addiction Coalition

138 For a full insight into the running of structured day care programmes see Structured Abstinence Day Care: Case Studies -1NE and The Living Room, briefing paper available at www.povertydebate.com

139 Ibid

The advantage of residential rehabilitation is for those that need detoxification in a safe environment leading straight into a supportive rehabilitation programme.[140] It is especially relevant where there is the need for someone to move out of their immediate environment i.e. to get away from destructive/negative influences. A residential situation is sometimes not only safer but provides a context in which someone's behaviour and attitude is on show for longer and can therefore be recognised and, where necessary, be challenged and worked on.

Even the most basic of residential rehabilitation programmes provide a therapeutic environment, in that simply living 'in community' can cause the resident to face the consequences of their attitude and behaviour. Having to adjust to basic routines, getting out of bed at a certain time, living in close confines with others, having to do chores (as in any well adjusted family) can have marked positive effects on a participant.

Such therapeutic environments are of course significantly enhanced by those services (also available in structural abstinence day-care) such as group therapy and/or individual counselling.

Second Stage Residential Care[141]

Too often however the impact of residential rehabilitation is limited either because they cannot afford the level of after-care or a client moves outside of their geographical influence.

The term 'secondary residential' is used to refer to a number of different situations, needs and requirements. For example, Clouds's six week programme is automatically followed by a much longer period of 'secondary' residential rehabilitation in Hope House or Thurston House – possibly lasting a further 9 months or a year. Sometimes it refers to released prisoners' needs following detoxification and rehabilitation in prison. In both cases, there is an urgent need for the expansion of such 'safe' accommodation, and of continuing peer and professional support. This, too, can be funded by treatment vouchers.

For former offenders and those with life histories of institutionalisation this 'stepped' peer supported and monitored journey into independent living is of huge importance. We advise replication of the following models:

- *The Ley Community* outside Oxford provides a leading example of an enlightened and supported approach to reintegration into work and the community through secondary and tertiary shared accommodation arrangements retaining contact with the main community
- *Phoenix Futures* also offers 'attached' stepping stone shared housing in the community
- *The Spitalfields Trust* in its *Second Stage Semi Supported Housing*, including Acorn House provides another model

140 As currently offered by the Clouds detoxification model in the context of 6 weeks primary residential care

141 Proposals for further 'aftercare' funding streams are to be found in Volume 6, Section 3.3.7

We would like to see the big providers of hostels for the homeless, like the Salvation Army and St Mungo's, commit to and prioritise the provision of safe 'dry' hostels to provide secondary residential accommodation for those recently out of or still first stage abstinence treatment in addition to their current predominantly 'wet' accommodation. For funding from treatment vouchers, safe abstinence-protected accommodation with peer support would have to be approved.

3.2.4 'Faith based communities'

A number of the most successful projects like Yeldall Manor, Victory Outreach and Betel are informed by faith which, given the nature of addiction, can provide an important dimension to recovery.[142] The benefit comes from an approach which 'cares about the whole person' and which includes his or her spiritual needs. This is distinctly different in quality to the typical delivery of services which, as so often happens in the statutory sector, end up as dispensaries.

The faith elements very often act to boost motivation to change, help keep motivation high and provide a non judgmental route back to normality if there is relapse at any stage. Faith should not be a barrier to voluntary providers receiving funding or referral. The decision as to whether to use such a service should be for the client alone.

> "Faith acts on a personal and practical level. Faith is the currency of motivation. Faith provides HOPE, which again is another vital ingredient if new behaviours are to take root and be sustained. On a practical level the faith's themselves, particularly the Christian faith in this country, are strongly integrated in communities. This means they are able to provide (where it is wanted) a very significant, practical element of ongoing help, support and the opportunity to serve and take ones place in that community, leading to real and meaningful social engagement. Faith based residential centres also provide the staff at those centres the opportunity to model the behaviour and attitudes inherent in their faith to the residents on a programme. In Christian terms this is modelling the fact of total acceptance of oneself as a unique individual, made in the image of God. Residents have the opportunity to see the reality (or otherwise) of that new identity lived out in the lives of the staff in everyday situations."
>
> David Partington, Director, International Substance Abuse and Addiction Coalition

142 Betel, a leading faith based rehabilitation centre in the UK, is independent of state support and monitoring. Their residents enter and exit voluntarily, though are invited to join for a minimum of 12 to 18 months. It thrives on its independence and autonomy with residents helping to fund their own recovery through meaningful work in Betel's own workshops and businesses. The 'De Hoop' in Holland by contrast receives state referrals and is well known and respected for providing abstinence based care. It is very large and provides excellent opportunities for addicts to rehabilitate back into society, re-skilling and revaluing them through its own on site business and industrial training programmes

A recent Greater London Alcohol and Drugs Alliance conference on funding opportunities for faith groups highlighted their current concerns in relation to funding:[143]

> *'There was a perceptible level of indignation. Many remarked that they were not prepared to sacrifice some of the very aims and beliefs which made them so successful to join organisations which tailored their programmes to central and local government aims in order to win bids. One delegate claimed that the front-line work his organisation did, counselling and helping people in the most practical of ways, was by-passed, because its outcomes were not recognised; they were not, he said, "in treatment"…. One practitioner from Redbridge voiced his disbelief at the antipathy of funders to faith based organisations although they offered programmes that not only worked well but had, at their core, some sort of faith, be it Christian, Muslim or Jewish, of a general belief in something outside of the individual.'*

A re-occurring theme was the difficulties facing smaller agencies embarking on bids for funding - long, complex processes requiring resources and manpower, which by their very nature they do not have. Bigger organisations, with the necessary track record, are more likely to secure further funds and longer-term contracts, but may offer a less committed or effective service. Smaller charities typically secure limited funding, described as 'pocket money'. Their contracts are short-term, usually one year, making it impossible to compete with organisations winning three and five year contracts.

The State needs to recognise the need for space and support for faith based rehabilitation and day care to be run on its own lines within statutory inspection and care standards etc. It must be able to take advantage of government funding without having to restructure to meet arbitrary government rules, compromise their ethos and independence or jeopardise the uniquely valuable nature of their work. The voucher system enables this to take place.

A case study

Victory Outreach is currently at risk of losing their Supporting People funding and at risk of closure unless their service is remodelled in line with Supporting Peoples' new requirements. These determine the selection of Victory Outreach referrals as a condition of funding - only local people with 'chaotic lifestyles' are now to be eligible.

The type of young people Victory Outreach currently helps are accepted immediately from custody, some on strict bail conditions and most on license conditions. It is a uniquely important service for these troubled young people

---

143 Sam Sheerer reporting on F*unding Opportunities - Understanding how Faith Groups can Access Funding for Drug and Alcohol Work* (organised by the Greater London Alcohol and Drugs Alliance), Friday 23rd February 2007

many of whom have experienced life times of institutionalisation and neglect. Victory Outreach's particular approach with animal management and horse therapy has helped the 'hardest' of cases rediscover and rehabilitate themselves all of which has proved highly successful and reduced re-offending rates.

Supporting People is also demanding that tenancy agreements replace the currently arranged residency agreements, allowing the young people freedom in the local community and removing previously agreed safeguards. This new demand places the organisation at too high a risk to the community, staff and residents, and undermines the principles on which it is run.

If Victory Outreach comply their service, their viability and integrity is undermined. If they do not, they will have to close.

3.2.5 Addressing costs

Current treatment spending per problem drug user in the UK is significantly lower than in either Holland or Sweden.[144] It is still lower after taking account of the NTA's revised calculations of 'real' treatment spending of approximately £2,800 per head (compared with the lower EMCCDA figure). Holland, by contrast, spends approximately £5,400 per head on treatment and Sweden even more.[145]

There is no doubt – even allowing for potential efficiencies as a result of the voucher system and reduced administrative overheads – that funding 'proper' treatment means something like doubling the spending per drug user.

In-patient detoxification service/residential expansion costs

Within this framework, much needed reform and expansion of inpatient detoxification in the context of expanded residential provision is viable.[146]

A recent needs assessment found that the current level of provision is insufficient to meet demand. It concluded that the number of residential rehabilitation places required is likely to be in the region of 24,585, covering 16,390 short term inpatient detoxification places and 8,195 residential rehabilitation places (representing increases of 90 per cent and 34 per cent respectively). Although this is from some points of view an unhelpful division, as detoxification needs to be part of an integrated residential programme either leading to further residential or to community treatment, it provides a benchmark for expansion and costs.

Previous costings made on the basis of daily NHS inpatient costs should not be used as a bench mark.[147] These are massively more expensive than superior

---

144 See section 4

145 Andy Horwood, A Perspective on the Commissioning of Recovery', briefing paper available at www.povertydebate.com. This analysis of drugs treatment spending in the South East Region of England shows that only 30% of what is spent on 'treatment' is actually spent on treatment

146 It identified considerable variability in detoxification provision across three main settings - specialist units, residential rehabilitation services and generic medical and psychiatric wards that provided detoxification from drug misuse. Problems were identified with the level of medical cover, the adequacy of staffing levels and the effectiveness of care planning and integration into through-care and aftercare. 'Tier 4 Drug Treatment in England: Summary of inpatient provision and needs assessment', Dr David Best, Alison O'Grady, Ionna Charalampous and Dawn Gordon, June 2005 Research Briefing, NTA

147 £3500 per day in NHS hospitals. In many cases this will not include anything other than the detox, which is known to be ineffective

detoxification in residential settings which have the added benefit of an integrated model. At Clouds, the highly intensive programme includes simultaneous, psychological treatment, costing in the region of £175 per day for up to two weeks for most detoxes. If the psychological components were removed, it would only marginally reduce costs and would be less effective. The cost for six weeks, therefore, is £175 x 42 days = £7,350 - this is an all-inclusive cost.

Other less complex detoxifications in residential centres are cheaper. Phoenix Futures detox programme costs per day are just over a £100. Subsequent weekly residential rehabilitation programme costs at their Sheffield Centre run at £542. Many of those graduating from the Phoenix programme were long term addicts and are former offenders. At £22,500 for a year of residential treatment, this is a far more effective investment than the current £40,000 a year which prison costs the tax-payer. And for many the period in residential rehabilitation will be significantly less. Treatment vouchers could be accumulated over more than one year or set against future years following careful assessment.

The cost of *not* achieving abstinence also needs to be computed in terms of emergency health admission costs, ongoing calls on health and medical services, incapacity benefits and welfare dependency costs as well as collateral damage costs to children, family and society and crime and or prison costs. The investment in residential rehabilitation needs also to be assessed in terms of significant methadone costs saving. Ten years on methadone, which is not unusual, currently costs around £20,000. This is without associated 'treatment' costs and continuing calls on health and social services.

Expansion of provision funded by treatment vouchers will also meet the needs of alcoholics and poly-substance abusers who require inpatient detoxification, who have suffered from both the recent cuts in hospital provision and the lack of any integrated treatment programme and for whom the current 'community' detoxification provision is inappropriate.

Structured Abstinence Day Care Costs

Structured Abstinence Day Care is an enormously cost effective treatment. The per head, per day calculation for The Living Room Treatment Service (2007) is £36.33:

It costs approximately £260,000 a year to run The Living Room each year.

- *Our three day a week Crèche costs: £51,244*
- *Our Friends and Family Support Group costs: £12,562*
- *Our Treatment costs: £196,194*

We would argue that our Crèche and Friends and Family support are integral in promoting good recovery and should be incorporated in any daily charge; equalling:

£260,000 (estimated at 2007 budget)
122 treatment clients = £2180 per client /60 days stay = £36.33 a day per person[148]

The unit costs for 250 clients per year in structured day care at 1NE, based on core funding, is very similar:

Core funding = £150,000. accounts for 50 per cent of total service cost
Per client = £600
Per week = £100 per six week programme

If a client stays longer this reduces the unit cost e.g.
Per week = £50 for a twelve week programme

External fundraising brings our annual turnover to £300,000 therefore
Per client = £1,200.00 (including costs of outreach work)
Per week = £200 per six week programme[149]

Many clients attend the programme for longer than six weeks which reduces the unit costs further.

As good practice examples it is important to emphasise that these are more than 'just' Structured Day Care, as currently delivered through 'models of care' commissioning. They also provide peer support, outreach, childcare facilities, individual counselling and family support.[150]

On this basis, they are even better value for money than the currently commissioned 'just' structured day care which NTA figures show to be nearly twice as expensive - a national average costing of £300 per week, and £3,600 per twelve week programme per client.

Since core funding at 1NE accounts for only 50 per cent of the cost of running the service, significant energy has to be expended in raising the rest of the money charitably. The current commissioning system is penalising best practice services. Under treatment vouchers and an abstinence policy direction they will be able to expand and at a lower cost, meeting more needs than current day care with prescribing provision:

My vision for my area would be to have 3 such centres to meet geographical and population needs, which equates to one centre for ~50,000 of the 15 to 64 age range. Not much you may think, but if they each saw ~250 per year that would exceed current numbers engaged (~620), and meet the wider range of addiction needs. And it would cost less! Only

148 Structured Abstinence Day Care: Case Studies -1NE and The Living Room, briefing paper available at www.povertydebate.com
149 Ibid
150 Ibid

~£750,000 as against ~£1.2million – I know that current figure includes all the currently accepted 'modalities', but you know I'm quite clear that prescribing is only symptomatic relief, for example.

If this benchmark were applied across the country (i.e. one centre per 50,000 target population) we would need ~1,000, at a total cost ~£30million, but you would be engaging and possibly getting ~250,000 addicts into recovery within a year!

A DAT Coordinator

3.2.6 Treatment priorities

Families with children

Families with children must be actively prioritised for treatment if we are to break the cycle of addiction and protect children and it is vital services are integrated. Social workers, drugs counsellors and child protection services must work together to identify and help families where children are at risk from parental substance abuse and are likely to go into the care system. Parental substance abuse should be deemed, in itself, as an 'at risk' situation. Effective, practical and responsible cooperation is imperative.

Immediate national implementation of *The Hidden Harm Report* proposals is urged. Government response to date has been inadequate.[151]

Treatment and Support in the Community

Families with children may need special services that are discrete from and additional to other adult structured day care services. We propose funding for the development of innovative projects, such as the 'Safer Families Projects' pioneered in Bolton,[152] to be open to tender from the third sector and faith organisations and from combined third sector/statutory sector bids, to be established in AAC areas according to need. AAC would seek start up funding from the National Treatment Trust for the successful bid.

Family Residential Expansion

The number of family residential services has halved, and their future is in jeopardy. This decline in numbers must be reversed. We would suggest that the three proven existing providers, *Gilead*, *Addaction* and *Phoenix Futures* should be supported to expand these services to other areas, increasing the number from five back to 15 as soon as possible. Start up funding would be matched by or met from the National Treatment Trust. Placements would be funded by family treatment vouchers.

These residential centres provide the 'dry dock' environment that allows families with substance abuse problems to address many areas of their life in

151 See Breakdown Britain interim report, Volume 3, 2006

152 Harbin and Murphy, *Secret Lives: growing with substance*, 2006, pp 95-108. The aim would be to keep children with their parents if possible while addressing the parent's addictions and giving good parenting guidance and support and watching over the children's needs.

one place, including their parenting skills, in an environment that is totally supportive and caring of the children. They will provide the opportunity and time to learn and practice new behaviours in a safe environment. Testing these new found skills and sometimes failing in the application of them provides fine tuning for re-entry into life outside that community. Most importantly, they protect against family break up and the removal of children into care.

Residential centres often have a good resettlement infrastructure. This is vital if change is to be lasting in the real world. We saw this in action at *Phoenix* in Sheffield.

3.2.7 Alcohol treatment

Figures released under the Freedom of Information Act show that most Primary Care Trusts allocate no special funding for the treatment of people with an alcohol problem.[153] In the last year the average amount spent on alcohol treatment by a primary care trust was £273,495 and compared to £4,156,082 spent on drug treatment.

'Brief Interventions' and alcohol screening in GP surgeries and A&E[154]

We propose nationwide training of GPs to provide this proven intervention. It is widely accepted that they are a cost effective tool in reducing consumption of heavy drinkers and associated alcohol related harm.[155] Analysis of Randomised Control Trials shows that heavy drinkers receiving brief interventions in a primary care setting were twice as likely to moderate their drinking when compared with drinkers receiving no intervention.[156] UKATT – by far the largest UK trial of treatment for alcohol problems to date – confirmed the effectiveness of brief interventions and asked for a broadening of the base of treatment and interventions for alcohol misuse. UKATT believed that such interventions were needed to respond to the full range of alcohol-related harm through:

- Early intervention to prevent severe alcohol dependence
- Secondary prevention of medical, psychological and social damage
- Reduction of current levels of alcohol-related harm
- Identification of alcohol misusers with serious problems who need specialised treatment

---

153 Obtained by David Burrowes MP

154 A key policy objective of a number of expert groups in the field including Action on Addiction who have run a major campaign on this; and Alcohol Concern's A Glass Half Empty: Alcohol Concern's Review of the Impact of the Government's Harm Reduction Strategy, May 2007

155 Excessive drinking behaviour, often described as problem drinking, heavy drinking, or at-risk drinking, is generally not associated with alcohol dependence such as major withdrawal symptoms, tolerance, complete loss of control, or preoccupation with drinking

156 Meta-analysis of Randomized Control Trials Addressing Brief Interventions in Heavy Alcohol Drinkers, Alev I Wilk, MD, Norman M Jensen, MD, MS, and Thomas C Havighurst, MS J Gen Intern Med, 1997

The Government's alcohol treatment policy is effectively limited to guidance on local development without any funding.[157] The £15 million nominally earmarked to improve alcohol interventions is not ring fenced. Where PCTs do not have alcohol as a key priority, as seen in Enfield, the £80,000 earmarked for alcohol screening has sometimes been withdrawn to cover financial deficits.[158] As a result, the Government's new alcohol strategy remains entirely inadequate.[159] Exhortation without treatment and without harm prevention will not work.

We propose a proper commitment to funding that is directed at GP training. We do not think this should be an 'add on' to GPs contracts but should be regarded as fundamental to 'prevention' health care work.

Those presenting with severe alcohol dependence should be referred to their local 'One Stop Shop' for detoxification and treatment, either residential or in structured abstinence day care funded by the treatment voucher system.

3.2.8 Peer support: Alcoholics Anonymous and Narcotics Anonymous

We advocate a greater recognition and use of Alcoholics Anonymous and Narcotics Anonymous. Peer support is one of the most effective forms of treatment and is the only one that is entirely free.

Addiction Action Centres should be expected to develop close contact with local groups and direct clients to them, to take advantage of the sponsorship, mentoring and additional peer support offered. The value of such groups cannot be over-emphasised. There is evidence to show that ongoing peer support of the type given by the AA and NA fellowships, along with associated support groups such as Families Anonymous, not only is beneficial to the individuals involved but saves statutory services significant costs. The 12 Step programme used by AA and NA has stood the test of time. For many of those who belong, it has resulted in many years of sobriety.

Twelve-step-oriented inpatient treatment programmes emphasise the importance of ongoing attendance at self-help groups, far more than cognitive-behavioural (CB) inpatient treatment programs. This needs addressing because the difference in therapeutic approach leads patients who are treated in 12-step programmes to *rely less on professionally provided services and more on self-help groups after discharge and thereby lowers subsequent health care costs.*[160]

There is little doubt that if such a group – the only 24/7 dependency service in the country – could be publicised better, and used more, they would have an

157 Identification and Brief Advice Trailblazer Programme, Department of Health
158 David Burrowes MP
159 Home Office, Safe, Sensible, Social: Next steps for the government's national alcohol strategy
160 Humphreys, Keith; Moos, Rudolf , Can Encouraging Substance Abuse Patients to Participate in Self-Help Groups Reduce Demand for Health Care? A Quasi-Experimental Study. Diagnosis and Treatment Alcoholism: Clinical & Experimental Research. 25(5):711-716, May 2001

even more significant impact on the overall wellbeing of our society. The 12 Step movement does not, in line with the philosophy of its 'traditions', communicate itself as well as we would wish. The annual AA presentation at the Houses of Parliament is an important step in this direction. We would hope to see NA mirroring this.

We would like to see AA and NA recognised by all statutory and voluntary 'services' that are involved in helping with any addiction or dependency problem.

3.2.9 Training and qualifications

Under Nick Barton's stewardship, Clouds has become a leading provider of addictions counsellors to the field, teaching degree level courses in partnership with the University of Bath.[161] This has provided a model of appropriate training which needs replicating at other universities. There currently exists a wide range of counselling qualifications of different levels.

Guidance would be required on appropriate or desirable training and qualifications for those working in 'One Stop Shops', as Addiction Action Coordinators and others working in Addiction Action Centres and the National Addiction Trust.

Guidance would also be required on the employment and training of recovered addicts. The NAT would need to stipulate, for example, how many years in recovery is appropriate and on what sort of programme, and the need for formal counselling qualifications.

3.2.10 The management of change

Under our proposals, the most challenging job of both the new National Addiction Trust and the Addiction Action Coordinators would be the management of change. The driving force is the redefined notion of treatment (the separation of the treatment of addiction for recovery from the management of public health and clinical needs).

Methadone prescribing would begin to be offered in the context of a 'change programme', as a stepping stone towards recovery. GP's and Addiction Action Coordinators would review their patients on methadone, paying particular attention to those in receipt of prescriptions for a number of years whose health and social functioning has shown little improvement. Shared care prescribing with GPs with pharmacy dispensing would need to be urgently reviewed. Other models like Kaleidoscope's which is well placed for a 'stepping stones' to change approach are preferable.

Addiction Action Coordinators would oversee contact between experienced drugs counsellors and those currently 'in treatment' on maintenance and reduction prescriptions, to establish their hopes from treatment and explain the possibility of recovery, the routes to be taken and the support available.

---

161 Nick Barton is now joint CEO of Action on Addiction

Such interviewing would ideally take place on every prescription renewal with an alternative offer of treatment made and encouraged, but working on the development of relationships. Practices developed by Darren Worthington and his SMART team in Oxford with their original arrest referral work is a model of best practice in approaching and motivating long term/ entrenched addicts.

Addiction Action Coordinators should be aiming to reverse the 70/30 balance between harm reduction and recovery as outlined in our 'Commissioning Recovery' briefing paper.[162]

The recovery/rehabilitation approach should become an extension and transformation of existing services. It is vital that seamless services exist not just in name but in reality. Addiction Action Coordinates need to work together with the structured day care and residential providers to plan a client's treatment journey rather than allowing the present, disjointed approach to persist.

3.2.11 Public health reform

The responsibility for public health promotion belongs with Public Health Authorities.

Under the present system, DAT commissioned harm reduction and harm minimisation services, set up with the clear intent of promoting public health as well as the personal health of addicts, are clearly failing. They are costing a significant proportion of the current 'treatment' budget while contributing to more complex problems for future treatment.

We therefore propose:

- Overriding responsibility for such services to lie with Public Health Authorities
- A clinical evaluation to be conducted of 'harm minimisation' services for the treatment and management of personal and public health harms. This should include prescribing services, needle exchange and safe injecting, outreach programmes. This should be undertaken by a known centre of excellence in preventative medicine and health science
- Public health authorities to establish clear protocols, goals and standards for viral testing and immunisation as well as for overdose prevention measures and risk assessment in relation to injecting techniques
- A statutory obligation for harm reduction and harm minimisation services to meet agreed clinical standards; to provide gateways to treatment; and to provide information about health risks and costs
- Closure of substandard services
- Addiction Action Coordinators to have a responsibility for liaising with public health services at a local level.

---

162 Andy Horwood, A Perspective on the Commissioning of Recovery, briefing paper available at www.povertydebate.com

Good public health promotion should also work towards prevention and this attitude should inform all those working in these services. We accordingly further recommend that:

- Any public health commissioned harm minimisation services should employ full time drugs counsellors enjoined to motivate, direct and support clients into treatment.
- Health assessments, including of the need for dental treatment, should be provided by harm-minimisation services.

Dental treatment

We were shocked to see the very poor dental health of most addicts in recovery and of drug using adolescents. By contrast we were incredibly impressed by the attention paid to the dental health of all the addicts entering the treatment at the Jellinek Clinic in Amsterdam in Holland. Not only did they treat their own patients but they took patients from all other local addiction treatment services in the vicinity whether faith based or services run by the local authority. They were sensitive to the extreme dental pain that addicts undergo during recovery lacking the pain killing effect of their previous drug use, with teeth that have massively deteriorated during their drug taking life span.

We would like to see such enlightened initiatives start in the UK – maybe starting at the National Addiction Centre under the direction of the newly amalgamated Action on Addiction. We feel this is an area for the largest addiction charities such as Addaction, Turning Point and Phoenix Futures to take a lead on.

3.2.12 Research needs

For a recovery oriented policy to be truly effective, clarity about outcomes is essential. We need to have settled definitions of what is meant by abstinence – from illicit drugs or from all psycho active substances – and what other outcomes 'count'. Improved mental health and social functioning, re-integration in to the community, capacity for work and independence are all possibly measurable outcomes.

Research is also required to identify which treatment programmes are most effective in achieving abstinence for particular types of users and their key ingredients. It is on the basis of 'outcomes success' in these terms that clients should be directed towards specific programmes.

We anticipate that, in response to this report, the National Treatment Agency will argue that they have this research in hand. This is not the case.[163]

---

163 Following the launch of the Treatment Outcomes Profile (TOP) in May 2007, the NTA are to roll out a national assessment of outcomes with effect from October 2007. The tool is to be an intrinsic part of reporting to the NDTMS system, with the aim of assessing the 'distance travelled' in treatment in terms of drug and alcohol use, physical and psychological health, social functioning, and offending and criminal involvement

Their new 'Treatment Outcomes Profile' is intended to be utilised as a part of standard care planning and management, to be administered at assessment, quarterly reviews, and at discharge from treatment. Depite the NTA's much vaunted and long-term emphasis on outcomes, the process of piloting and validation of the tool raises several questions and issues.

The piloting was undertaken with a sample of 829 service users of the range of Tier 3 and 4 structured interventions, with only 700 of these engaged a week later as part of the validation exercise, and only 500 re-engaged after 30 days to assess the tool's effectiveness at capturing change. Whilst retention is a different issue, it is disappointing to note that this equates to only 60 per cent of the original sample of service users being engaged in the exercise.

The timescale of the piloting of the tool was also rushed through over a period of six months, with no opportunity to undertake the envisaged follow up at three months. After such a time period the only significant capture of 'change' was with regard to drug use. It was noted that such a time frame meant it was "too early" to measure impact in physical and psychological health, and quality of life categories.

The national launch has now embedded a further thirty information items within NDTMS requirements, with no opportunity for feedback or refinement "for at least a year". Feedback on implementation and how the TOP may or may not be useful is not anticipated before March 2008, relying entirely upon field-testing as a 'live' tool until then.

Furthermore the 'harm reduction' departmental drives for the National Drug Strategy are evident in the emphases accorded to 'injecting risk behaviour' from the Department of Health and 'crime' from the Home Office, which comprise two of the four sections of the tool. The other sections, which seek to record the past month's useage of alcohol and illicit drugs, use the term 'abstinent' to mean 'not using on top'. In short, the NTA document itself is symptomatic of much that needs reforming in the attitude to and delivery of 'treatment'.

Innovative research – the case of neuro-electric therapy (NET)[164]

Part of the reason for the poor level of information currently available is that only a quarter of one percent of the drugs budget is currently spent on research.[165] More is required. Relatively small amounts of money are needed to fund proper randomised trials of the innovatory and possibly revolutionary approach to detoxification, neuro- electric therapy (NET) detoxification trials.[166] This approach was pioneered in the 1970s but has never met with the approval of the scientific establishment wedded to psycho-pharmacology. A small trial recently conducted in Scotland on six highly entrenched addicts

164 Neuro Electric Therapy, a non pharmacological detoxification procedure pioneered by Dr Meg Patterson, based on electrical-wave frequencies appropriate to each drug of dependency or combination of drugs, claiming 6-8 days for heroin and for methadone 8-10 days

165 Professor Neil McKeganey, evidence to the Social Justice Policy Group

166 Lorne Patterson, evidence to the Social Justice Policy Group

reported a reduction in cravings. A trial conducted in the 1980s showed the NET process of detoxification to be shorter and more effective, even if more extreme than methadone detoxification. But this has never been followed through by the medical establishment.[167]

3.3 Breaking the cycle 3: Addiction and Crime

The Criminal Justice system has great potential as a route to treatment. Our analysis in Part One of this report showed the Government's current target-driven handling of this process is not working and is counter productive due to both coercive processing into substitute prescribing and to the low threshold of expectation of recovery implicit in this treatment. There is no doubt however of the impact abstinence based treatment programmes can have on the prevention of criminal behaviour by increasing offenders' ability to reassess their former lifestyles and values.

Addiction Working Group members, and staff and clients at Phoenix Futures Adult Residential Rehabilitation Centre, Sheffield

3.3.1 Criminal justice interventions reform[168]

We propose halting the current roll out of the Criminal Justice System's Drugs Intervention Programmes until Drugs Courts and appropriate treatment can be put in place. We propose also a review of the role of 'fast prescription' nurses for arrestees, in order to determine the appropriateness and pressure of this intervention.

Drugs and alcohol rehabilitation requirements

Once our proposed new arrangements for drug and alcohol begin to come into place, we would propose the introduction of combined drugs and alcohol treatment orders at the discretion of magistrates and following advice from arrest referral workers. Some evidence of motivation on the part of the arrestee must be established if these orders are to work.

Abstinence Orders

It is essential that rehabilitation requirements are made in designated and meaningful residential settings or in highly structured community based abstinence programmes such as that offered by SHARP. For serious offenders they could be made within the dedicated rehabilitation prison wings.

The current orders require testing only for opiates and crack. Judges have told us that those on orders return for testing 'stinking of methadone and alcohol' but still achieve negative tests. This requires reform. Appropriate treatment settings will require abstinence.

---

167 Gossop et al 'The Clinical Effectiveness of Electrostimulation vs Oral Methadone in Managing Opiate Withdrawal '

168 For back ground discussion see section 2.1.6

Arrest Referral

We propose some reversion to the original less coercive arrest referral procedures. Drugs counsellors should access custody suites and cold call individuals offering help for their drug problem and seek prior agreement for otherwise mandatory drugs and alcohol testing. This gives time for the counsellors to develop relationships with the arrestees, and enables them to use professional judgement in identifying those most likely to benefit and 'stay the course'.

Family Member (substance abuse) Court Orders.

We believe families should have the opportunity to seek orders for family members who they deem to be at serious risk either to themselves or to other family members.[169]

3.3.2 Drugs Courts[170]

The existing experimental drugs courts, as in West London, are clearly effective, have great potential, and should be continued and replicated. Their target clientele should be 'revolving door offenders' with serious drug and alcohol abuse problems.

Addiction Working Group hearing

Drugs Courts should have local drugs counsellors or advisors attached – ideally to be drawn from the local NA or AA community.

As above the orders must both be abstinence based and only given when appropriate treatment facilities are found for the order to take place.

We believe that Drugs Courts require careful trialling and monitoring.

We believe they should funded by a special drugs court budget from the Home Office NOMs budget to cover treatment and process costs.

3.3.3 Prison treatment reform[171]

In Part One we identified the huge gap between need and provision of treatment in prisons. Our key proposal is that the prison treatment budget should primarily be directed to assessment and detoxification in the context of rehabilitation programmes, taking unique advantage of the prison setting and length of sentence.

We are concerned about the massive expansion of methadone prescribing implicit in the Integrated Prison Treatment Strategy and its disappointingly low aspirations for treatment, constrained by arbitrary targets and limited per-

169 Highlighted by the case of Fiona Hones, who died from alcohol abuse. *The Sunday Times,* 11th February 2007

170 See 2.1.6

171 See2.1.6; and Russell White, op cit

formance indicators. This requires review. At present it constitutes a backwards step and will have a knock on effect for the current 'methadone log jam' in the community.

A therapeutic community or 12 step programme dedicated wing in every prison
This is our key long term recommendation. We propose an expansion of the existing 16 such dedicated programmes (currently mainly provided by RAPT and Phoenix Futures) to every prison within the estate. Abstinence programmes in prison settings are highly cost effective and much cheaper than residential programmes in the community for obvious reasons. We have calculated that a modest budget of £30 million would cover a tenfold expansion required to place 'dedicated wing' 12 step programmes in each of the 109 prisons and could be easily and productively funded from the NOMS budget.[172]

Such programmes currently reach a tiny minority of prisoners. Evidence of effectiveness was set out in Part One. The desirability of discrete wings is clear. It allows the development of a genuinely supportive therapeutic community and acts as a necessary protection from the high level of drugs activity that exists in many prisons.

Our immediate recommendations within the current framework are for:

Broader HMP key performance indicator targets to reduce target driven pressure on services and incorporate quality indicators.
New indicators should ensure a holistic approach concentrating on outcomes, not processes or activity levels. They should cover:

- Infrastructural concerns including but not limited to quality of basic facilities, computers per staff member, available assessment rooms, quality of training and numbers of trained clinical staff;
- Types of intensive treatment programmes provided assessed against the establishments treatment needs;
- Aftercare provision packages arranged before exit;
- A range of assessed outcomes of rehabilitation treatment;
- Analysis of prisoner surveys to assess satisfaction.

The separation of audit and inspection from in-house drug treatment development, and an enlarged inspection role.
The Correctional Services Accreditation Panel's (CSAP) recommendations for enhanced inspection should be implemented. However, CSAP itself currently has a conflict of interest in assessing its own drug treatment programmes. An enlarged audit and inspection role should be undertaken by a clearly inde-

172 Based on our understanding that the annual budget to run one dedicated wing is £300,000. NOMS - National Offender Management Strategy

pendent body. The new body should provide enhanced monitoring, flagging failing institutions and conducting short term inspections when required.

Independent research, review and analysis of the state of 'joined up' services.
At the moment it is difficult to assess the functioning of service 'elements' together. A thematic paper should assess these interactions and provide recommendations for improving 'joined up' service delivery.

Better research and evaluation of intensive treatment programmes.
Further research would inform best practice. In particular, a study of the recently introduced Short Duration Programmes (SDP) should be undertaken. Given the importance of this programme to CARAT clients who predominantly serve shorter sentences, the importance of maximising best practice and highlighting areas for improvement is obvious. More research is required overall into the needs of drug addicted prisoners, and into the comparative outcomes from different types of intervention.

Population needs analysis research at every prison establishment in the UK as standard:
This is essential to allow services to be tailored to assessed need and to provide a strategic picture for future policy development.

The provision of proper alcohol treatment services in prisons.
Assessed need for Alcohol treatment as the main problem drug for CARAT clients is very high. Alcohol should be included in the CARAT services remit for those whose sole problem is alcohol. Funding should be available and properly aligned. Failure to do this currently is incoherent and inconsistent with aims to properly treat offenders.

Specific development of treatment programmes designed for prisoners whose problem drug is crack cocaine (in connection with the development of abstinence services).
The prisons inspectorate have recognised that there is a lack of attention to crack cocaine. This should be addressed by the provision of adequate programmes and capacity. Since there is no pharmacological intervention this suggests that abstinence based therapeutic programmes are the logical and desirable response.

Women's Prisons and Treatment.
We have not been able to extend our policy review to the specific questions that arise in women's prisons, but have noted the recommendations of the Corston Report published recently.[173] We were struck by Baroness Corston's recommendation for the closure of womens' prisons within the foreseeable future and for womens' sentencing to take place in the community. In this context, we feel the

173 Baroness Jean Corston, 'AReview of Women with particular vulnerabilities in the Criminal Justice System', Home Office, March 2007

development of family and or mother and child residential centres as described earlier in the report to be of great importance.

HARM PREVENTION

3.4 Alcohol Solutions

As well as ignoring treatment needs, the Government has consistently failed to address the most effective way of preventing and reducing alcohol related harm – through taxation. The recent update of this Government's alcohol strategy, in face of the growing number and cost of problem drinkers, finally indicates a willingness to engage in the issues of price and availability subject to research.

At our request, the Institute of Alcohol Studies has provided such research. It has conducted a comprehensive and rigorous review of expert research on the evidence base regarding the most effective way to limit the detrimental effects of alcohol on society and the individual.[174] This is available for the Government to consult and we advise they do so as they undertake their review of the relationship between alcohol price, promotion and harm.

> *The level of taxation on alcohol should be raised in order to benefit public health and public order. This is the conclusion drawn from an analysis of the available data and existing literature concerning alcohol and price. An increase in the level of excise paid on alcohol will lead to a decrease in the consumption of alcohol. This will reduce the social, economic and health costs that result from alcohol consumption.*
>
> *The best form of alcohol taxation from a public health perspective is unit taxation, by which excise levels are set according to the volume of alcohol contained in a drink. This is an easy to administer and effective means of taxing alcohol and it reflects the most basic and obvious consideration that it is alcohol that does the damage, and alcohol is alcohol, irrespective of the beverage in which it is contained. As alcohol taxes comprise a fixed sum of money for a given quantity of alcohol, it is necessary to ensure that they increase as a minimum in line with inflation in order to avoid their constant erosion.*
>
> The Institute of Alcohol Studies

Our key proposals to prevent alcohol related harm is based on this research.

The informed conclusion of the IAS review is that given the strong link between the overall level of alcohol consumption and the level of alcohol-related harm, it is wrong to suppose that alcohol harm can be stabilised or reduced while overall consumption continues to rise.

---

174 IAS Submission to the Social Justice Policy Group: Alcohol, Pricing and Tax Issues, Russell Bennetts, Gustavo Renaldi, April 2007. Available at www.povertydebate.com.

Yet people now have the means to purchase more alcohol than at any time in the previous three decades. This is due to some combination of:

- The reluctance of successive Chancellors to put up alcohol taxes.
- Lower costs in the alcohol industry itself, due to more efficient production and marketing, along with a trend for consolidation of the market.
- Increasing amounts of disposable income as the UK continues a prosperous growth pattern.

The most pressing need, therefore, is for any Government publicly to recognise this link and to adapt its public health strategy accordingly. A commitment to preventing overall consumption rising further and, preferably, over time, to bringing it down to an agreed lower level, would help to provide a rational goal and focus to the alcohol harm reduction strategy that is presently lacking. Alcohol is no ordinary commodity.[175] Here we provide the summary argument for the need to raise the level of taxation on alcohol which we believe is compelling.

3.4.1 Raising the price of alcohol[176]

There are three factors to consider when looking at levels of taxation on alcohol.

The first is whether the present price structure reflects the true cost associated with alcohol consumption. We have already shown in Breakdown Britain that the amount of alcohol consumed has increased dramatically, a doubling of consumption by women in recent years, children as young as 11-12 years old binge drinking regularly, over 60 per cent of boys admitting to doing so by the age of 15, and over a third of young people having an alcohol misuse disorder. Cirrhosis of the liver has gone up 350 per cent and is increasingly common amongst young adults. It is also evident that that there is a strong link between underage drinking and illegal drugs.

The social problems and health problems associated with excessive drinking are also evident to everyone. Regular violence in the city centres around the clubs and bars late at night, putting pressure on ambulance and accident and emergency services.

As a result of this, the cost to our Health Services and the Police has risen accordingly. These costs are borne by the general public through their tax bills and are directly related to the quantity of alcohol consumed by the population. This has to be set against the fact that the price of alcohol is at historically low levels when compared to income. Prices alone are not enough to allow us to see

175 It is important for policy makers, treasury officials and health economists to consult the full IAS document, available at www.povertydebate.com.

176 See 1.15, over

whether alcohol has become relatively cheaper; instead we need to look at *affordability*. The IAS economists have computed an affordability index by comparing per capita income with the price of a single unit of beer, wine and spirits. This tells us how many units of a product a consumer would be able to buy if they spent all of their available income on that good.[177]

In addition to VAT, the main pricing instrument used by the government in relation to alcohol is excise duty. But over the period 1975 to 2006, excise levels have risen only with the growth in consumer prices.[178]

Beer has become increasingly affordable: for wine and spirits, affordability has been rising at a rate even greater than that for beer.

In other words, there has been no signal through price that alcohol is a commodity different to any other. From a public health perspective this is disturbing, since the same period has seen increasing levels of harm due to alcohol in most domains. There is clear evidence in the IAS report that changes in the level of excise paid on alcohol affect the consumption of alcohol, and hence the social, economic and health costs that result from alcohol consumption.

The second factor is that evidence shows that even people dependent on alcohol are affected by price increases (economists speak of them as suffering from a form of 'rational addiction'). Young people are also affected by price of alcohol more than other groups, reflecting their lower disposable income. So the price has a significant effect on levels of consumption, including the levels of consumption of more problematic groups. Therefore levels of comsumption can be affected and lowered according to the price and affordability of alcohol.

The third factor to be considered is the increase in the demand for treatment, including addiction and associated behavioural problems, resulting from 'affordability' and increased consumption. Revenue in the form of a treatment tax would be one way of raising the relevant amount of money to pay for such treatment. Revenues raised could also extend to funding addiction treatment more generally, including drugs, where there is a need for proper rehabilitation. Our earlier recommendations are for a change to the present drugs strategy to include greater levels of rehabilitation in line with the Swedish and Dutch systems, the cost of much of this could be borne through a treatment tax on alcohol.

Our recommendation in the light of these three factors is that an incoming Conservative Government seriously considers how to affect the price of alcohol including the possibility of a treatment tax.

---

177 i.e. Affordability = $\frac{\text{Available Income}}{\text{Price of One Unit}}$

178 After a decrease in 1970s followed by a steep increase in the first half of the 1980s, the Chancellor has kept the tax burden on beer relatively proportional to any rises in consumer prices (with a slight rise since 2000). This is similar for wine, where we can observe a fall in the late 1970s, a brief rise then fall in the early 1980s, and a constant level since (albeit with some small growth). The case for spirits differs from that of beer and wine in that the tax burden has been almost continually eroded over the past few decades.

Pre 1997 Pricing Policy

The last time a UK government committed itself to including taxation policy as part of its effort to improve public health was in 'Health of the Nation'-the final public health strategy published by the Major government which committed the treasury to set excise duties with some view to public health. This pledge was discarded with Labour's election to power in 1997 and the 2004 Alcohol Harm Reduction Strategy explicitly rejects the use of taxation policy, arguing that the drivers to excessive consumption are too complex for a blunt instrument and that any such proposal is politically unfeasible. In the words of an Institute of Alcohol Studies analysis, "the Government was rejecting the advices of virtually the whole scientific and public health community based on the accumulated international evidence that the price of alcohol is one of the principal influences on levels of consumption and harm, and, particularly, in a high alcohol tax country like the UK, tax is a major determinant of price.[179, 180]

3.4.2 Drink Driving – lowering the blood alcohol concentration limits

We recommend that alcohol concentration limits be lowered to 0.5g/L and to 0.2g/L for inexperienced, two-wheel, large vehicle or dangerous goods drivers.

The case for this is clear. More than one in three road accident fatalities across Europe are caused by drink driving. Setting a low level of blood alcohol limits for the most dangerous categories of driver and vehicle, together with frequent and visible enforcement of existing blood alcohol limits for other drivers, and establishing a high risk of punishment especially through randomised enforcement, is a combined strategy with strong potential for success. License disqualification is the punishment that seems to have consistent impact and is effective for both alcohol involved and non alcohol-involved accidents.

3.4.4 Reviewing the Licensing Act 2003

The effect of the Government's controversial licensing liberalisation on both alcohol consumption and alcohol-related problems has not yet been fully assessed not least because it was introduced by the Government without associated monitoring to allow for the measuring of subsequent changes in consumption and patterns of drinking.

Studies from other countries have always suggested that longer hours increase alcohol related problems[181] and that controlling alcohol availability can contribute to the reduction of alcohol problems. Reductions in the hours

179 Institute of Alcohol Studies (2006) Tax and Price and Public Health, IAS, London
180 Alcohol Concern Submission
181 Raistrick et al 1999

and days of sale, number of outlets, and restrictions on access, are associated with reductions in use and related problems. The Licensing Act 2003 ran counter to this evidence.

All available evidence indicates quite clearly that prevention regulations directed toward commercial sellers and backed up with law enforcement are more effective than education programmes or persuasion strategies directed at individual drinkers – the type of interventions that typify present policy on harm reduction. A full review of the Act is therefore recommended.

Alcopops – time to call time

Alcopops have been around since the summer of 1995 and have quickly fed into an already increased drinking pattern among young people with an explosion of brands and types of drinks from alcoholic milkshakes buzz drinks that contain herbal stimulants. The voluntary code of practice relating to their marketing does not appear to be working. 10 per cent of young people now drink alcopops on a regular basis. Most of these drinks have an alcohol content of around 5 per cent which is stronger than normal strength beers. A reformed system of pricing would negatively impact on sales.

3.5 Drugs Solutions

3.5.1 Controlling supply and availability

In our interim report, we critically reviewed the Government's supply reduction strategy and found it to be beset with problems typical of the rest of their performance managed 'reduction' strategies.[182]

Controlling the supply of drugs into the country is extraordinarily challenging by any standards. The economics of the international drugs trade, described by the Transform Drug Policy Foundation183 as worth over £100 billion a year with incomparable profit margins, effectively eliminate normal risk factors associated with enforcement, arrest and punishment. That drugs are cheaper and more available than ever before is incontrovertible. However, the step from this to the conclusion that their supply is uncontrollable is not. There is no existing bench mark of supply in a totally uncontrolled market against which to measure what is happening. It could be a lot worse.

It is further argued, by both the 'drugs prevention' lobby and by the 'legalisers', that it is demand that accelerates supply. We suggest, after looking at the case of the nations' favourite licit drug, alcohol, that it is not demand that has driven supply and increasing consumption in recent years but availability and affordability. It is of the utmost importance to see the implications of this for drugs supply, especially in view of the direct relationship between consumption and harms. As with alcohol, there is reason to be sceptical about the abil-

182 UK Drugs Policy A Critical Overview Part Two: The Governments Supply Reduction Strategy, Breakdown Britain interim report, 2006

ity of education and persuasion alone to change behaviour in a cultural climate which lacks moral consensus about the importance of prevention. This is unlike Sweden where limited availability guarantees reduced consumption and it is this that fundamentally drives Swedish policy.

Comparing policies – enforcement

An analysis of the comparisons between Dutch, Swedish and British drugs policies by Andy Horwood revealed the surprising finding that both Holland and Sweden spend significantly more of their drugs policy budgets on enforcement, in the context of an overall higher spend on drugs policy as a whole per head of the population, than we do in the UK. To date, in the case of Holland the relationship between this and the fact that their problem drug using populations are significantly smaller has not been drawn.

> " …to go from a drug-free society vision to a harm reduction society vision - and the whole parliament said in one voice, 'no'. So that's why they created the National Drug Coordinator, and this office. "
>
> Walter Kego CEO Narcotics Police-Sweden

It would appear that control over the supply and availability of drugs does prevent harm to the population, and effective policies are possible – contrary to the defeatist views sometimes expressed. That this government has been relatively unsuccessful is no measure of whether or not the basis of the policy is justified. Even within the UK, in Northern Ireland, port controls and surveillance established for security purposes appear to have been more effective at controlling supply than the relatively porous borders in the rest of the country. Sweden also has a more effective control of supply policy and operation, while accepting it does not have the same position, in northern Europe, on the drug route.[184]

As with other unacceptable trades or behaviours, the law must be seen to be working and government must continuously strive to make the enforcement of the law more effective.

3.5.2 Measurement and market sizing.

Information about seizures, disruptions, dismantlements and asset recovery make sense only if they can be directly measured and compared year on year against estimated annual market size. This is not currently provided by government.[185] Without such measures it is impossible to gauge the impact of seizures.

---

184 See section 4 A perspective on Comparative Drugs Policies and Implementation in the Netherlands, Sweden and the UK

185 UK Drugs Policy A Critical Overview Part Two: The Governments Supply Reduction Strategy, Breakdown BritainVol 3, 2006

We recommend that attempts be made to 'size' the market in order to establish bench marks against which seizures etc can be measured. This can be estimated in relation to street prices and purity. The UN Office on Drugs and Crime monitors and records this information, which currently shows prices falling in the UK and higher levels of purity.

The available evidence suggests that trends in all seizures have dropped since 1998.[186] The first question to be asked is whether complex performance management administration has disrupted effective working practices.[187] The second is whether the current SOCA (Serious Organised Crime Agency) targets have been 'softened 'to disguise poor performance.[188]

3.5.3 Effective interventions – the right framework, a coordinated policy and the right resources

In his evidence to us, David Raynes identified some historic strategic policy errors which have made the current trafficking all the more overwhelming and difficult to deal with.

Mr Raynes outlined three key policy errors in his evidence to us: The first was the decision by CIDA[189] to stop targeting big cannabis imports at the end of the 1990's, causing the UK to be flooded with cannabis, creating a 'mature' market.

The second was the strategic error to fail to provide resources to intercept at Heathrow and Bristol at the time that Customs moved to 'upstream disruption', interdiction on the high seas between Columbia and Spain.

The third was the impact of the changeover to SOCA which occurred last year, its failure to take on specific cases, namely targeting the Turkish heroin trade, and also its failure to take up the most effective customs and excise work leading to a drop in effectiveness since Customs was the lead agency.

> *They used to do high seas interceptions, upstream disruptions and they used to do targeted interceptions - where you intercept, bug their telephones bug their cars, bug their houses – all target work against major traffickers, who could be in the UK or abroad. And then there were what are called the cold pulls. These may be intelligence-based, maybe profiling lorries, people, cars, freight consignments and so on, but essentially they are pulls of drugs, large consignments of drugs, about which you know very little when it arrives and when it's discovered. Now, customs used to investigate those, you have to take a view about whether you should investigate each one, sometimes you deduce there was local involvement in a dock area or an airport, and there is local criminality*

186 Ibid. Total seizures fell 2005/6. Between 2003/4 and 2005/6 cocaine seizures dropped from 20,727kg to 5,798kg and cannabis from 57,617kg to 41.611kg, heroin from 1,626kg to 1,057

187 For a detailed analysis, see Breakdown Britain interim report

188 David Raynes, Evidence submitted to the Social Justice Policy Group

189 Concerted Inter Agency Drug Action Group

who know you've found the drugs. So each case has to be dealt with on its merits, but customs investigated most of those, did controlled deliveries, substituted the drugs, and so on… Now, the problem at the moment - and all my information comes from people who give the information, in customs and in SOCA, is that SOCA are not adopting many of those cases. (Yet) they took the resources and they took the money, and they've overspent massively, and now they've run out of mone

David Raynes[190]

> "We have heard about SOCA, and we don't have any experience yet about this huge organisation, personally I hardly believe this is the correct way to tackle organised crime, it's too huge an organisation, you can't run it. The idea is good, but I think it's too big, in my opinion."
>
> Walter Kego Narcotics Police-Sweden

One year after SOCA was established the evidence is it has yet to make a significant impact particularly in combating drugs. Sir Stephen Lander, its CEO, has said it will be three to five years before you should expect significant impact.[191] In the meantime, effective operations are needed and it is of concern if they are not taking place.

We would also suggest an independent audit of the figures in SOCA's Annual Report for 2006/07 to see the basis on which previous up stream figures were compiled.

Operation Airbridge – a case study in effective intervention.

Customs believe that 25-30 per cent of cocaine/crack smuggled into the country each year comes carried by individual drugs mules. A large portion are currently from West Africa (previously from Jamaica). Operation Airbridge, a cooperative enterprise between the Jamaican Authorities and UK customs, shared intelligence screened passengers over two days. They found 30 people per flight smuggling cocaine. Since this crackdown, the numbers from Jamaica have plummeted.

> "When they complete the sentence they go back to a devastating situation that is far worse than before they came. When they get back they are more equipped in terms of international movements, because they meet other people in the prison system that helped them to achieve this, they go back to absolutely nothing, so they need to find another way of surviving, so they do it again, they go to other countries."
>
> Olga Heaven, CEO, Hibiscus

190 David Raynes - Former ACIO, UK HM Customs and Excise, Consultant, Pheon Management Services
191 The Guardian, 31st March 2007

Operation Airbridge worked in conjunction with Hibiscus, a small international charity committed to helping women imprisoned for drugs importation. It runs innovative media campaigns in host countries telling women of the reality of 3 – 16 years in jail separated from their children, and helps them resettle. It has been highly effective in stemming their exploitation at a modest cost while saving high prison costs running into millions.

We recommend the development of this work. To date there are still 1200 female foreign nationals imprisoned in the UK, 80 per cent of them for drugs importation.

In light of the Corston Report we recommend that the position of these women is reviewed with Hibiscus to establish the resettlement and reintegration support required in their home countries in order to prevent their further exploitation.

3.5.4 Effective local drug squad enforcement.

A presentation by Detective Inspector Neil Kerr of the Fife Drugs Squad revealed how effective a committed, resource supported, intelligence led local drugs squad can be. In the preceding months his team has discovered the largest single consignment of cannabis in Scotland. At 340kg along with one kg of cocaine, the street value was £2 million. They had also taken out 10kg of heroin at a value of £11/2 million.

In England, however, though all forces have force wide drug enforcement capabilities, some have specific area 'drug squads,' while others do not.

For work that requires specialist expertise and cumulative experience we suggest that this is too vague. We propose a review of middle level operations. We believe that police commitment to tackling drug

> "By 1984 the Metropolitan Police had a network of area drug squads who effectively capped middle-level drug dealing and associated crime (including firearms) across London. They were particularly effective in the busy boroughs of Southwark and Lambeth. Additionally the central drug squad at Scotland Yard, alongside Customs & Excise, tackled major traffickers. By 2000 this police response had all but been disbanded. Maintaining good drug squads requires substantial resources, dedication, long working hours, integrity and above all strong leadership with effective management. Some very senior officers viewed drug policies as more trouble than they were worth and indeed even began sending out mixed messages on the possession and consumption of drugs."
>
> Graham Saltmarsh, Metropolitan Police 1969-99, letter to The Times, February 23rd 2007

> "My experience since being in […] is of good liaison between police and treatment services on the potential impact of operations, but poor execution - little details like the wrong address on a warrant for the 'key location' and attempts to raid 9 premises staggered on a two at a time approach, which I would of thought severely comprises the chances of success…"
>
> A DAT Coordinator

dealing should be uncompromising and efficient, requiring dedicated drugs resources.

A recent operation involving a one year preparation, 500 officers and 20 pre-dawn raids resulted in only 6 kilos of cocaine[192] Unless this caused serious disruption at middle market level or above it is questionable whether it was an effectively run exercise.

3.5.5 Overall Enforcement Spending Review

	Netherlands	Sweden	UK
Prevention/Young people	2%	1%	12%
Law enforcement/Supply	75%	54%	28%
Harm Reduction/Social Care/Communities	10%	23%	22%
Treatment	13%	22%	38%
Totals	€2,186m	€1,200m	€2,000m
PDU population	34,000	26,000	327,000
'Addiction care' budget per PDU[193]	~€4,500	~€20,000	~€2,300

A comparative analysis of drugs policy spending puts the need for a spending review on drugs to the top of the agenda. Holland spends significantly more on enforcement.

3.5.6 Lessons from Sweden[194]

> "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 2 kilos, you get six months in prison and if you have more than 2 kilos, it is at least two years."
>
> Office of the National Drugs Coordinator, Sweden

Advice we received from the Office of the National Drugs Coordinator in Sweden was for the need for effective operations on all levels. Specifically they argued that 'prevention' without the back up of law enforcement was pointless if there was no risk of getting caught by the police and customs; as they put it, you must involve the law enforcement people in the prevention work as well. Their rules of thumb were:

192 The London News, 18th April 2007

193 All proportions and funding derived from national reports for 2005, available at http://www.emcdda.europa.eu/

194 An Addiction Working Group visit to Sweden took place in February 2007

- It is no good arresting people who use drugs if you don't arrest people selling them. This requires street level expertise and specialist policemen.
- People convicted of use must be put into treatment, fining is not enough.
- Police should work more closely with key stakeholders including customs, social workers, and health care professionals.
- Act when you see an upward rising trend. Don't wait.
- Failure to fight cannabis effectively leads to bigger problems fighting the other drugs.

They also expressed their concern about the inadequacy of Europol.

They explained their tradition, of working together with the Nordic countries in a Police Customs Nordic Network since 1970s using pan Nordic liaison officers. They advised a similar network for the UK with its immediate European allies. In their system, they have sub-regional offices that are operational, working aggressively against the criminal networks in the region.

PROTECTING CHILDREN

3.6 Confronting cannabis

Anyone caring is bound to be concerned about the significant minority of children who take drugs and who drink significant amounts of alcohol whose life chances are blighted as they increase their consumption of both.

In this section of the report we propose a fundamental reform of and new approach to meeting adolescent needs and preventing their use of drugs.

> "In spite of the hype, there's an enormous number of children who, from their teens to their twenties have decided to turn their backs on everything from cigarettes to heroin. In 2006, 17 per cent of young people admitted having taken drugs in the past year, according to a Home Office survey published in March. Nine per cent had taken drugs in the past month and a mere 4 per cent said that they usually took drugs once a month or more. Department of Health figures show that for pupils aged 11 to 15, the most frequently used illicit drug in 2003 was cannabis, but this was taken by only 13 per cent."[195]

3.6.1 Assessing adolescent needs

The first priority is for a formal adolescent needs assessment to establish on what basis the current 17,000 adolescents are in 'treatment', and whether the doubling of numbers promised by the Government is based on need. This should be conducted on the lines of the high profile Alcohol Needs Assessment Project conducted by Professor Colin Drummond. We would propose it be led

195 The Times, June 11th 2007

by someone of the status of Professor Robin Murray of the Institute of Psychiatry, Kings College London. It could be informed by the RELACHS Research with East London Adolescent Community Health Survey.[196] Input would be required from all adolescent addiction psychiatrists, the Youth Justice Board, from Social Services, from The Children's Commissioner, from DfES school exclusion records, pupil referrals information and from truancy data.

This needs survey should take account of depression, anxiety and associated mental health problems presenting alongside substance misuse and parental background of substance misuse.

3.6.2 Reviewing adolescent substance services – an assessment of effectiveness and appropriateness

We believe that the survey should include a special enquiry into substitute prescribing - with a view to addressing the 'recovery' treatment needs of those currently deemed to require substitute prescribing.

3.6.3 Developing residential treatment

The development of specialist residential facilities and programmes for young people deemed most in need and at most risk is a high priority. The Minister of State for Health is under the impression that four such services already exist. The reality is that there is just one dedicated centre, Middlegate, to which we referred in Part One of our report.[197]

3.6.4 Juvenile treatment orders - alcohol and drugs testing allied with early therapeutic interventions

We propose the introduction of court orders to provide courts with the capacity and authority to order youths to receive drugs and alcohol abstinence treatment in designated residential settings, with appropriate combined treatment for depression and anxiety. We propose that this should be informed by the Swedish practice where juvenile drug courts are based inside the young people's treatment clinics, as in the Maria Youth Clinic on the outskirts of Stockholm which treats all types of addiction.

The Maria Clinic deals with alcohol and gambling addiction as well. It started a year ago, is fully state funded, has 110 staff and sees 2,000 families a year. This insistence on early treatment for addiction is crucial.

We believe that this approach to adolescent treatment needs is preferable to the multiplicity of vague, ill defined and sometimes counter productive services that have evolved in the UK.

---

196 A cohort study of 1615 adolescents. Findings at follow up concluded that psychological health at baseline was the strongest predictor of psychological health at follow up. Engagement in two or more health risk behaviours increased the risk of poor psychological health, suggesting that prevention strategies targeting co-curring substance abuse may reduce burden of disease.

197 Answer to written question from David Burrowes MP, 4/06/07 listing four residential adolescent services. However, there is one non dedicated service with just three beds available and then only after the adolescent has been detoxed. Promis, which the government listed, would accept statutory referrals but none are made - not surprisingly given the cost of over £5,000 per week.

Maria Youth Clinic, Stockholm

Its central theme is early and heavy intervention. Take an example: a youngster is arrested on the Stockholm streets in possession of drugs. He is taken to the Juvenile Drug Unit which is a police room actually inside the Maria Clinic. He is interviewed and compelled to give blood and urine samples. If he has taken drugs, he is charged and offered immediate treatment. He does not go to court – instead his case is assessed by a state prosecutor and is given a modest fine. The drug offence stays on his record for five years but if he behaves himself it is removed completely.

Treatment is available immediately. This is key. Almost inevitably he accepts the treatment. He is moved over to the clinic side of the building and begins to undertake rehab. Let's assume it was cannabis. The clinic's cannabis programme aims to achieve permanent sobriety in the young patient and straight away he has individual counselling and his parents and the school are brought in. Nobody in the police station or the clinic wears a uniform. Quite often our youngster will stay in the clinic for a number of days but will be required to undergo counselling for up to 10 weeks. The emphasis in the counselling is the rebuilding of self esteem and the tackling of depression – something that is often at the heart of drug addiction in teenagers. Time after time the head of the clinic stressed to me the importance of youngsters receiving treatment immediately – waiting lists are not acceptable.

Humfrey Malins MP CBE[198]

3.6.5 Cannabis reclassification and national action plan

Our most widely used illegal drug should not be in the category which conveys the impression that we need to be less concerned with it than the other drugs classified. The government should be giving out a clear message that cannabis use is regarded as a serious matter which should be actively discouraged and certainly not seen as something that is rather a fruitless waste of police time.

> "The great irony is, three years on from reclassification, the drug has changed. I think it's time to pause, reflect . . . and I think the health, criminal justice system, and police, have got to start dealing with it differently."
>
> Bernard Hogan-Howe Chief Constable of Merseyside Police [19]

> "At the time the decision was made three or four years ago, there was a debate. That debate has passed."
>
> Bernard Hogan-Howe Chief Constable of Merseyside Police [200]

Given the unquestionable health dangers to young adolescents, the primary thrust of government policy should be focused on quickly bringing down the high level of consumption.

Immediately reclassifying cannabis as a Class B drug would send a clear message about its potential for individual and social harm. Such a decision would show that the Government does not regard this drug or its consumption

198 Malins, Crackpot: A Fresh Approach to Drugs Policy, 2006, Policy Brief from the Bow Group
199 Chief Constable of Merseyside Police, Bernard Hogan-Howe. The Daily Politics, 27th March 2007
200 ibid

> "What we're seeing now is that the local criminals are seeing that there is some money that they can make locally. They've taken out the middleman, the middleman used to import from Morocco or from wherever else they could get it…because of the increased potency, with a hundred plants, with four crops a year in a terraced house that they have converted to the purpose . . . you're seeing £65,000 profit from 100 plants. Now we are now seeing professional air conditioning, professional lighting."[201]

as a recreational matter. The fact that tobacco (for everyone) and alcohol (for many) are enormously harmful does not mean we should let all other potential recreational substances become as embedded as tobacco and alcohol are in our culture. In public health terms alone this is totally unacceptable.

Confronting cannabis requires more than its reclassification. In 2004 Holland launched a national action plan to discourage cannabis use. We propose the UK does the same.

3.6.6 Trialling school drugs testing

We propose the proper trialling of drugs testing in schools. We suggest that the new National Addiction Trust should tender for a well designed research project, encompassing different types of schools and different areas.

Months or even years can pass before parents realise a child is using drugs, by which time treatment is much tougher. Drug testing in schools might close that gap. More than 1,000 high schools and middle schools in the USA now conduct random drug testing.[202] Students who turn up positive are typically barred from after-school activities briefly and required to get counselling and another test. Only the school, a drug counsellor and parents find out; the point is to treat this as a health problem, not a police matter.

Advocates of testing say it gives students a powerful reason to say no to peer pressure — critics have argued that the tests are invasive and expensive, and that studies show testing doesn't deter drug use. What is missing is definitive research that would allow policy makers to make confident decisions, balancing costs against benefits. This needs to be remedied.

3.6.7 Trialling effective addiction education

The evidence that drugs and alcohol education is effective is thin, as shown in Part One. There is no evidence that the harm reduction education approach is effective in moderating children's and adolescent's behaviour.

However there exists a powerful role for drugs educators to equip young people with a solid foundation of information to empower them to make the right decisions, with the understanding of the real dangers of drug abuse and addiction.

---

201 Ibid
202 USA Today, 8th May 2007

Drugsline's schools outreach team for example, is made up of recovering addicts and those who work in frontline addiction services, headed by Darren Gold. Darren is an ex-heroin addict who has served time in prison, who was homeless and estranged from his family and suffered dramatic ill health because of his addiction.

> "The team use their experience to inspire the trust and confidence of the young people and are honest and frank with the pupils, from the age of 8-18, neither sensationalising or diluting their personal stories. The team understand the pressures young people face on a daily basis, and are therefore well equipped and willing to answer the questions that young people are often too embarrassed or afraid to ask their parents and peers - questions that need adequate and appropriate responses if young people are to truly understand drugs and addiction"[203]

Evidence presented to us further suggests that peer-led and interactive classes are a potentially effective approach. Our own observations were that the potential for even the most disadvantaged recovering young addicts to absorb information about the brain science of addiction was high.[204]

Systematic carefully designed research to test the impact of different approaches – scientific, informational, experiential and personal, and peer led interactive – to be tested and compared across different school settings Is required. Impact measures need to look at comprehension and retention in addition to longer term behaviour change. This requires a 'capture and recapture' method or other form of longitudinal, cohort study.

203 Letter to Drink and Drugs News Magazine from Drugsline, 7th May 2007

204 Mary Brett, Biologist and former Head of Health Education, Dr Challoner's Grammar School, Amersham and UK spokesman for EURAD: Physical effects and controversies surrounding cannabis, Drugs Free Scotland Conference, 9th March 2007

Section 4
A perspective on comparative Drug Policies and Implementation in the Netherlands, Sweden and the UK

4.1.1 Introduction

This briefing paper is based on preliminary findings from ongoing research commissioned by the Centre for Policy Studies, and informed by on-site visits undertaken by members of the Addiction Working Group of the Social Justice Policy Group.

The context for this paper is the often-cited use of the Netherlands and Sweden as countries with which comparisons may be drawn in any examination of the scale and impact of drug use, and the response of Government policy as potential 'lessons to be learned' for application in the United Kingdom. Such policy applications are premised on the conception of the Netherlands as operating a 'liberal' drugs policy and Sweden as operating a 'restrictive' drugs policy.

It should be noted that the use of the term United Kingdom within this briefing principally refers to issues in England.

4.1.2 Legislation

Contrary to the perception of differentiation between 'liberal' and 'restrictive' drugs policies, all national policies are in accordance with the UN Conventions of 1961, 1971 and 1988, and other bilateral and multilateral agreements on drugs.

Netherlands

Contrary to popular belief about a more liberal framework in Holland, all drugs are illegal. In 1976 the law changed and a distinction was drawn between hard and soft drugs with the underlying idea of acceptable and unacceptable

risk. The use of cannabis was redefined as a misdemeanour rather than as a crime which effectively allowed personal use and small scale selling.

In 2004, a national action plan was launched to discourage cannabis use, and to promote research on problem use of cannabis, especially in the field of its relationship with mental disorders.

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, and supported through the funding emphasis of the national strategy.

Sweden

Over the years, the drug control policy in Sweden has been subject to scrutiny numerous times, at both national and international levels. A recent publication by the United Nations Office on Drugs and Crime has highlighted the success of Swedish policy in limiting problematic drug use. This included the reflection of national findings that a liberal view is expressed in youth groups interviewed regarding cannabis but that there is widespread support for the observed restrictive policy. Qualitative studies indicate 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.

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, and supported through the funding emphasis of the national strategy.

United Kingdom

Since the implementation of the Misuse of Drugs Act 1971 the UK has operated a 3-tiered system of criminal sanctions, dependent on levels of perceived harm. Harm is adjudged as attributable to the drug itself. Whilst this approach may appear to reflect legislation in the Netherlands and Sweden, in practice the idea of 'relative harm' has served to 'de-sensitise' the issue of illegal drug use.

For example, the re-classification of cannabis in January 2004 was seen as a 'green light' for its use, especially amongst younger people. The popular conception has become that there are no longer legal sanctions applied for cannabis use. This conception then undermines the overall framework of 'relative harm', wherein, if cannabis is perceived as relatively harmless, then how harmful can drug use be per se.

4.1.3 Population

Netherlands

From a total population of around 16.5 million, the estimated problematic drug using (PDU) population was 34,000 in 2005. This equates to a population prevalence rate of 3.1 per 1000 people aged 15 to 64 years.

Problematic drug use is dominated by heroin and cocaine, although significant numbers of cannabis users also access treatment services.

Between 1996 and 2003, the age of first cannabis use remained stable. These trends among youth are hard to explain, since they may be due to, for example, effective prevention, ceiling effects in drug use, effects of policy measures, or market factors.

Local data from the club scene in Amsterdam suggest that the prevalence of the use of cannabis, amphetamine and ecstasy decreased between 1998 and 2003. Nationwide observational data suggests that cocaine use is on the rise and has spread through the whole country and to all types of settings. The popularity of the combined use of cocaine and alcohol seems to be growing. This situation appears to mirror that in the UK.

Again, similarly to the picture in the UK, local studies point at the still growing importance of crack in groups of problem hard drug users. Virtually all problem opiate users also consume crack and for a (probably growing) minority crack appears to be the main hard drug (without opiates). In spite of variations in estimation methods, the number of problem opiate/crack users seems to be relatively stable in the past ten years. There are no reliable estimates of the numbers of primary crack users who do not consume opiates.

Geographically, the Netherlands can be seen as a 'hub' country for the international drug market. As well as being acknowledged as a source country for many 'dance' and synthetic drugs, it lies on the transit routes for opium-derived drugs for much of Western Europe, including the UK.

Sweden

From a total population of ~9 million, the estimated PDU population was 26,000 in 2005. This equates to a population prevalence rate of 4.5 per 1000 people aged 15 to 64 years.

Problematic drug use is dominated by heroin and amphetamine.

Amphetamine has always been the most used substance among problematic injecting drug users, but its share is decreasing. In the 1998 case-finding study 32 per cent had amphetamine as their drug of choice. Heroin, on the other hand, is increasing its part and reached 28 per cent in 1998. The most obvious trend is the growing role for heroin, with both clinicians and drug users reporting increased use and availability.

Sweden has no registration that gives an overall view of clients in treatment. The existing system covers only a part of all specialist units and is not fully representative of clients in treatment. Cannabis has been the predominant drug for 34 per cent of the clients in outpatient care and for 13 per cent in inpatient treatment. Heroin and other opiates was the 'drug of choice' for 28 per cent in outpatient care and for 31 per cent in inpatient treatment. Amphetamine and other psycho-stimulants (including cocaine) was the main drug for 28 per cent in outpatient care and for 45 per cent in inpatient care.

Presently treatment data can only partly be used as an indicator of the development of the drug problem.

Geographically, Sweden is not seen as a 'hub' country for the international drug market. Despite, or perhaps because of, the populations' historic preference for stimulants, enforcement has been more focussed on the restriction of the supply of stimulants and cannabis and Sweden does not lie on the transit routes for opium-derived drugs for much of Western Europe.

United Kingdom

From a total population of 58.8 million (England), the estimated PDU population was 327,466 in 2006. This equates to a population prevalence rate of 9.93 per 1000 people aged 15 to 64 years.

Problematic drug use is clearly conceptualised in the UK as regarding opiate (primarily heroin) and/or crack cocaine use.

Population surveys in the UK suggest that for the most part drug use is stabilising. Use of cocaine has increased within the general population. In general, the number and quantity of seizures are decreasing in the UK. However, seizures of crack cocaine are increasing.

Lifetime prevalence of cannabis use is stable in the adult population and there is a slight decrease in use amongst school children in England and Wales, albeit with evidence of earlier initiation and increased use amongst younger age groups.

Amphetamine use has fallen considerably over time amongst the general population. This is consistent with a continuing fall in seizures and offences.

Treatment systems have historically been established to manage opiate use, but have seen increasing presentations of crack cocaine use as part of an escalating poly-drug using population profile.

Geographically, the UK can be seen as a 'hub' country for the international drug market, serving as the 'target' country for the range of illegal drugs from opiates from Afghanistan, via Turkey and the former Soviet Union, stimulants from South America, and synthetics from Europe, as well as developing a significant domestic market in 'skunk' cultivation.

4.1.4 Legislation in Application

Structure

Netherlands

Implementation of the national strategy appears to be 'hands off' in the Netherlands, with medico-clinical treatment and care organised on a regional health structure, utilising a number of accredited service providers. In practice, these providers are the UK equivalents of healthcare trusts offering the range of specialist addiction services encompassing alcohol, heroin, cocaine, gambling, cannabis, etc.

The harm reduction and reintegration elements are funded and provided by the municipalities (equivalent to local authorities), allowing for a more appropriate response to the needs of local populations.

Sweden

The implementation of the national action plan on drugs (introduced in 2002) is run by the National Drugs Policy Co-ordinator (NDPCo). This central co-ordination is credited with overseeing a marked increase in drug prevention activities. With central government support, two-thirds of the 290 local authorities in Sweden have been able to appoint local drug coordinators for alcohol and drug preventive work. Central co-ordination by NDPCo has also initiated a wide variety of activities in the areas of research, supply and demand reduction, opinion forming, treatment and rehabilitation - including the prison and probation area, training and mobilisation at the local level as well as interventions in the recreational area.

It is further proposed that an agreement should be established between the state and the municipality sector (the equivalent of local authorities) with the purpose to strengthen and clarify the actions to be taken by the municipalities on the treatment of alcohol and drug addicts.

United Kingdom

Oversight for the national strategy in England is provided by the Drug Strategy Directorate within the Home Office, which aims to co-ordinate the strategy as a cross-department initiative.

Department of Health funding is channelled through the National Treatment Agency for Substance Misuse (NTA - a Special Health Authority established in 2001) via regional structures to 149 Drug Action Teams (DATs) across England.

Whilst DATs are charged with the local implementation of all strands of the strategy (young people, supply, treatment, and drug-related crime), all activity is performance managed against a template approach of pre-defined best practice and targets. This performance management function is fulfilled through nine Government Offices, through structures including the Home Office and the NTA.

4.1.5 Funding

Whilst it is difficult to draw direct comparison across the differing methodologies utilised, the figures below illustrate the proportionate funding of anti-drugs initiatives in the three countries, assessed against projected populations.

	Netherlands	Sweden	UK
Prevention/Young people	2%	1%	12%
Law enforcement/Supply	75%	54%	28%
Harm Reduction/Social Care/Communities	10%	23%	22%
Treatment	13%	22%	38%
Totals[278]	€2,186m	€1,200m	€2,000m
PDU population	34,000	26,000	327,000
'Addiction care' budget per PDU	~€4,500	~€20,000	~€2,300

Netherlands

In 2003 the Netherlands Court of Audit identified 154m spent on addiction care. This figure would suggest an 'addiction care' budget of ~ 4500 per 'problematic drug user'. Further estimates suggest an additional 124m is spent on treatment in judicial settings.

Sweden

Whilst not directly comparable, if health and social care costs are combined to denote 'addiction care', the budget would be 20,000 per 'problematic dug user'.

United Kingdom

In 2004/05 the National Treatment Agency for Substance Misuse administered €761m of treatment funding. This figure would suggest an 'addiction care' budget of €2,300 per 'problematic drug user'. This does not include elements of 'local funding' at a DAT level, which the NTA have assessed as increasing the average available funding to €4,140.[206]

4.1.6 Treatment

Netherlands

A thematic report on the 'Treatment of Problematic Use of Drugs' usefully makes the following distinctions in treatment:

- Achieving abstinence or, less ambitiously, moderation of drug use. In aiming at abstinence there may be two phases: (1) detoxification and (2) prevention of a relapse to the use of drugs
    1 In detoxification the consumption of the drug is stopped abruptly or gradually. As a rule, the person is administered medicines in

205 All proportions and funding derived from national reports for 2005, available at http://www.emcdda.europa.eu/

206 Hayes, P. (2006) The National Strategy: What we have done to get where we are now, available at http://www.nta.nhs.uk/news_events/events/previous_nta_events/te_summer_2006/Hayes.ppt#5

order to complete the detoxification successfully and to moderate withdrawal symptoms.

2 In aiming to prevent relapse, succeeding in breaking craving may well be the largest challenge of addiction therapies

- Harm reduction. Here the intention is not so much a decrease in or cessation of drug use, but rather the reduction or prevention of personal and social negative effects of consumption. Examples of interventions are needle exchange services and the opening of user rooms. Under this heading replacement treatment, such as the administration of methadone to heroin addicts, may also be partly included. Replacement treatment serves several intervention purposes, including the attempt to moderate the use of illegal drugs
- Reintegration: improvement of personal and social conditions to help the person concerned to find a satisfactory place in society

There is a general split in responsibility between these key areas. Specialist, generally clinical, services are accredited to provide detoxification and relapse prevention services, working to a 'bio-psychosocial model', whilst the municipalities take the lead responsibility for harm reduction and aftercare services. There are agreements in place in which tasks of municipalities (including prevention and aftercare) and those of justice and police (law enforcement, sentencing and re-socialisation) are fine-tuned.

Sweden

Drug treatment can be arranged by the social services in the local community (within mainstream services or at specialist units such as outpatient clinics), hospitals (detoxification or treatment for certain complications related to drug abuse such as infectious diseases, i.e. hepatitis, HIV/aids, psychiatric symptoms, etc) or therapeutic communities. After-care after a period in hospital, therapeutic community or prison is arranged by the social services.

In a report to the Parliament in 2005 the Government judged that the drug-related treatment has developed in terms of methods and availability. An observed trend is that the funding and quality of professional care seems to be improved.

Similarly to the method of organisation in the Netherlands, it is proposed that an agreement should be established between the state and the municipality sector with the purpose of strengthening and clarifying the actions to be taken by the municipalities on the treatment of alcohol and drug addicts.

The National Board of Health and Welfare has counted 611 specialist units for treatment of alcohol and drug problems with a total of 23,500 clients (31 per cent women). Specialist units can be found in all systems, including community social services, hospitals, therapeutic communities, and prisons. Outpatient treatment comprised 82 per cent of all contacts, residential treatment 12 per cent and 2 per cent were undergoing inpatient treatment in hos-

pitals. Four per cent participated in various programs in prison. Forty-five per cent of all patients received treatment for alcohol misuse only, 22 per cent for drugs and 33 per cent for both alcohol and drug problems. The 2005 national report identified 3,376 patients as injecting drug users (13 per cent of the projected PDU population).

From January 1st 2005 all medically assisted treatment of drug abuse (opiates) must be performed at clinics with special authorisation and could only be given to patients aged 20 years or older, with at least two years of opiate dependence.

No inventory of the prevalence of the availability of interventions for different groups or different problems is performed in the 290 municipalities in Sweden.

Availability of treatment is reported to vary from year to year, with a reduction in funding over a number of years. There is reported to be less funding, shorter treatment periods, less residential treatment and less outreach work. It is also reported that responses to patient needs varies throughout the country. This is partly explained by professional or ideological standpoints but not least by economic considerations as there is a clear tendency to choose outpatient treatment before residential treatment. It is only the larger towns, principally in the south of the country, that can afford to have resources specially directed to alcohol and drug abusers.

The NDPCo highlights the unmet needs of drug abusers in the 2004 annual report. The report concludes that a functional treatment system has a positive effect on health and on decreased mortality; problematic abusers and immigrants with drug problems do not receive the kinds of treatment they need; and that outreach work is nearly extinct. The NDPCo proposes that there should be a strengthening of resources, a guarantee securing treatment for those in need, and professional drug treatment within the prison system.

Traditionally, specialist outpatient treatment has different roles in different phases of the drug career. Whilst earlier 'recreational' use is generally picked up by police and social authorities, contacts when drug use has been established and different forms of problems emerge is usually with the specialist outpatient clinics. The third point of intervention is after-care to long-term treatment in residential treatment or after a period spent in prison.

United Kingdom

Opiates continue to be the main drug for most treatment presentations, for which substitute prescribing, primarily of methadone, remains the main treatment (63 per cent of treatment options).

Local DATs are charged with co-ordinating the commissioning and delivery of the range of interventions, from education and prevention, through harm reduction to treatment and aftercare interventions, with anticipated links to enforcement and supply interdiction efforts. The channelling of funding only for 'treatment' and young people through the local DATs effectively curtails this range of responsibilities.

Despite the establishment of the National Treatment Agency in 2001, examples of the lack of equity, parity and consistency in drug treatment provision persist across the country. The introduction of a framework for the development of services has been useful, but the aspiration for a joint commissioning approach amongst DAT agencies (i.e. health, social services, education, police, probation, etc.) has not materialised. The Models of Care tiered framework has been reviewed in the light of changing practice and shifting strategic priorities. Budgets for, and the relative importance of, substance misuse services are seen as marginal and often irrelevant to mainstream statutory service agendas.

The emphasis on 'specialist treatment' as the 'treatment that counts' has served to diminish the potential and actual contributions to be made by generic, community, rehabilitative, and 'low threshold' services. The result of this emphasis is an over-dependence on methadone prescribing, with few alternatives or complementary treatments available to maximise any treatment benefits accrued in terms of drug use, health or social functioning.

4.1.7 Supply and Enforcement

Netherlands

Despite the observed operation of "the expediency principle" in the Netherlands, three-quarters of identified funding is targeted at law enforcement. Supply focussed initiatives include a programme aimed at enhancing the efforts to combat ecstasy production and trafficking, a programme aimed to combat cocaine trafficking via airplanes coming in at Schiphol Airport, and a programme to intensify enforcement on cannabis crimes.

Sweden

Similarly to the position in the Netherlands, the majority of identified funding is expended on law enforcement initiatives. Two areas of priority for the NDPCo are to develop the prison and probation system to a high-qualitative treatment system for drug abusers and to upgrade and coordinate the efforts against the organised crime in drugs, commonly international. This internationally focussed work is co-ordinated by the NDPCo and is viewed as an intrinsic element of the overall strategy.

United Kingdom

Unlike the comparator countries in this analysis, only 28 per cent of funding is identified as expended on supply-related initiatives. Whilst the stated aim of the supply strand of the strategy is to tackle supply at every opportunity: internationally, nationally, regionally and locally, and to focus on all points in the supply chain, one recently published analysis notes that it is "difficult to estimate government expenditure on drug policy, as it is not transparently reported", concluding that "enforcement expenditure (includ-

ing police, courts and prisons) accounts for most of the total expenditure on drug policy."[207]

Despite the ambitious aims, the emphasis of supply-related activity remains on seizures, which fail to indicate the volume of drugs available in society, and appear to be co-ordinated at the local police force level.[208]

Evidence given to the Addiction Working Group suggests that there has been a lack of focus on the supply element, with a confusion in roles and responsibilities between HM Revenue & Customs and the Serious Organised Crime Agency (SOCA). This confusion appears compounded by the relative inefficacy of the Assets Recovery Agency prior to its merger with SOCA.

4.1.8 Criminal Justice System/Civil Action initiatives

Netherlands

Since 2002, the Netherlands have had an explicit national policy to divert drug users to care programmes, with the aim of reducing re-offending. The criminal justice system is perceived to offer the opportunity to divert criminal drug users to care programmes under the judicial pressure of a conditional sentence.

In 2004, about 2,200 referrals of addicts (alcohol, drugs and other addictions) to care programmes were carried out. These referrals can take place before conviction. Most referrals concern placement in residential care (41per cent) or in outpatient/semi-residential addiction care (35 per cent). Research on effectiveness is inconclusive to date. The process evaluation report in 2005 concluded that there was a considerable gap between the programme as intended and as delivered. Proposals have been made to offer treatment options as a condition of early release from prison.

Additional legislation, introduced in 2001, allows for the committal of prolific offenders to compulsory treatment for up to two years. This has been piloted in four institutions across the country to a total of 219 places. This and other initiatives targeted at prolific offenders are predicated on the basis that about 20 per cent of these compulsory treated offenders might give up committing crimes after completion of this programme.

Sweden

Sweden operates a clear system of early intervention for young people to gain access to treatment services, utilising a 'carrot and stick' approach combining judicial sanctions with treatment options which reflects society's dim view of substance misuse. Humphrey Malins[209] has cited the example of Stockholm's Maria Youth Clinic, wherein the combination of a treatment requirement of up to 10 weeks counselling is combined with a five-year record of offending,

---

207 Reuter, P. and Stevens, A. , An Analysis of UK Drug Policy: Executive Summary, 2007

208 see, for example, Breaking Drug Networks to Cut Crime

209 Malins, Crackpot: A Fresh Approach to Drugs Policy, 2006, Policy Brief from the Bow Group, available at http://www.bowgroup.org/harriercollectionitems/BowGroupDrugsPaper27Dec[2].pdf

liable to be expunged for good behaviour, allows for early interventions in terms of self esteem and depression, rather than drug use per se which is not likely to have become entrenched.

In severe cases, assessed on a 'harm to self and/or others' basis, drug users may be committed to an institution for compulsory treatment. Such treatment is arranged by the National Board of Institutional Care and it is regulated through legislation.

There is a significant emphasis on the potential for treatment through the prison and probation system, with the recognition that about half of all prisoners have drug problems. Treatment for drug use is now offered during prison terms with all custodial institutions reported to have access to a physician to help with a detoxification procedure.

United Kingdom

The evidence base for focussing on and prioritising drug-using offenders as a target of policy is still emerging. This is based almost exclusively on Home Office commissioned research since 1999. One of the earliest key papers concludes that the link between drug use and crime is complex, and that for the majority criminality predates drug use. This view of drug use as a 'sub-set' of criminality is supported by research findings that as few as 7 per cent, and as many as 37 per cent, of individuals under probation supervision are PDUs. Of these, only "a minority can be helped and succeed in changing drug use and offending behaviour".

Regardless of this evidence, the Home Office intends that drug work in the criminal justice system will become "the normal way of working".[210] The National Audit Office has noted that the effectiveness of such interventions should be judged on the quality of outcomes for individuals rather than meeting targets.

Emerging research indicates that young people and males may benefit more from interventions. In practice, younger people are less likely to be placed on a Drug Treatment and Testing Order and females more likely. For those who 'successfully complete' a court order, over half are convicted of further offences in the following two years.

Despite Government assurances that engaging PDUs through the criminal justice system is the 'flagship' initiative, budgets for the community-based Drug Interventions Programme have seen across the board cuts of 11 per cent in 2007/08, and there are no assurances of funding beyond March 2008.

There are currently plans for the regional development of the Integrated Drug Treatment System (IDTS), an ambitious programme to improve the provision of drug treatment to offenders in prisons, and ensure drug specialist end-to-end management of offenders with drug dependence.

---

210 See http://www.drugs.gov.uk/drug-interventions-programme/

4.1.9 Conclusions

Netherlands

The general perception of the Dutch drugs policy as 'liberal' has lead to conclusions that "one of the most striking aspects of the Dutch strategy is its compassion. Missing are the rhetoric of a 'war' on their own people and massive expenditures on police, prisons and punishment. Their efforts seem to be driven by a genuine concern to prevent further human suffering and disease. Their policies and programmes are rational, pragmatic approaches calculated to reduce risk-taking behaviour."[211]

In reality, the main emphasis is on law enforcement, with clear responsibilities in terms of commissioning, management and delivery for both harm reduction and treatment interventions, with dedicated funding allocated.

Sweden

The UNODC has often cited Sweden as an exemplar country, but acknowledges that "it is difficult to establish a direct and causal relationship between specific policy measures and the resulting drug situation".[212]

Drug prevention is increasingly considered a part of public health prevention, targeting vulnerable groups or risk groups in society. This is not the strategic direction observed in the UK.

Traditionally, specialist outpatient treatment has different roles in different phases of the drug career. There is a much clearer emphasis on early intervention with those at risk of escalating drug use, and the whole system is underpinned by a moral and Governmental consensus which manifests as a level of funding of at least four times the per head spend of the drug strategy in the UK.

United Kingdom

The UK has seen a proportionate increase in problematic drug use over the last ten years and the rate of use is at least double that of the comparator countries included in this paper. Given the geographic, economic and cultural characteristics of the UK, it is perhaps unrealistic to compare the application of policy to that of the Netherlands and Sweden. However, several lessons may be learned for potential application.

There needs to be a clearly articulated consensus on the respective roles and responsibilities for both harm reduction and treatment interventions for problematic drug use. The current configuration sends out mixed messages and lacks clarity in conveying the goals of treatment.

There needs to be clear accountability in terms of enforcement of legislation. In practice, enforcement suffers from the same 'postcode lottery' as seen

---

211 Duncan, D.F. and Nicholson, T. Dutch Drug Policy: A Model for America?, available at http://www.druglibrary.org/schaffer/other/dutch.htm

212 UNODC, Sweden's Successful Drugs Policy: A Review of the Evidence, 2007, available at http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

in health and social care, reflecting a philosophy that the 'war' on drugs is lost. The challenge is to apply existing legislation consistently and coherently 'on the ground' whilst also co-ordinating enforcement at the level of 'middle market' supply and national and international markets, for which there is a lack of transparency and public accountability.

A cost benefit analysis is required to assess the impact of the current strategy across all the strategic strands. This will allow for a clear, evidence-based assessment of impact and effectiveness. In this context, substance misuse needs to be viewed as not just a health or criminal justice issue but also as part of the communities and regeneration agenda.

A technical review of the schedules of the Misuse of Drugs Act and associated penalties is proposed. This review would include consideration of the simpler and more effective Dutch and Swedish legislative frameworks.

It has been observed that the current emphases on treatment and crime serve to 'treat the symptoms' of drug use without seeking to address underlying causes. 'Treatment' needs to include the wider needs of individual drug users, their families and communities.