



NO QUICK FIX

Exposing the depth of Britain's drug and alcohol problem

September 2013



THE CENTRE FOR
SOCIAL
JUSTICE

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About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British politics.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Managing Director: Christian Guy

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About Breakthrough Britain II

When the Centre for Social Justice (CSJ) published *Breakthrough Britain* in 2007, the British political landscape was fundamentally altered. The policy-making context was changed and a tired national debate about tackling poverty was reinvigorated.

These experience-led reports – shaped by mass domestic and international evidence-gathering – presented an unprecedented diagnosis of poverty in the UK and outlined a fresh vision for fighting it. This vision rested on recognising that using money alone to combat disadvantage, as important as income is, is too narrow an approach.

Through these conclusions and the thousands of people who shaped them, the CSJ demonstrated the need to identify and tackle the root causes of poverty, not merely the symptoms. We showed that for too long, five pathways to poverty have characterised life in our poorest neighbourhoods. These are: family breakdown; economic dependency and worklessness; educational failure; drug and alcohol addiction and serious personal debt. These pathways are interconnected. For example, a child who experiences family breakdown is less likely to achieve at school. Someone who fails at school is less likely to enter work and more likely to be on benefits. Consequently they are then more likely to live in financial poverty and debt. And so the cycle continues.

As a result of *Breakthrough Britain*, a debate was initiated about social and family breakdown in the UK. Yet much has changed in the policy-making environment since we published in 2007. In particular, the economic crisis has led to one of the deepest and longest recessions on record and there will be significant public expenditure reductions to deal with the national deficit. We also have the first Coalition Government since 1945.

However, what remains clear within the debate about putting Britain on a secure financial footing is the need for a social recovery, as well as an economic one. The costs of social breakdown are significant and often preventable. The CSJ believes it is time to revisit *Breakthrough Britain*. In view of the monumental challenges now confronting policy-makers and society, such a review would lay fresh foundations for tackling poverty in an age of austerity. Once again, this must be based on recognition of poverty's root causes.

The CSJ has conducted a national audit of social breakdown for each of the six policy areas which comprise *Breakthrough Britain II*. This 'State of the Nation' report sets out the key problems and trends in relation to addiction and will act as a 'springboard' for the main report to be published in Spring 2014, comprising a number of policy recommendations for government in relation to each of the policy areas.

Preface

This report lays bare the reality of substance abuse and addiction in Britain today. This ongoing challenge affects millions of people and has huge costs. Alcohol abuse costs taxpayers £21 billion a year and drugs £15 billion. While costs matter, it is the human consequences that present the real tragedy. The abuse of substances is a pathway to poverty and can lead to family breakdown and child neglect, homelessness, crime, debt, and long-term worklessness. From its impact on children to its consequences for those in later life, addiction destroys lives, wrecks families and blights communities.

The scale of the problem is shocking. 1.6 million people are dependent on alcohol in England alone. One in seven children under the age of one live with a substance-abusing parent, and more than one in five (2.6 million) live with a parent who drinks hazardously. 335,000 (one in 37) children live with a parent who is addicted to drugs.

In 2007, Breakthrough Britain identified a fatalistic drug treatment system which trapped many thousands of addicts in state-sponsored dependency and provided few answers for those with non-opiate addictions. Alcohol abuse was neglected as a problem but the previous Government made it even more accessible with liberalised licensing laws. In schools, very little was done to prevent young people starting on a path to substance abuse – the only support they received was the ill-informed FRANK campaign; as ineffective as it was inappropriate.

The Centre for Social Justice (CSJ) has been encouraged by some of the commitments contained within the Drug Strategy 2010 and by the efforts of some reformers within government. The move to a recovery-oriented system is an important step to ensuring that harm reduction is only the first step along a path to abstinence and full recovery.

Challenges persist, however, as many vested interests remain entrenched within the treatment system. Supporters of substitute treatment remain unconvinced by the possibilities of full- and long-term recovery, and are resistant to reform.

Alarming, some commissioners are withdrawing support for effective services. The CSJ has learned that 55 per cent of local authorities have cut funding to residential rehabilitation centres whilst harm reduction services that maintain people in their addiction have been preserved under the NHS ring-fence. These rehabilitation centres, which the Prime Minister has rightly backed in the past, have proved time and again to be an effective way of breaking the cycle of addiction and must be supported.

In this report, we also highlight the system's lack of ambition to tackle alcohol abuse, despite its rising cost. While two-thirds of the 300,000 drug addicts in England get treatment, only a small minority (approximately seven per cent) of alcohol dependants get similar help. Furthermore, by withdrawing its plans for a minimum unit price, the Government has missed an opportunity to tackle the increased availability of super cheap, strong alcohol.

A better approach than minimum unit pricing would have been a treatment tax. We were disappointed that the Government did not follow our recommendation to introduce one, which, unlike a minimum unit price, would see the proceeds go to the taxpayer rather than boosting retailers' profits. The revenues could help fund treatment for alcoholics and offset the costs borne by the taxpayer in alcohol-related crime and rising NHS bills.

Furthermore, although funding to the FRANK campaign has mostly been withdrawn, it remains the chief prevention tool championed by the Government. We can do better than that, to ensure that schools help children to be resilient in the face of the increasing availability of drugs.

In publishing this report, I want to thank Noreen Oliver and the rest of the Working Group who have poured their time, energy and wisdom in to this report. I am grateful to Rupert Oldham-Reid and the wider CSJ team for their excellent work too. Thanks must also go to all those – named and anonymous – who have contributed evidence to this report, and to all the members of the CSJ Alliance who regularly remind us why we exist.

Parents and children, together with addicts and taxpayers, are calling for action. In this report we outline the challenges; in the coming year the CSJ will publish policy recommendations to help solve Britain's drug and alcohol crisis.

Christian Guy
Director, Centre for Social Justice

Members of the Working Group



Noreen Oliver MBE, (Chairman)

Following her own personal experience of addiction to alcohol and her own journey into Recovery, Noreen Oliver MBE, set out to provide a rehabilitation programme in the community in which addiction had developed. This led to Noreen Oliver being recognised by the Daily Mirror People's Justice Award in November 2006, followed by the accolade of MBE by Her Majesty Queen Elizabeth II in June 2009.

Today the BAC O'Connor employs 84 staff from clinicians through to resettlement staff; fifty per cent of the staff are in Recovery and have gained qualifications from NVQ's through to Degree level.

In September 2012 The O'Connor Gateway Charitable Trust launched, founded by Noreen Oliver, with a new Social Enterprise called Langan's Tea Rooms and Training Centre, the Social Enterprise was opened by The Rt Hon Iain Duncan Smith MP.

The Recovery Group UK (RGUK) was established by Noreen Oliver in September 2009 to provide a platform for the reform of the UK drug & alcohol treatment system. To remove the polarisation of the system and to bring together a group of experts from across the spectrum of care. Building upon the success of RGUK, The Recovery Partnership was formed in May 2011; Noreen Oliver invited Drugscope and The Skills Consortium to partner with RGUK to provide a new collective voice for the drug and alcohol sector to ministers and government.

Noreen is also Chair of the Addictions working group, *Breakthrough Britain II* – CSJ (Centre for Social Justice) and on 14th July 2010, was the recipient of Centre for Social Justice 'Lifetime Achievement Award'. As of 2013 Noreen is also a member of the CVLS Honours Committee.



Rupert Oldham-Reid, Author and Researcher

Rupert joined the CSJ team in January 2012. After managing the CSJ's presence at the party conferences and organising the Prime Minister's first major speech on criminal justice,

Rupert now leads the CSJ's research into addiction as part of *Breakthrough Britain II*. He has worked with an addiction rehabilitation centre and an MP's office in Westminster. Rupert read History and Politics at Newcastle University, and went on to gain an LLB at the College of Law. As well as serving with the Royal Naval Reserve, Rupert took prizes in debating and mooting whilst at law school.



Lisa Bryer, Co-founder of Cowboy Films

Lisa Bryer has worked as a film and documentary producer for the last 30 years. She co-founded the independent production company COWBOY FILMS. She is best known for having produced the Oscar and Bafta winning film 'The Last King of Scotland'.

Lisa was addicted to drugs including heroin, for 8 years and is still suffering from the effects of Hepatitis C, resulting from her addiction. After a friend recommended that she attend Narcotic Anonymous, she realized that she could break the cycle of drug use, and she eventually managed to overcome her addiction by attending a residential rehabilitation centre in Weston-super-Mare.

Today Lisa has not had a drug or a drink for 31 years and spends a lot of her time helping other addicts, either through one-to-one mentoring or as a trustee for various charities. She is the mother of 16 year old twin boys, conceived and parented within her recovery from drugs. She has also been happily married for 18 years.



Huseyin Djemil, Founder and Director of Green Apple Consulting

Huseyin Djemil is the founder and director of Green Apple Consulting, a specialist substance misuse consultancy which works mainly in the UK criminal justice and drug treatment sector. Huseyin has worked in the drug and alcohol misuse field for over 18 years, and was personally addicted to heroin and cocaine for 7 years before recovering through a residential rehabilitation programme. In his capacity as the director of Green Apple Consulting he advocates abstinence-based rehabilitation as necessary in all stages of treatment and recovery.



Andrew Griffiths, Member of Parliament for Burton and Uttoxeter

Andrew Griffiths is a Conservative Member of Parliament for Burton and Uttoxeter. He works closely with the Burton Addiction Centre and also serves as the Secretary of the All-Party Parliamentary Group on the Misuse of Drugs.



James McDermott, Founder & Chair of Recovery is Out There (R.I.O.T)

James McDermott is the founder & chair of Recovery is Out There (R.I.O.T). R.I.O.T advocates a recovery champion-based model for overcoming addiction through abstinence at all levels of treatment. He is also a founding member of the Recovery Champions network, a broad spectrum of service user groups which aims to improve the opportunities for people to move from treatment to recovery. James personally experienced 20 years of substance abuse which he eventually overcame through a residential rehabilitation programme.



Richard Phillips, Director, SMART

Richard Phillips is the director of SMART (Self-Management and Recovery Training) Recovery UK. It works to assist recovery from any type of addictive behaviour and helps people overcome their addictions through peer-led mutual aid groups that advocate self-help as a method of recovery. He has worked in the field of substance misuse for over 20 years and strives to integrate treatment and recovery programmes.



Chip Somers, Chief Executive, Focus I2

Chip Somers is the Chief Executive of Focus I2, an independent charity which provides residential rehabilitation for drug and alcohol abuse. As a former drug addict himself Chip recently appeared before the House of Commons home affairs select committee, alongside comedian Russell Brand, and advocated abstinence as the best form of long term rehabilitation for those misusing drugs and alcohol.

Advisor to the Working Group



Nick Barton, Chief Executive, Action on Addiction

Nick Barton is the Chief Executive of Action on Addiction, the only charity working across the addiction field in treatment (residential and non-residential), research, prevention professional education and family support. Previously Nick worked in the US as a psychotherapist and family counsellor before becoming involved in the addiction field in the UK in the mid 1980s.

Nick was one of the principal architects of the merger of the three charities: Clouds, the Chemical Dependency Centre and the former Action on Addiction in 2007. He has been instrumental in developing a variety of interventions to support families and carers affected by substance misuse since 1986. He has championed professional workforce development, and the Charity opened its Centre for Addiction Treatment Studies in 2008.

He has sat on many panels advising government on aspects of treatment delivery, family support and workforce development. He currently sits on the board of Substance Misuse Management in General Practice. He was a member of the Topic Expert Group for NICE standards in drug treatment. He has advised organisations in several countries, taught courses and written numerous articles.

Acknowledgements

The CSJ would like to thank the many people and organisations who have contributed to this report. Our thanks also go to the working group for giving up their time and valuable experience. Special thanks to Nick Barton and Pat Merrick for their contribution to the group before commitments elsewhere prevented their continued contribution. Particular thanks go to the Group's Chairman, Noreen Oliver, MBE, for her tireless commitment and leadership. Special thanks also to CSJ staff, in particular Alex Burghart, Director of Policy, for his assured guidance and help with the report.

Chairman's foreword

Drug and alcohol abuse affects individuals, families and communities, it cuts across every agenda, crime, health, welfare, children protection, worklessness and much more.

In *Breakdown* and *Breakthrough Britain I* in 2007, the CSJ revealed the startling facts of the previous drugs policy which had little ambition and failed to look beyond the prescription pad, failing to enable individuals and families to build a future free from addiction.

Today, whilst the Coalition has adopted the language of Recovery and an ambitious drug strategy that looks beyond the Maintenance model and culture, little has changed in practice and there are too few areas that have been able to deliver this ambition.

We must now start to build on the gains that are being made in treatment and in order to do this we need to engage and mobilise communities to work together to solve the drug and alcohol problems in their areas, engage local authorities to develop joined-up local strategies and partnerships where all departments contribute and provide solutions.

The addictions working group intend to tour the country to find those communities that work together and that can evidence to those still in active addiction that there is a life beyond addiction. We want to hear from Recovery Champions, individuals, families and those working in the sector; where you think we should go, what more can be done, your experiences and what can be done to improve the current policy or system, what are the road blocks and what prevents you from getting into recovery or developing a Recovery Community.

We must not forget that alcohol admissions to hospitals have doubled in a decade and use of new legal highs has soared.

Our aim is to provide hope and solutions, to inspire and motivate communities and local authorities to turn the ambitions of the drug strategy into practice in every community across the country.

This State of the Nation exposes the striking level of addiction in our country today and the devastation that it leaves in its wake. After endless research and evidence from experts, we have enabled our addiction problem to grow. We hope that you will work with us and help us to enable communities and individuals to believe in change and to find hope and Recovery.

Noreen Oliver MBE

Executive summary

I. Introduction

Addiction and alcohol and drug abuse are taking a heavy toll on Britain. One in 20 adults in England (1.6 million) is dependent on alcohol¹ and one in 100 (380,000) is addicted to heroin or crack cocaine.² This human tragedy is accompanied by eye-watering economic costs. The annual bill to society is over £21 billion in alcohol-related harm and a £15 billion cost from illicit drugs.

There is a perception amongst some that alcohol and drug abuse are in remission. Our research shows the opposite. The costs to society of substance abuse are rising. Use of opiates and crack remains high and roughly one new drug enters the market each week. Alcohol-related admissions to hospital have more than doubled in a decade, costing the NHS more every year. Since the CSJ published *Breakthrough Britain* in 2007, the amount of opiate substitutes the state prescribes to heroin addicts has increased by 40 per cent. New 'legal highs' are entering the market at the rate of one a week, whilst 'virtual currency' is making it possible for illegal drugs to be bought and sold anonymously over the internet without fear of detection.

The consequences of addiction and abuse are dire with the effects felt most by those who are already highly vulnerable. There are communities across Britain that are still ravaged by drugs and alcohol. Alcohol and drug-related violence, domestic abuse, worklessness, child neglect, debt and educational failure, all disproportionately affect poorer communities and are regularly intertwined.

While government has promised to tackle these issues, too many barriers remain. An established interest has continuously prevented the Coalition Government from promoting the ambition that addicts should be helped to lead drug-free lives. Local authorities have cut funding to the most effective residential rehabilitation services whilst funding for ineffective programmes has been maintained.

There are reforms underway which present an opportunity to improve how addiction is tackled. As the reforms are presently constituted, however, there is a risk that they will fail to reach their full potential. There is a danger that the fight against addiction will be diluted by the wide focus of

1 Health and Social Care Information Centre, *Adult psychiatric morbidity in England: results of a household survey, 2007, 2009* [accessed via: <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf>] and National Institute of Clinical Excellence, *Alcohol-use disorders*, London: The British Psychological Society and The Royal College of Psychiatrists, 2011 [accessed via: <http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf> (09/08/13)]

2 United Kingdom Focal Point, *UK Drug Situation 2012*, London: Department of Health, 2012

Public Health England, whose target outcomes of tackling alcohol and drug abuse must compete with numerous other concerns. Similarly, the Government's drugs and alcohol payment-by-results pilots currently in operation are not focusing on helping addicts achieve full recovery and become drug free. This threatens to undermine the entire project's laudable aims.

2. Drug and alcohol addiction in the UK

Lives are being ruined and if these trends continue the cost to society, to the NHS, social services, and the police will increase significantly.

a) Opiates and Crack

Opiate and crack cocaine are particularly harmful drugs. Their use has remained near constant in the UK since 2004 and the state is supplying increasing amounts of opiates to addicts. At present:

- Over 380,000 people are addicted to opiates and/or crack, 300,000 of them in England;³
- 335,000 children are growing up in homes with a parent addicted to opiates and/or crack;⁴
- A rising number of people are 'parked' on opiate substitutes: 150,000 people are being prescribed an opiate substitute, of whom one in three have been on their prescription for more than four years (up 30 per cent since 2010), and one in 20 for more than ten (up 40 per cent since 2010);⁵
- Whilst the number of people addicted to heroin and/or crack has fallen very slightly in England in the past three years, the number of people being prescribed opiate substitutes is 40 per cent higher than it was at the time of *Breakthrough Britain* in 2007;⁶
- The annual cost of prescribing-based treatment system is £730 million.⁷

In some regions, problems are now particularly acute. In the North East, for example:

- All but one local authority have seen a rise in opiate and/or crack use since 2006/07;⁸
- One in forty adults in Middlesbrough is an opiate and/or crack user.⁹

3 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012, p87 and National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)] and 2006/07 [accessed via: http://www.nta.nhs.uk/uploads/north_east_prevalence_data_0607doc.pdf (08/08/13)]

4 Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

5 Department of Health, *Deposited Paper DEP2013-1196* in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

6 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2007; 2008; 2009; 2010; 2011; and, 2012

7 National Treatment Agency [accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08/08/13)]

8 National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)] and 2006/07 [accessed via: http://www.nta.nhs.uk/uploads/north_east_prevalence_data_0607doc.pdf (08/08/13)]

9 National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)]

b) Cannabis – a new hard drug

The majority of cannabis sold on our streets is now 'skunk' which is up to six times stronger than the cannabis of the 1960s and causing increasing harm, particularly to young people.

- 80 per cent of the cannabis in Britain is 'skunk' or skunk-strength;¹⁰
- Increasing amounts of research show the harm of cannabis to developing brains, particularly to those with pre-existing mental health problems;¹¹
- Each year more people are seeking treatment for their cannabis use, with a 36 per cent increase since 2005/06.¹²

c) New drugs on the rise

New drugs and 'legal highs' available in high street 'head shops' and on the internet, are being used by an increasing number of people. They are often very harmful yet users know little of the damage they can cause. The costs include a rising death toll and young people in the twenties losing their bladders and being forced to spend their lives on catheters.

- Use of the club drug ketamine, still classified as class C, has doubled since 2006.¹³ During the same time the numbers entering treatment for the abuse of club drugs has increased almost 40 per cent;¹⁴
- New drugs are emerging at a rate of one a week and now outnumber illegal drugs classified under the Government's official A, B, C system.¹⁵

d) Alcohol – the growing cost

While frequent alcohol consumption has decreased, dangerous drinking is on the rise. The most widely abused drug in the UK, alcohol, is causing increasing harm to society. Currently the bill stands at £21 billion a year.¹⁶

- Alcohol-related deaths have doubled since 1991 and liver disease is now one of the 'Big Five Killers' and the only one which is increasing;¹⁷
- Serious drinking has increased: alcohol-related admissions to hospital have doubled in a decade and are continuing to rise.¹⁸ Increasing readmissions to hospital show that treatment is not working.¹⁹

¹⁰ Hardwick S, King L., Home Office Potency Study, London: Home Office, 2008

¹¹ Swift W et al, Analysis of cannabis seizures in NSW, Australia: cannabis potency and cannabinoid profile, Sydney: National Drug and Alcohol Research Centre Sydney, 2013 [accessed via: <http://ndarc.med.unsw.edu.au/news/high-levels-thc-australian-cannabis-new-study> (08/08/13)]

¹² National Treatment Agency, Statistics from the National Drug Treatment Monitoring System, London: Department of Health, 2012

¹³ United Kingdom Focal Point, United Kingdom drug situation 2012, London

¹⁴ National Treatment Agency for Substances Misuse, Club drugs: emerging trends and risks, London: NTA, 2012

¹⁵ United Nations, World Drug Report 2012, Vienna: UN, 2013 [Accessed via: http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf] p59

¹⁶ Home Office, The Government's Alcohol Strategy, London: Home Office, 2012

¹⁷ Office for National Statistics, Age-standardised alcohol-related death rates, London: ONS, 2013

¹⁸ Department of Health, Deposited Paper DEP2013-0340 in response to PQ 144032 [accessed via: <http://data.parliament.uk/DepositedPapers/Files/DEP2013-0340/PQ144032.xlsx> (10/7/13)]

¹⁹ Answers to Freedom of Information requests submitted to a sample of health authorities in England

3. Consequences of drug and alcohol addiction and abuse

Drug and alcohol abuse lead to child poverty, family breakdown, welfare dependency and severe personal debt. It also fuels crime. The impact of this is felt particularly in Britain's most deprived communities and continues to trap people in poverty.

a) Addiction damages childhood

90 per cent of people think that having a parent addicted to drink or drugs is important when deciding whether a child is growing up in poverty. The evidence supports this view, with poorer outcomes in education and health for those with a drink or drug addicted parent.

- Over one in five of all children (2.6 million) live with a parent who drinks hazardously;²⁰
- Annually, 9,000 mothers are admitted to hospital with alcohol-related miscarriages²¹ and every month 100 babies are born addicted to drugs such as heroin that their mothers have been using during gestation.²²

b) Addiction drives families apart

The abuse of alcohol and drugs is a destructive force on family life. From theft and domestic violence, loss of friends and poorer health, addiction is very harmful to families. With one in three adults drinking too much and the increasing costs of family breakdown, the consequences for society are severe.

- Heavy drinking by a spouse is more likely to lead to divorce;²³
- 1.5 million adults are affected by the drug addiction of a relative and far more by the one in three adults who drinks too much.²⁴

c) Addiction leads to welfare dependency and worklessness

The costs of alcohol and drug addiction to the welfare bill are massive. As well as the welfare benefits to addicts unable to maintain employment, childcare burdens of abandoned children are also falling on the state. According to the most recent data:

- The welfare burden of addiction is over £3 billion annually;²⁵

20 Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

21 NHS, *NHS Choices: Can I drink alcohol if I'm pregnant?* NHS [accessed via: <http://www.nhs.uk/chn/Pages/2270.aspx?CategoryID=54&SubCategoryID=130#close> (08/08/13)]

22 Dr Daniel Poulter, Parliamentary Undersecretary of State for Health Services, Written Parliamentary Answer: 8th November 2012 citing Hospital Episode Statistics (HES), The Health and Social Care Information Centre

23 Ostermann J, Sloan FA, Taylor DH, 'Heavy alcohol use and marital dissolution in the USA', *Soc Sci Med.*, 2005 Dec; 61(11) [Accessed via: <http://www.ncbi.nlm.nih.gov/pubmed/16139939> (08/08/2013)]

24 UKDPC, *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*, London: UKDPC, 2009 [accessed via: http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Adult%20family%20members%20and%20carers%20of%20dependent%20drug%20users_%20prevalence,%20social%20cost,%20resource%20savings%20and%20treatment%20responses.pdf 08/08/13]]

25 Gyngell K, *Breaking the Habit*, London: CPS, 2011; United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf> (08/08/13)]

- Only 18 per cent of those entering drug treatment in England are in employment.²⁶ Similarly, state benefits are claimed by approximately 80 per cent (240,000) of opiate and crack users;²⁷
- Addiction to drink and drugs means over 340,000 people are on welfare rather than in work, with a further 100,000 carers picking up the pieces, not able to work.²⁸

d) Drugs, alcohol and the criminal justice system

So much of crime and reoffending is fuelled by addiction and yet the system is incapable of breaking the cycle. More inmates are now being medicated by the state than ever before but offending rates persist.

- In half of the 700,000 violent crimes committed each year, the victims think their attacker has been drinking;²⁹
- Half of inmates report committing offences connected to their drug-taking, with the need for money to buy drugs the most commonly cited factor.³⁰

4. The new commissioning landscape

Despite strong rhetoric, the response to these problems has been ineffective. In 2007 the CSJ identified a broken system of drug addiction treatment which trapped tens of thousands on state-supplied heroin substitutes – a system akin to giving an alcoholic state-supplied vodka. Despite pledges to address this national scandal, nothing meaningful has changed. Substitute prescribing is still the only addiction treatment received by the vast majority. This stagnation has been compounded by a complete lack of culture change.

a) Debilitating strategy

Part of the failure to address addiction has been the dilution of the Government's aim that an addict's treatment should aspire for them to lead a drug-free life. This is manifested in the treatment both drug addicts and alcoholics currently receive and in the context of the drugs and alcohol payment-by-results pilots.

In 2007 the CSJ called for a combined addiction strategy to address the inadequate and inconsistent response to drug and alcohol addiction. The current inadequate provision of alcohol treatment, despite its status as the most widely abused drug, can be attributed to the lack of a combined strategy. Whilst over half of drug addicts receive treatment, only one sixteenth of alcohol dependants do, and cheap strong alcohol made more accessible than ever before.

26 Department for Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department for Health, 2012 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf>]

27 Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010

28 Nandy S., and Selwyn, J, *Spotlight on kinship care*, University of Bristol, 2011

29 Flatley J, Kershaw C, Smith K et al, *Crime in England and Wales 2009/10*, London: Home Office, 2010

30 UK Drug Policy Commission, *Reducing drug use, reducing reoffending*, London: UKDPC, 2008; Prison Reform Trust *Bromley Prisons Briefings Factfile*, London: Prison Reform Trust, 2010

b) Reducing demand (i) – Prevention

There are serious weaknesses in the current drug and alcohol prevention strategies. The ineffective Talk to FRANK is still the Government's flagship prevention programmes and schools are not doing enough to address the needs of their pupils.

- Only one in ten children would call the 'FRANK' helpline to talk about drugs;³¹
- Drugs, alcohol and tobacco are covered once a year or less by more than 60 per cent of schools for children aged seven to 11 and 74 per cent of schools for pupils aged five to seven.³²

The CSJ is hopeful that the newly established Early Intervention Foundation will be able to offer fresh alternative prevention strategies in the coming years.

c) Reducing demand (ii) – Treatment

Although committing itself to an individual, recovery-focussed strategy to help more addicts beat their drug and/or alcohol problem, the Government's definition of recovery has not been ambitious enough. By not specifying that treatment needs to help addicts achieve full recovery and become drug-free, the Government has allowed providers off the hook. Instead addicts are leaving treatment clean from one drug but still struggling with others.

Unhelpfully, cuts have occurred to effective treatment services whilst the ineffective have been protected:

- 55 per cent of local authorities have cut funding to the most effective form of treatment, residential rehabilitation;³³
- The NHS ring-fence has protected the pooled treatment budget which supports prescribed interventions.³⁴

Employment law has also ensured that the providers of drugs treatment within the NHS and the third sector have largely remained the same.

d) Restricting supply

Although the Government have continued to tackle traditional supply routes for narcotics, new, internet-based operations are outpacing enforcement agencies.

- The UK is now one of the leading hubs for the internet-based dealing of NPS (legal highs). There are over 130 sites registered in the UK providing a range of legal highs;³⁵

31 Addaction, 'One in five young people say they think parents have taken drugs, according to Addaction commissioned survey', October 2008 [accessed via: <http://www.addaction.org.uk/news.asp?section=253&itemid=297&search> (08.08.13)]

32 Formby E, 'It's better to learn about your health and things that are going to happen to you than learning things that you just do at school: findings from a mapping study of PSHE education in primary schools in England, *Pastoral Care in Education*, 29 (3), 2011, 161-173

33 Answers to Freedom of Information requests submitted to all local authorities in England

34 National Treatment Agency [accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08.08.13)]

35 International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

- Ebay-like websites, such as the Silk Road, are allowing illegal drugs to be bought on the internet and delivered to any home in Britain by the likes of Royal Mail and Parcelforce;
- The online currency, Bitcoin, has rendered it nearly impossible to trace these transactions.

In *Breakthrough Britain*, the CSJ argued for an increased levy on alcohol so that the additional revenue could be used to fund addiction support. However, the Government has now dropped its plans to tackle cheap, strong alcohol with a minimum unit price and to restrict multi-buy promotions.³⁶

5. Future challenges

There are several significant challenges which threaten to undermine attempts to deliver full recovery from addiction. Current health and crime strategies present opportunities for drug and alcohol treatment but also carry risks. At the centre of these risks is the lack of an ambition to help addicts become drug-free.

a) Public Health England (PHE)

There is great potential for Directors of Public Health based in local authorities to effect change and deliver recovery yet there are concerns that not enough focus will be given to drugs and alcohol issues:

- Specific drugs and alcohol criteria by which local authorities will be judged represent only three of 66 Public Health Outcomes however one third of the PHE budget comes from former drugs and alcohol funding;³⁷
- Concerns remain about the lack of culture change, with the same staff responsible for the fatalistic, maintenance-based system now in charge of delivering recovery.

b) Police and Crime Commissioners (PCCs)

The advent of PCCs presents a real opportunity to develop effective ways of tackling addiction. However, as PCCs now have ten per cent of the former drugs budget there is a danger that the funding of recovery programmes may be diluted or side-lined as they compete with other concerns.³⁸

36 Hansard, 17 July 2013 : Column 1113 [Accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130717/debtext/130717-0001.htm#13071772000005>]

37 Department of Health, *Improving outcomes and supporting transparency*, London: DH, 2012 [Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193619/Improving-outcomes-and-supporting-transparency-part-1A.pdf.pdf]; Department of Health, *Public and General Interest*, [accessed via: <http://www.nta.nhs.uk/funding.aspx> (08/08/13)]

38 Home Office, Community Safety Fund, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/143831/community-safety-fund.pdf (08/08/13)]

c) Payment-by-results treatment

Although promising in theory, the current pilots for PbR drug and alcohol services are failing due to a design flaw. By not focussing on getting addicts drug free, they are diluting the potential benefits of the scheme. One year after they were set up, the PbR schemes were performing worse than the national average.³⁹

Furthermore, small, effective providers have been prevented from taking part due to the structure of the contracts to run the PbR schemes. It is possible that the result is that financial capacity to take a risk on a contract has trumped best practice.

6. Conclusion and next steps

There is a persistent danger to society from addiction and abuse. Old problems have not yet been effectively tackled and new trends risk overtaking current policies. This report has identified the barriers to tackling addiction and over the next year we will travel the country looking for solutions. Some recommendations are already self-evident, and indeed supported by those in power; what is needed is the political will to see reforms through.

Recovery for addicts is still not the aim for addicts in treatment, alcohol abuse is rising and costing the nation more, new drugs are being abused by increasing numbers and costing more and more lives, and new, high-tech supply routes are opening up. Currently government is not addressing these issues adequately.

The problem of drug and alcohol addiction and abuse is one which causes huge and avoidable harm. By exposing where this harm lies, and how the current system is failing to address it, we can start to beat addiction. In its main report into addiction, the Centre for Social Justice will focus upon how to tackle the rise in alcohol abuse, the dangers of the internet-based supply of drugs, and the challenge of ensuring recovery is the aim for all addicts.

³⁹ Department of Health, *Performance of Payment by Results pilot areas: April 2012 to February 2013*, London, Department of Health, 2013

chapter one

Drug and alcohol addiction in the UK

1.1 Introduction

Addiction and abuse of drink and drugs is taking an increasing toll on Britain. Growing sections of society are dependent upon mind-altering substances. Approximately one in 20 adults in England are dependent on alcohol. Alcohol-related admissions to hospital have doubled in a decade, a figure which, by the end of this Parliament, will surpass 1.5 million a year.⁴⁰ Within the UK, roughly one in 100 people (380,000) are addicted to heroin and/or crack.⁴¹ This human tragedy is accompanied by eye-watering economic costs. The annual bill to society is over £21 billion in alcohol-related harm and £15 billion resulting from illicit drugs.⁴² The costs to society, both human and financial, are enormous and growing.

More people are reliant on state-supplied opiates despite Government ambition to the contrary.⁴³ Added to this, new drugs are entering the market at the rate of one per week.⁴⁴ Indeed there are now more new psychoactive substances (NPS or 'legal highs') than illegal drugs, available in 'legal high' or 'head' shops and on Ebay-like internet shopping websites.⁴⁵

40 Health and Social Care Information Centre, *Adult psychiatric morbidity in England, 2007* [accessed via: <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf> (20/08/13)]

41 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

42 Home Office, *The Government's Alcohol Strategy*, London: Home Office, 2012; Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

43 Department of Health, *Deposited Paper DEP2013-1196* in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

44 European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2013

45 United Nations, *World Drug Report 2012*, Vienna: UN, 2012 [accessed via: <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2012.html> (08/08/13)]

Britain is the addicted man of Europe, with the highest rate of opiate (mainly heroin) abuse.⁴⁶ We have the greatest number of people in drug treatment (double that of Germany)⁴⁷ and the rise since 2005/06 suggests that our interventions are not adequately undermining the drug problem.⁴⁸ We spend the most in Europe on drugs policies, and yet seem to get a poor return.⁴⁹ Britain is also leading the way in the distribution of new psychoactive substances (NPS or 'legal highs'), which are chemically near-identical to many illicit drugs, with UK-based servers hosting a fifth of all suppliers.⁵⁰

The consequences of addiction and abuse are dire, the effects felt most by those who are least able to cope. There are communities across Britain ravaged by substance abuse. Alcohol and drug abuse fuels violence, domestic abuse, worklessness, child neglect, debt and educational failure, all of which disproportionately affect poor communities. Lives are being ruined and if these trends continue the cost to society, to the NHS, social services, and the police will increase significantly.

Despite a promising start in its 2010 Drug Strategy, the Coalition is yet to deliver on its pledge to tackle addiction. The CSJ has learned that local authorities have disproportionately withdrawn funds for rehabilitation and are failing to provide support for people to lead drug-free lives. On alcohol, rather than dealing with cheap drink, the Government has retreated on plans for a minimum price.⁵¹

This report will set out the levels of addiction in the UK along with the costs and consequences. It will examine the barriers to recovery from addiction and contrast them with the statements and pledges made by those in power. Finally, it will identify particular areas of concern for the future and chart the next stage of *Breakthrough Britain II*.

1.2 Opiates and crack-cocaine

Opiate and crack abuse remains shockingly high in the UK and the state is one of the biggest suppliers. While the abuse of all types of drug is harmful, opiates, like heroin and methadone, and crack-cocaine are the Class-A drugs commonly associated with the most harm, yet despite billions spent, successive Governments have done little to reduce their use.

46 European Monitoring Centre for Drugs and Drug Addiction, *Drug Treatment Overview for Germany*, 2013 [accessed via: <http://www.emcdda.europa.eu/data/treatment-overviews/Germany>] and National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012*, London: Department of Health, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf> (08/08/13)]

47 European Monitoring Centre for Drugs and Drug Addiction, *Drug Treatment Overview for Germany*, [accessed via: <http://www.emcdda.europa.eu/data/treatment-overviews/Germany> (22/08/13)] and European Monitoring Centre for Drugs and Drug Addiction, *Drug Treatment overview for United Kingdom*, [accessed via: <http://www.emcdda.europa.eu/data/treatment-overviews/The%20United%20Kingdom> (22/08/13)]

48 United Kingdom Focal Point, *UK Drug Situation*, 2012, p105 [accessed via: <http://www.cph.org.uk/wp-content/uploads/2013/03/23779-FOCAL-POINT-REPORT-2012-B5.pdf> (22/08/2013)]

49 European Monitoring Centre for Drugs and Drug Addiction, *Towards a better understanding of drug-related public expenditure in Europe* [accessed via: <http://www.emcdda.europa.eu/publications/selected-issues/public-expenditure> 08/08/13]]

50 United Nations, International Narcotics Control Board Report 2013 Vienna: UN, 2013 [accessed via: http://dl.dropboxusercontent.com/u/64663568/library/INCB-Annual-Report-2012_ENGLISH.pdf (08/08/13)] p105

51 Hansard, 17 July 2013 : Column 1113 [accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130717/debtext/130717-0001.htm#1307172000005> (22/08/13)]

Problem drug use – opiates and crack

'Problem drug use' (PDU) is a term used to identify addicts that governments deem are causing the most harm to themselves and others. The effect of this is to send a message that the use of other drugs is not problematic and data relating to costs of use focus on opiates and crack.

The term, PDU, is not homogenous, with different authorities using different definitions. The European Monitoring Centre for Drugs and Drug Addiction, (EMCDDA) defines problem drug use as 'injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines'.

The four UK nations all assess 'problem drug use' in different ways. In England estimates are produced for opiate (heroin etc) and/or crack cocaine users (OCU) and injecting drug use. In Scotland problem drug use refers to the problematic use of opiate and/or the illicit use of benzodiazepines and drug injecting. In Wales it is the long duration or regular use of opioids, cocaine powder and/or crack cocaine; and in Northern Ireland problem opiate and/or problem cocaine powder use.

The *United Kingdom drug situation* report uses all the definitions from across the UK to encompass the problem and to allow for comparisons across Europe to be made by the EMCDDA.⁵² The EMCDDA uses each nation's own definition when comparing rates of addiction.

Nearly 400,000 people in the UK are addicted to opiates, crack or both.⁵³ This represents one of the highest rates of drug abuse in Europe.⁵⁴ The use of these drugs comes at great cost to addicts, their families and society, and disproportionately hits our poorest communities.⁵⁵ Yet despite spending approximately £3 billion on tackling these drugs since 2010, the number of opiate and/or crack users has remained stubbornly persistent.⁵⁶

Although an improvement on the previous system, the current Government needs to be more ambitious still. There are three main suppliers of these most harmful drugs. Heroin originates from the lawless poppy fields of Afghanistan, crack-cocaine is derived from the coca cartels of South America. Methadone, however, is manufactured by pharmaceutical firms and distributed by the UK authorities as a 'treatment' for heroin addiction. In England alone, 262,000 abuse heroin, 171,000 crack-cocaine and 150,000 receive state-supplied methadone or other substitutes.⁵⁷

The failure to tackle the supply of opiates and crack, or to reduce significantly dependency or abuse of them, suggests that the £854 million annual drugs budget has been ineffectively used.⁵⁸

52 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

53 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

54 European Monitoring Centre for Drugs and Drug Addiction, 2012 *Annual report on the state of the drugs problem in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2012 and United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

55 National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xlsm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xlsm) (08/08/13)]

56 National Audit Office, *Tackling Problem Use*, London: The Stationary Office, 2010 [accessed via: <http://www.nao.org.uk/wp-content/uploads/2010/03/0910297.pdf> (08/08/13)]; 'there has been non-significant decrease in the number of problem drug users from 398,845 in the 2007 estimate to 383,534 in the 2012 estimate': United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

57 The National Treatment Agency for Substance Abuse, *National And Regional Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010-11*, London: Department of Health, 2013 [accessed via: [http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofocu201011\[0\].pdf](http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofocu201011[0].pdf) (08/08/13)]; Department of Health, Deposited Paper DEP2013-1196 in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

58 National Treatment Agency, *Drug Treatment Funding* [accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08.08.13)]

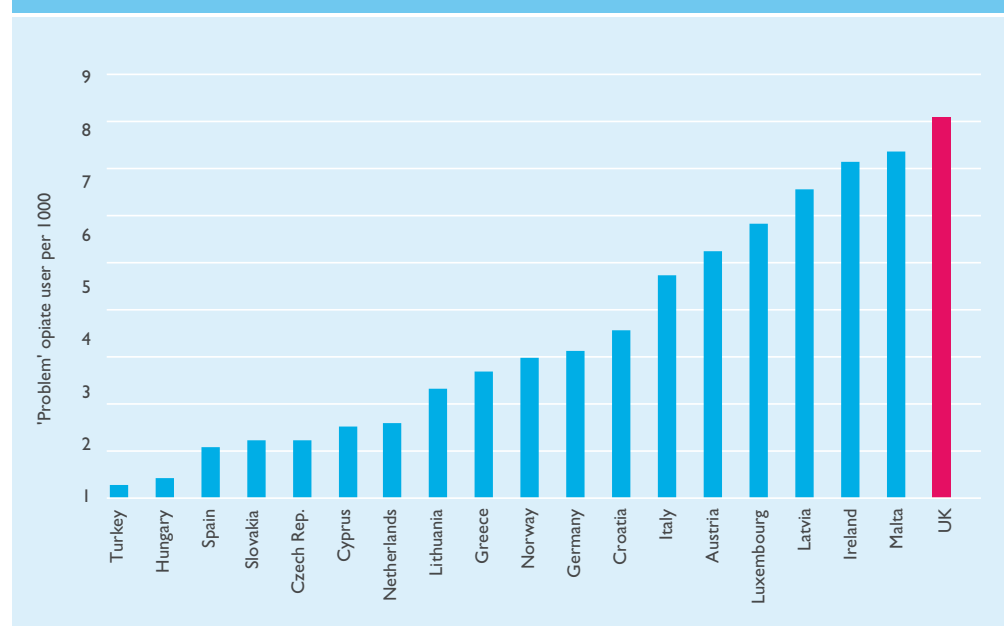
Perversely, the current mainstay of treatment, whereby the Government endlessly supplies addicts who use heroin with methadone, is failing to help addicts overcome their addiction. Indeed, methadone is involved in an increasing number of deaths, and it is also causing more to enter treatment for addiction to the methadone they were once prescribed. It continues to trap many in dependency.

The costs of opiate and crack use in Britain are high. It is estimated that annual costs to society associated with opiate and crack abuse are as high as £15 billion, and 90 per cent of this cost is spent 'picking up the pieces' rather than preventing or tackling addiction and abuse.⁵⁹

The estimated annual cost of opiate and crack-related crime is £14 billion, mainly consisting of acquisitive crime committed by opiate and crack users such as theft and burglary. This breaks down to a £10 billion cost to victims of these crimes and £4 billion incurred by the criminal justice system.⁶⁰ Yet only £854 million of the £15 billion cost of drug addiction and abuse is spent tackling drug abuse, most of which (£736 million) is spent by the Department of Health.⁶¹

In comparison to western European countries, the UK has a far larger drug addiction problem with a higher rate than France or Germany (Figure 1). Despite having a population 30 per cent larger than the UK, Germany has half the total number of drug-related deaths.⁶²

Figure 1: National estimates of prevalence of problem opioid use and injecting drug use per 1000 aged 15–64⁶³



59 Home Office, *Drug Strategy 2010*, London: Home Office, 2010; Gordon, L., et al – 3. *The economic and social costs of Class A drug use in England and Wales, 2003/04 (Measuring different aspects of problem drug use: methodological developments)*, Home Office Online Report 16/06 *The economic and social costs of Class A drug use in England and Wales*

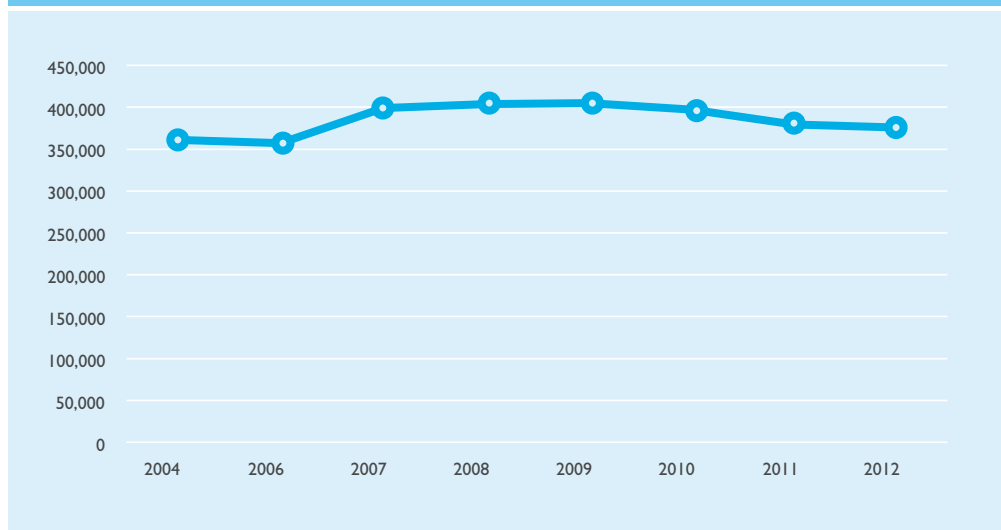
60 National Treatment Agency for Substance Abuse, *Why Invest?*, 2012 [accessed via: <http://www.nta.nhs.uk/uploads/whyinvest2final.pdf> (08/08/13)]

61 National Treatment Agency, *Drug Treatment Funding* [accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08.08.13)]

62 EMCDDA, *Statistical Bulletin 2012*, Table DRD 1, [accessed via: <http://www.emcdda.europa.eu/stats12#display/stats12/drdrtab1a>]

63 European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report 2013: Trends and Developments*, Lisbon: EMCDDA, 2013, p65

Figure 2: Contemporary estimates of total number of heroin, other opiate and/or crack users in UK⁶⁴



Despite the aim of the Coalition Government to get more people through treatment and into recovery, the number of heroin and/or crack users has remained stubbornly high. As Simon Bloomfield of Living Room clinic told the CSJ 'we're seeing the same numbers come through as we did in 2010'. Figure 1 shows the negligible impact treatment programmes have had throughout the UK.

Within the UK, the consequences of drug and alcohol hit the poor more than anyone else. From the Bleach Green Estate in Gateshead to Lowestoft in East Anglia, those communities which struggle with intergenerational worklessness, family breakdown, debt and educational failure are also damaged by alcohol and drugs.

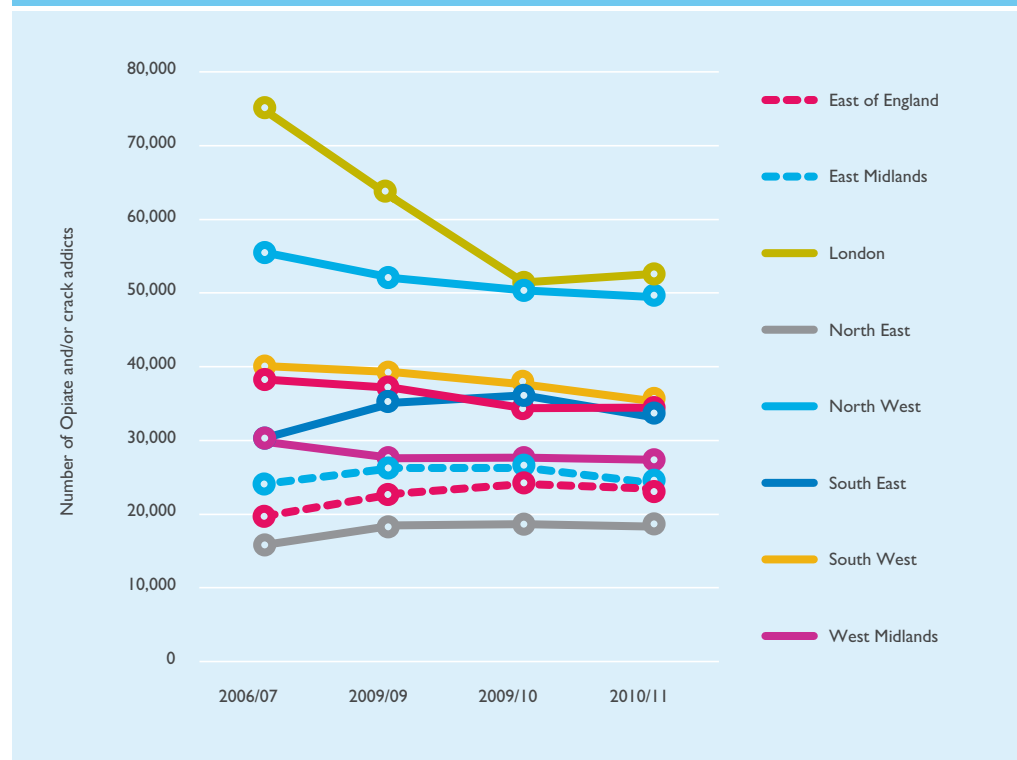
Whilst addiction and abuse hits all parts of society, those with fragile family networks and who are only offered methadone, the heroin substitute, find it hardest to recover. Consequently addiction is not evenly spread across the UK. Scotland has a particularly high rate of 'problematic drug use' at 1.7 per 100 adults; double that of England and Wales.⁶⁵

Despite large investment in drug treatment programmes, they have proved largely ineffective at helping people overcome their addiction. Only in London has there been a marked fall in the use of opiates and crack (Figure 3). Though as Fiona Dunwoody of One North East London told the CSJ, London has a more developed drug market, with newer drugs available, therefore people struggling to source heroin and crack can find New Psychoactive Substances (NPS or 'legal highs').

64 Reuters, P., and Stevens, A., *An Analysis of UK Drug Policy*, London: United Kingdom Drugs Policy Commission, 2007; The National Treatment Agency for Substance Abuse, *National And Regional Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010-11*, London: Department of Health, 2013 and United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2007; 2008; 2009; 2010; 2011; and, 2012. Though the Glasgow Prevalence Estimates, begun in 2004, there is now a more accurate number of opiate and crack users, before this limited samples and the Home Office Addicts Register were all that was available

65 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012, p86

Figure 3: Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2006/07–2010/11⁶⁶



Although since 2006 London has seen a decrease and most regions are stable, there is a worrying increase in addiction in some regions and communities. Every upper tier local authority in the North East, except Newcastle-upon-Tyne, has seen an increase in the number of opiate and crack users since 2006/07.⁶⁷ In Gateshead this rise has been over 30 per cent.⁶⁸

By one estimate, addiction to opiates and/or crack has risen by 10 per cent in the last four years for which figures are available in Middlesbrough.⁶⁹ One in 40 adults⁷⁰ in Middlesbrough is either a heroin and/or crack user, a number that has risen since 2007.⁷¹ This is despite a treatment budget which rose from £3.9 million in 2008/09 to £4.9 million in 2010/11.⁷²

⁶⁶ National Treatment Agency for Substance Misuse, *Prevalence of Opiate Use and/or Crack Cocaine Use*, Annual Reports from 2006/07 – 2010/11, University of Glasgow [Accessed via: [http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofoc201011\[0\].pdf](http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofoc201011[0].pdf) (22/08/13)]

⁶⁷ National Treatment Agency for Substance Misuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)] and 2006/07 [accessed via: http://www.nta.nhs.uk/uploads/north_east_prevalence_data_0607doc.pdf (08/08/13)]

⁶⁸ *Ibid*

⁶⁹ *Ibid*

⁷⁰ People aged 15–64 years old

⁷¹ National Treatment Agency for Substance Misuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)] and 2006/07 [accessed via: http://www.nta.nhs.uk/uploads/north_east_prevalence_data_0607doc.pdf (08/08/13)]

⁷² National Treatment Agency for Substance Misuse, *Regional Teams, North East, Middlesbrough* [Accessed via: http://www.nta.nhs.uk/uploads/ne_middlesbrough_adtp_1011_part4a_finalv2.xls and http://www.nta.nhs.uk/uploads/middlesbrough_trpl4_0910.xls (08/08/13)]

Other areas of England have seen a far larger rise:

Figure 4: Opiate and/or crack use per 1000 adults⁷³

Rank	Local Authority	2010/11 Opiate and/Crack Use per 1000
1	Middlesbrough	25.13
2	Blackpool	21.89
3	Hartlepool	18.57
4	Kingston upon Hull, City of	18.03
5	Liverpool	17.42

In other parts of the UK, such as Essex, Hampshire, Plymouth, increasing numbers of people are becoming addicted to opiates and/or crack: Southampton has seen a rise of over 40 per cent since 2006/07.⁷⁴

1.2.1 The Methadone-maintenance response

Much of the system's response to addiction remains to supply methadone to heroin addicts, a policy akin to supplying an alcoholic with vodka in place of his preferred gin. Methadone is an opioid (artificial opiate) invented in Germany which mimics some of the effects of heroin but without the 'high'.⁷⁵ However, many abuse it, with some addicts selling their prescription to other addicts. It is a legal class A drug supplied to addicts through the public purse.

Methadone is useful in detoxifying a heroin addict as part of their journey to recovery. Beyond this, the benefits become less certain. Methadone can bring some sort of order to an addict's life; the addict's health can be stabilised and improved by not injecting (methadone is usually taken orally) and HIV rates have been contained.⁷⁶ Some argue that crime falls as the state supply means the addict no longer is associated with the world of procuring illicit drugs, though this is disputed.⁷⁷

It is, however, doubtful that prescribing methadone long-term actually helps people tackle their addiction when not combined with further support.⁷⁸ Yet in 2012, for 49 per cent of those in treatment for addiction their treatment was based solely on prescribing, while only two per cent receive residential rehabilitation.⁷⁹

73 National Treatment Agency for Substance Abuse, *Prevalence estimates by local authority* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm)] (08/08/13)]

74 National Treatment Agency for Substance Abuse, *Prevalence estimates by local authority* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm)] (08/08/13)] National Treatment Agency for Substance Misuse, *Prevalence estimates by local authority, 2006/07* [accessed via: http://www.nta.nhs.uk/uploads/south_east_prevalence_data_0607doc.pdf] (22/08/13)]

75 FRANK, *Methadone* [accessed via: <http://www.talktofrank.com/drug/methadone>] (08/08/13)]

76 Strang et al, *Medications in recovery*, London: NTA, 2012

77 Lind et al, *The Effectiveness of methadone maintenance treatment in controlling crime: An aggregate-level analysis*: NSW Bureau of Crime Statistics and Research, March 2004 [accessed via: [http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/BB24.pdf/\\$file/BB24.pdf](http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/BB24.pdf/$file/BB24.pdf)] (08/08/13)] and Daniels, AM, 'Methadone replacement therapy: tried, tested and ineffective' in *JR Coll Physicians Edinb* 2012; 42:133-8 pp136-138

78 Strang et al, *Medications in recovery*, London: NTA, 2012

79 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012*, London: Department of Health, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf>] (08/08/13)]

Figure 5: Methadone-maintenance

Methadone-maintenance positives	Methadone-maintenance uncertainties	Methadone-maintenance negatives
<ul style="list-style-type: none"> • Attracts clients to clinics where they can also receive clean needles, thus tackling HIV • Can bring stability to a heroin user's life enabling time to consider tackling addiction 	<ul style="list-style-type: none"> • Reducing crime • Reducing heroin use 	<ul style="list-style-type: none"> • Obscures a long-term problem • Harder to detox from than heroin • Leakage into black market • Cushions addicts reducing incentive to tackle addiction

The ineffectiveness of current treatment in tackling addiction can be seen in the number of illicit opiate users. Despite billions of pounds spent on attempting to reduce opiate use, there has only been an 8.6 per cent decline in the number of users since 2005/06.⁸⁰

There has been a steep rise in the number of people parked on substitute prescriptions. Of the 146,660 people in substitute prescribing treatment, nearly a third (43,984) have been on a substitute prescription for four years or more – this figure is up by 28 per cent since 2009/10. Over one in 25 of those on substitute prescriptions (6,255) have been on a continuous substitute prescription for more than ten years – a 40 per cent rise since the Coalition entered office.⁸¹

The small reduction in the number of opiate users has come at a high price. Although there has been a slight fall in the numbers using heroin there has been an increase in those prescribed opioids (mainly methadone) as seen in Figure 5. This shows that addiction and its root causes are not being tackled; rather it is being covered-up. As Figure 5 shows, there has been a slight decline (-8.6 per cent) in those addicted to *illicit* opiates since *Breakthrough Britain* was published in 2006, but this is more than countered by the 45 per cent rise in those now prescribed an opiate over the same period.

The human cost of prescribing methadone is increasing, with more people being admitted to hospital suffering its effects. The decline in heroin-related discharges from hospital is almost matched by the rise in those which are methadone-related. While heroin poisonings dropped from 3,071 in 2007 to 2,500 in 2012, methadone poisonings rose from 1,365 to 1,954 in the same time (Figure 7).⁸²

80 United Kingdom Focal Point, *United Kingdom Drug Situation*, 2008, p78 [accessed via: <http://www.medicine.manchester.ac.uk/healthmethodology/research/ndec/factsandfigures/UKFocalPoint/ukfocalpointannualreport2007.pdf> [22/08/2013]] and The National Treatment Agency for Substance Abuse, *National And Regional Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010–11*, London: Department of Health, 2013 [accessed via: [http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofocuf201011\[0\].pdf](http://www.nta.nhs.uk/uploads/estimatesoftheprevalenceofocuf201011[0].pdf) (08/08/13)]

81 *Department of Health, Deposited Paper DEP2013-1196* in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

82 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

Figure 6: Numbers of opiate users in England together with the number receiving substitute medication⁸³

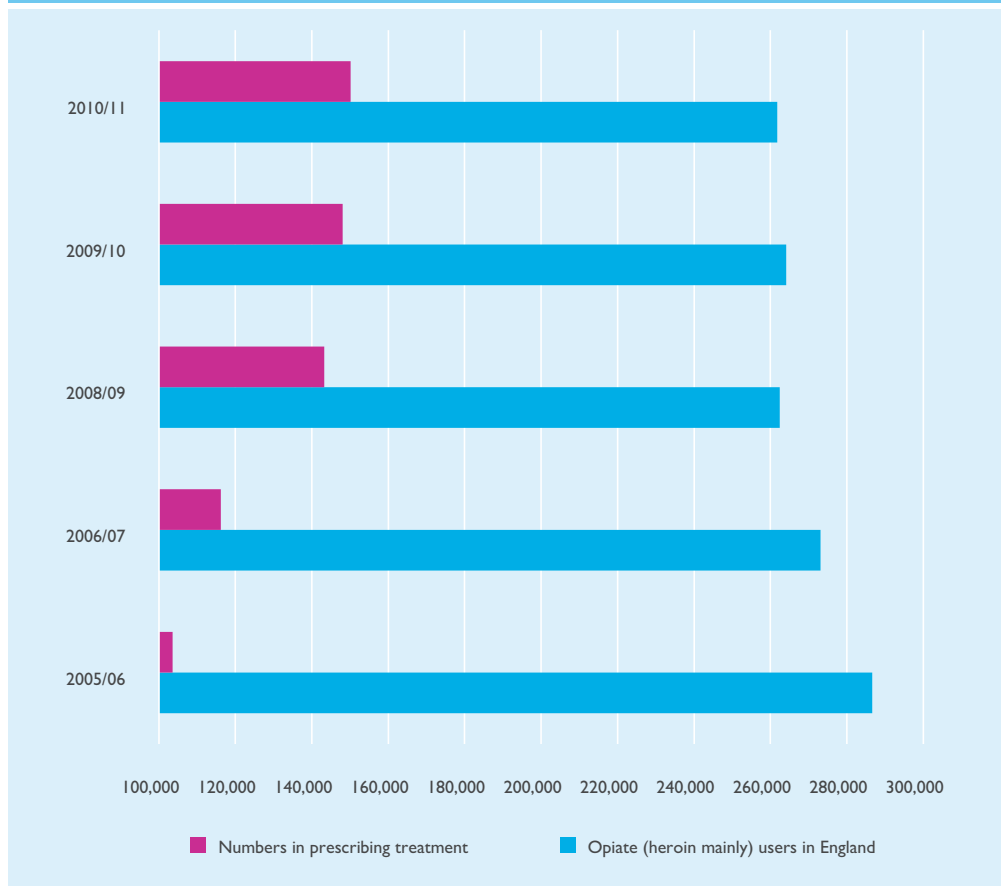
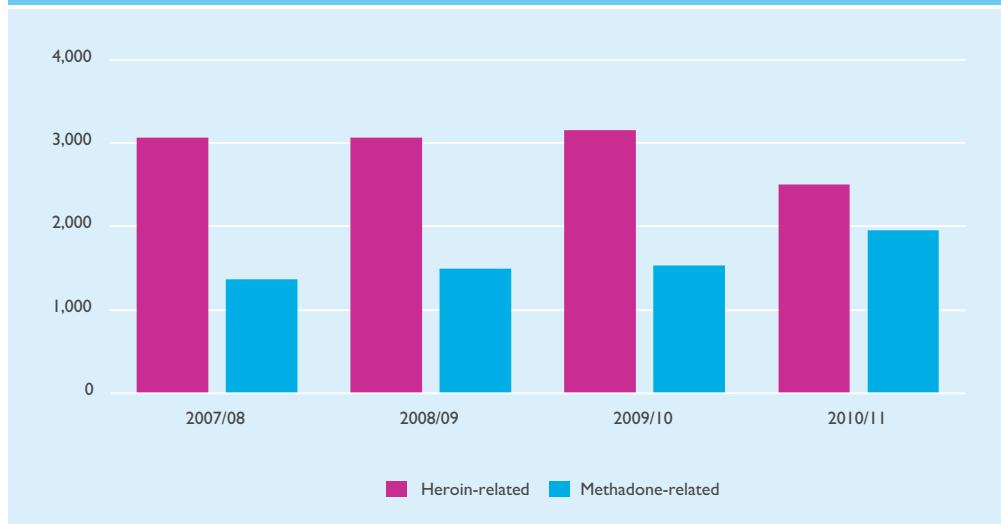


Figure 7: Inpatient discharges recording poisoning by drugs in the United Kingdom, 2007/08 to 2010/11⁸⁴



⁸³ The National Treatment Agency for Substance Misuse, *National And Regional Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010-11*, London: Department of Health, 2013 and United Kingdom Focal Point, *United Kingdom Drug Situation*, London: Department of Health, 2007; 2008; 2009; 2010; 2011; and, 2012. More recent data is available showing a slight decrease (2.5 per cent) in the number on a substitute prescription. The corresponding data for opiate prevalence is not yet available however.)

⁸⁴ United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012.

Methadone does not necessarily stop heroin addicts using heroin or other drugs. Indeed one study found the prescribing methadone did not lead to a higher rate of abstinence from heroin.⁸⁵ Some procure methadone by illicit means. Speaking to the CSJ Judith Spence, of Loughborough residential rehab unit, the Carpenter's Arms said 'people on prescribed methadone either sell their methadone or use it on top of other drugs'.

The long-term futility of methadone maintenance in tackling addiction – interviews conducted by the CSJ

The CSJ heard from Matt, a plumber now 38, who started using drugs when he was 25. When he first entered treatment, aged 29, he was prescribed methadone for heroin abuse yet this did not stop him taking heroin. Even when he stopped abusing heroin, he continued to abuse crack-cocaine and alcohol. Perversely, Matt told the CSJ how methadone was by far the hardest drug from which to detoxify, a factor which prevented him from getting well sooner. Matt finally got clean 18 months ago after attending abstinence-based rehab and now has two volunteering roles.

Scott, a carpenter now 46, told the CSJ how after sniffing glue, gas, and drinking alcohol at 16, he was soon using heroin. Although prescribed methadone, it made him feel so ill that he would only take it when he could not 'score' other drugs. Despite this, Scott was continually told he could not hope to be sent to rehab by his local authority until he had been on a methadone-course for one year. Scott is 18 months clean after moving to a different local authority and attending abstinence-based rehab. Like Matt, he has two volunteering roles.

Long-term prescribing fails to tackle the root causes of addiction and can lead to wider problems. For example, the long-term prescription of methadone also fuels a burgeoning black market. Known as 'diversion', prescribed drugs are sold, given or stolen, then consumed by someone other than the patient, often with deadly consequences.⁸⁶ Deaths involving methadone have risen by 50 per cent since 2006.⁸⁷ In Britain, over 50 per cent of all deaths where methadone was present, it had been obtained from illicit sources.⁸⁸ In Scotland, which currently has a record rate of drug-related deaths,⁸⁹ methadone is associated in 47 per cent of all drug-related deaths – more than any other drug (after alcohol) including heroin.⁹⁰

85 Bloor et al, 'Topping up' methadone: An analysis of patterns of heroin use among a treatment sample of Scottish drug users' in *Public Health* Volume 122, Issue 10, October 2008, pp 1013–1019

86 Duffy P and Baldwin H, 'The nature of methadone diversion in England: a Merseyside case study', *Harm Reduction Journal*, 9(3), 2012 [accessed via: <http://link.springer.com/content/pdf/10.1186%2F1477-7517-9-3.pdf> (08/08/13)]

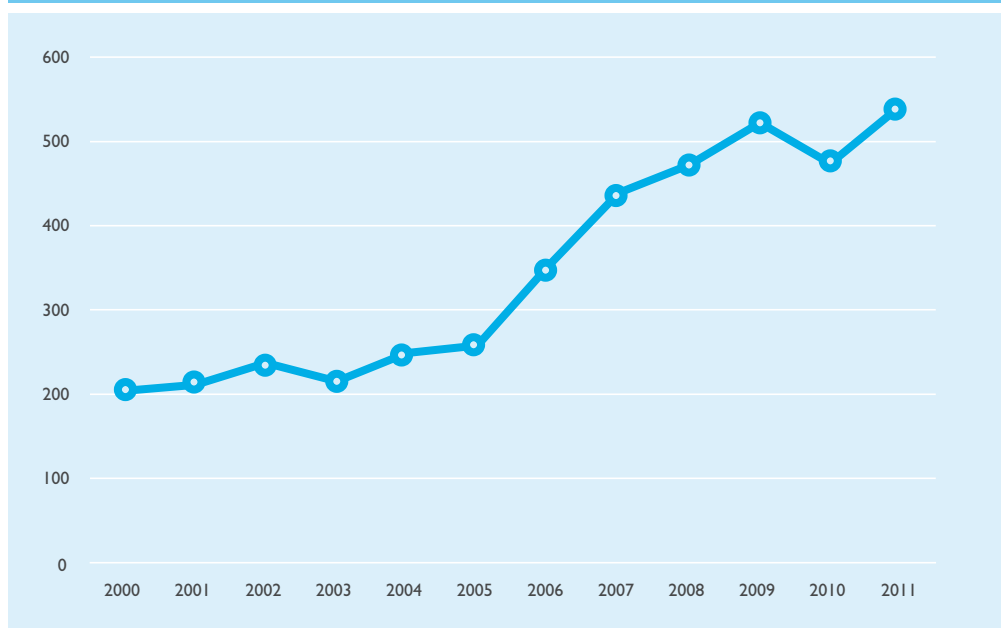
87 Ghodse H et al, *Drug-related deaths in the UK: Annual Reports 2006 – 2012*, London: St George's University, 2012 [accessed via: <http://www.sgul.ac.uk/research/projects/icdp/pdf/np-sad-13th-annual-report-2012.pdf> (08/08/13)]

88 Ghodse H et al, *Drug-related deaths in the UK: Annual Reports 2006 – 2012*, London: St George's University, 2012 [accessed via: <http://www.sgul.ac.uk/research/projects/icdp/pdf/np-sad-13th-annual-report-2012.pdf> (08/08/13)]

89 National Records of Scotland, *Drugs related deaths in Scotland 2011*, Edinburgh: National Records of Scotland, 2012 [accessed via: <http://www.gro-scotland.gov.uk/files2/stats/drug-related-deaths/2011/drug-related-deaths2011.pdf> (08/08/13)]

90 National Records of Scotland, *Drugs related deaths in Scotland 2011*, Edinburgh: National Records of Scotland, 2012 [accessed via: <http://www.gro-scotland.gov.uk/files2/stats/drug-related-deaths/2011/drug-related-deaths2011.pdf> (08/08/13)]

Figure 8: Number of methadone-related deaths in the UK, 2000–2011⁹¹



Considering that it is used to 'treat' opiate addiction, it is ironic that presentations to treatment for methadone addiction have increased by one third since 2003/04.⁹² The number of cases where an addict was seeking treatment for methadone dependency for the first time increased by 61 per cent between 2009/10 and 2010/11.⁹³ Mel Dunseith of Serenity House a Bristol community-based rehab confirmed this to the CSJ saying that while she is seeing fewer clients with heroin addiction problems, more are appearing with methadone dependency.

Financially too the cost of methadone and other substitute prescriptions to the taxpayer is large. The cost of the entire apparatus involved in the substitute prescribing system was put at £730 million by one estimate.⁹⁴

The supply of methadone has failed to curb Britain's opiate problem and has seen the state give heroin-like drugs to tens of thousands. Many people prescribed methadone use illicit drugs on top and users often sell their methadone prescription to buy other drugs.⁹⁵ As Matt told the CSJ, 'I kept on using when they prescribed me methadone, maybe a bit less heroin (though still some) and topped-up with more alcohol'.

As will be seen in Chapter Three, the welfare consequences of long-term methadone maintenance show it to be a false economy, with only an extra three per cent in work six months after treatment – from 18 per cent to 21 per cent – and the vast majority receiving

91 Ghodse H et al, *Drug-related deaths in UK 2006 – 2012*, London: International Centre for Drug Policy, 2006–2012

92 United Kingdom Focal Point, *UK Drug Situation 2012*, Department of Health, 2013, p89 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf> (08/08/13)]

93 United Kingdom Focal Point, *UK Drug Situation 2012*, Department of Health, 2013, p88 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf> (08/08/13)]

94 Centre for Policy Studies, *Breaking the Habit*, London: Centre for Policy Studies, 2011

95 Baldwin H et al, 'The nature of methadone diversion in England: a Merseyside case study', *Harm Reduction Journal*, 9(3), 2012 [accessed via: <http://www.harmreductionjournal.com/content/9/1/3> (08/08/13)]

welfare benefits.⁹⁶ Added to this is the impact on up to 335,000 children, be it neglect or educational attainment.⁹⁷

Parked on methadone – Paul was interviewed by the CSJ

Paul was 18 when he started using heroin. He regularly went to nightclubs and would use cannabis and pills, but started using heroin when his friends introduced him to it. Within a few weeks he was injecting heroin and after a year he had lost his job and realised he was addicted. To fund his addiction, as he was unable to work, Paul began to commit crime and many of his relationships deteriorated.

Paul had numerous encounters with various services that tried to help him. Several times he tried a medically-assisted detoxification at home, involving GP-prescribed painkillers. However it was not long before he relapsed.

During one of many prison sentences, Paul detoxified and went on to a heroin substitute called subutex.⁹⁸ But methadone, he found, was better. Positively he opted for methadone as it meant that he could reduce the amount of heroin he was taking, but it also allowed Paul to 'use on top on' with other drugs – this involves taking methadone and using crack, alcohol and heroin at the same time.

After collecting his prescription, Paul would often 'palm it' – pretending to take it in front of the pharmacist, but actually putting it in his pocket. This he could then sell for other drugs.

Paul attended a treatment clinic, which consisted of a methadone prescription and a quarterly interview. In order to maintain his supply, Paul would lie at the interview. Even when Paul had managed to reduce his use to a couple of times a week and he wanted to reduce his prescription, positive drug test results meant he was kept on high dosages.

Paul continued this cycle of dependency for eight years, out of work and on methadone. At no point in treatment did anyone mention rehabilitation, which Paul thought was just for celebrities. As Paul told the CSJ, 'I didn't know people like me could get clean. Someone in recovery was like a unicorn – a mythical creature'.

This situation continued until Paul met someone in recovery who told him that it was possible to access rehabilitation. Gaining access to residential rehabilitation, Paul detoxified from all drugs in a supported environment and then addressed the issues that were driving his use. Subsequently Paul is clean, working and most significantly for him, was able to attend his sister's wedding, something that would not have happened if he was still using drugs.

Methadone in itself is not full recovery. Too often it allows those responsible to say that they have discharged their duty of care. Rather than being a first step on the road to recovery, too many are parked on methadone. It has already been shown that in England, of the 146,660 opiate users in substitute prescribing treatment, 30 per cent have been on a substitute prescription for four years

96 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012*, London: Department of Health, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf> (08/08/13)]

97 Manning et al., 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

98 Subutex is the trade name for Buprenorphine Hydrochloride. It is a complex drug, with a number of important considerations to be taken into account by anyone prescribing or using it. Buprenorphine was licensed for the treatment of opioid addiction in the UK in 1999. Essentially, it is a long acting opioid (heroin or methadone) substitute, though it has some unusual properties' – [accessed via: <http://www.release.org.uk/drugs-law/drugs-a-to-z/subutex> (08/08/13)]

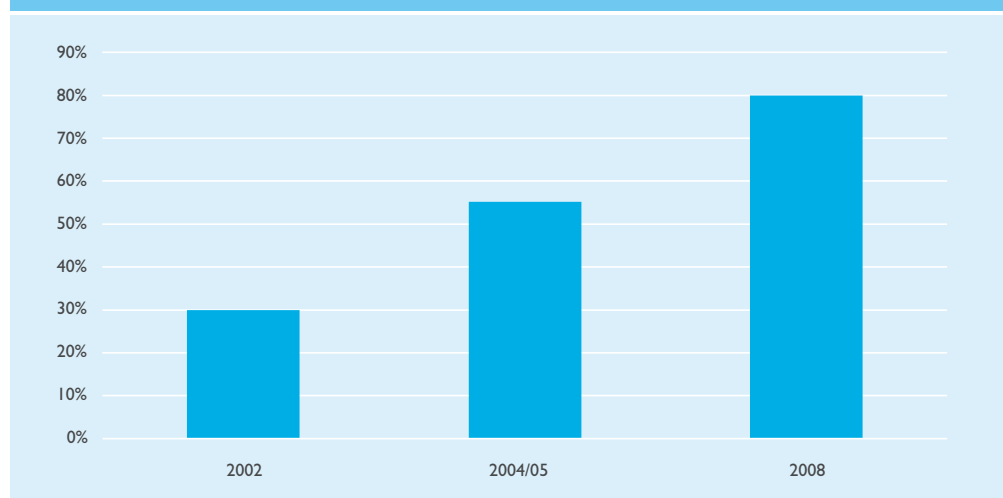
or more.⁹⁹ This represents a 28 per cent increase since 2009/10, and includes 6,255 addicts who have been on a continuous substitute prescription for more than ten years.¹⁰⁰

1.3 Cannabis – a new hard drug

Over the last decade, the strength of cannabis across Britain has nearly trebled and more people are seeking help for its effects.¹⁰¹ With an increasing number of studies reporting the adverse effects of this stronger cannabis upon mental health and the brain development of under-25s, the long-term impact of cannabis may increasingly be felt by society.¹⁰² Be it children caring for a parent suffering extensive mental health problems, or indeed parents looking after their damaged children, the costs of cannabis are great and rising.¹⁰³

Despite the dangers of this drug, it was used by over two million people aged 16–59 years old.¹⁰⁴ Although there has been a reduction in use since 2003, more people, especially young people, are seeking treatment for cannabis addiction and corresponding mental health problems.¹⁰⁵ Drugs treatment centres, although still dominated by heroin and/or crack addicts, now see one-fifth of all treatment presentations and one-third of first-ever presentations due to cannabis.¹⁰⁶

Figure 9: Herbal ‘skunk’ cannabis as a percentage of police seizures¹⁰⁷



99 Methadone is the usual substitute. *Department of Health, Deposited Paper DEP2013-196* in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

100 *Department of Health, Deposited Paper DEP2013-1196* in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

101 Hardwick S, King L, *Home Office Potency Study*, London: Home Office, 2008; National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012*, London: Department of Health, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf> (08/08/13)]

102 University of Maryland, 'Univ. of MD finds that marijuana use in adolescence may cause permanent brain abnormalities', 2013 [accessed via: http://www.eurekalert.org/pub_releases/2013-07/uomm-uom072413.php (08/08/13)]

103 University of Maryland, 'Univ. of MD finds that marijuana use in adolescence may cause permanent brain abnormalities', 2013 [accessed via: http://www.eurekalert.org/pub_releases/2013-07/uomm-uom072413.php (08/08/13)] and Griffith-Lendering et al, 'Cannabis use and vulnerability for psychosis in early adolescence – a TRAILS study' 2013 [accessed via: <http://onlinelibrary.wiley.com/doi/10.1111/add.12050/full> (22/08/13)]

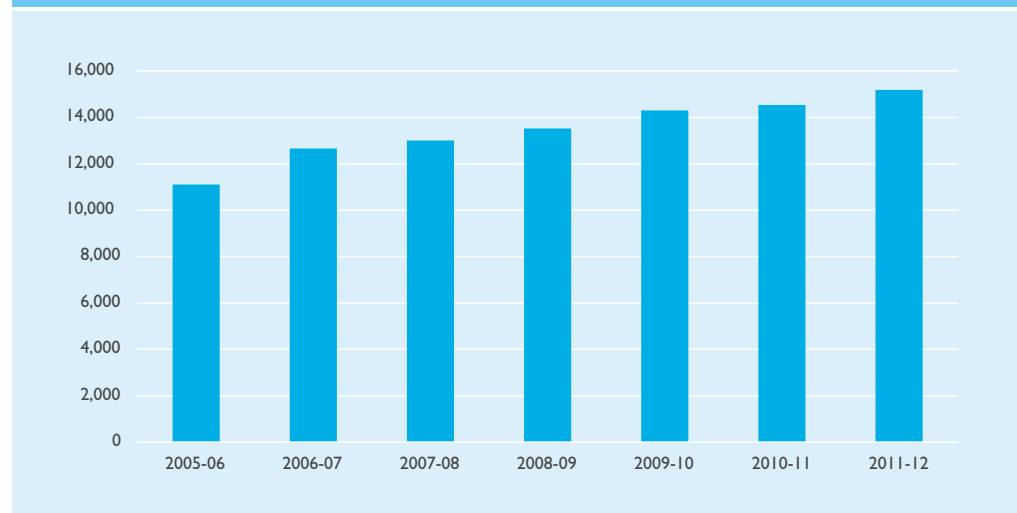
104 Information Centre for Health and Social Care, *NHS Statistics on Drug Misuse*, 2012 [accessed via: http://www.dependencias.pt/ficheiros/conteudos/files/drug_misu_eng_2012_rep.pdf (08/08/13)]

105 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012,

106 United Kingdom Focal Point, *UK Drug Situation 2012*, London: Department of Health, 2012 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf>]

107 Hardwick S, King L, *Home Office Potency Study*, London: Home Office, 2008

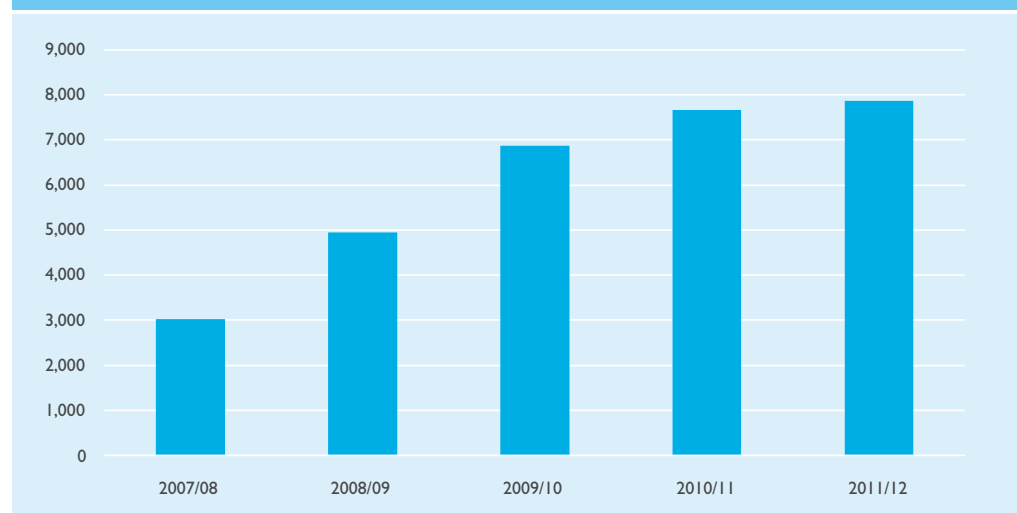
Figure 10: Number in treatment primarily for cannabis addiction, 2005/06–2011/12¹⁰⁸



This increase has accompanied the rise of super-strong herbal cannabis – ‘skunk’. In 2002, ‘skunk’ made up about 30 per cent of the British market. Today that figure has grown to 80 per cent of the cannabis available, and it has a tetrahydrocannabinol (THC) concentration of 16.2 per cent. The cannabis of the 1960s had a THC content of three to four per cent making today’s cannabis at least four times stronger.¹⁰⁹

This rise in potency has corresponded with a rise in the numbers accessing treatment for cannabis addiction. As can be seen above, there has been a 36 per cent increase in those coming forward for help with cannabis dependency and abuse since 2005, with 15,000 people getting help in England last year.¹¹⁰

Figure 11: Number of cannabis farms in the UK, 2007–2012¹¹¹



¹⁰⁸ National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012

¹⁰⁹ Hansard, HC Deb 6 Jun 2013: c291wh [accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130606/halltext/130606h0001.htm> (22/08/13)]

¹¹⁰ National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012

¹¹¹ Association of Chief Policy Officers, *Commercial Cultivation of Cannabis*, London: ACPO, 2012

SARAH'S STORY, mother of Andrew. The case study was given to the CSJ by the charity CanSS, which focusses on the impact cannabis/skunk can have on children

Andrew first became noticeably unwell during the summer holidays, aged 16. Sarah found some cannabis in his room and yet at the time she no idea, indeed Andrew did not even drink alcohol as far as she was aware. His mood changes were almost immediate. Laughing one minute, crying the next. He spent days in bed and had no energy or motivation. Previously he loved sport and was an accomplished ice-skater.

His return to school was the beginning 'of a journey to hell'. Andrew had been a 'Grade A' student and yet after his drug use began he missed days from school and did not work. Andrew tried going to different schools to ascertain if his problems stemmed from a particular environment.

After several months of continuing problems, Andrew's mother discovered he was still using 'skunk'. He went to a private hospital and was sectioned under the Mental Health Act. Sarah said it was the worst day of her life, he cried for his parents and had to be held down. 'He just screamed, it was heart wrenching.'

After being there for over three months he was discharged, and Sarah believed it was the end. Unfortunately it was the 'beginning of a road that I would not wish on my worst enemy.' Repeated inpatient stays resulted over the next eight years.

In that time, he stayed between three months and up to a year. Yet he always returned to 'skunk'. Sarah said that 'it is very addictive. He hears voices, has no motivation. He is very depressed and has attempted suicide. He has been beaten up, tied up and robbed, and not just once.'

Andrew has become very vulnerable and is terrified a lot of the time. 'It is absolutely heartbreaking. My son was a happy, highly intelligent young man who has had his life wasted, destroyed! As well as mine and his father's.'

Andrew sadly has no friends anymore. 'Most of the patients I have met in the various hospitals over the last eight years have taken drugs in one way or another the psychiatric hospitals are full of young people who have drug related psychosis.'

Andrew is now 25, it is nine years since this began.

The police too have reported the growth in 'skunk' production, which tends to be grown in indoor farms, under lights, using hydroponics.¹¹² The number of such farms has increased from 3,000 in 2007 to about 8,000 last year.¹¹³

Skunk has the potential to have far more damaging effects than the cannabis available in previous decades, especially on the developing brain. There are also links to damage to the lungs, behaviour, psychosis, educational attainment, complications in pregnancy and foetal development.¹¹⁴

¹¹² Association of Chief Policy Officers, *Commercial Cultivation of Cannabis*, London: ACPO, 2012

¹¹³ Association of Chief Policy Officers, *Commercial Cultivation of Cannabis*, London: ACPO, 2012

¹¹⁴ Ministry of Security and Justice, *Strong cannabis becomes a hard drug*, Government of the Netherlands, 2011; British Lung Foundation, *The effect of cannabis on your lungs*, London: BLF, 2012; NHS Choices, *More evidence on cannabis psychosis*, NHS, 2011; Griffith-Lendering et al., 'Cannabis use and vulnerability for psychosis in early adolescence—a TRAILS study' 2013 [accessed via: [http://onlinelibrary.wiley.com/doi/10.1111/add.12050/full\(22/08/13\)](http://onlinelibrary.wiley.com/doi/10.1111/add.12050/full(22/08/13))]; and NHS Choices, *The dangers of cannabis* [accessed via: <http://www.nhs.uk/Livewell/drugs/Pages/Cannabisdangers.aspx> (22/08/13)]

The CSJ has heard first-hand what cannabis abuse can do to a developing brain and how it can be the first step on a journey to harder drugs. Addictions charity, One North East London, told the CSJ: 'We are seeing a familiar progression of younger people using cannabis and as they get older moving on to class A drugs mixed with alcohol'.

The dramatic rise in potency should be considered in any discussion about the classification of cannabis. Those making policy should take account of how the strength of the drug has increased and with it the harm it is causing to young, developing brains – a group which also happens to be the most likely to use it.¹¹⁵ Such is the danger of this development that the Dutch government plans to classify cannabis with a THC content of 15 per cent or more a Class A drug, in the same bracket as heroin and cocaine.¹¹⁶

It is of concern that ever increasing numbers of people (particularly young people) are being taken into treatment for the effects of ever more super-strength cannabis. It remains the most commonly consumed illegal drug in Britain, meaning that there is a mental health time-bomb ticking.¹¹⁷ This has been observed by Dr Wendy Swift whose recent study into cannabis in Australia found a similarly high THC content to that in the UK. She cautions 'these results suggest that the profile of cannabis currently used in Australia may make some users vulnerable to mental health problems...the high THC/low CBD profile of Australian cannabis has been linked to increased risks for cannabis dependence, increases in treatment seeking and increased vulnerability to psychosis'.¹¹⁸

Cannabis cannot be dismissed simplistically as a soft drug. The drug that many of its appeasers grew up with is very different from the 'skunk' which has come to dominate the market. More people are suffering harm and a growing body of evidence points to the dangers to developing brains.

1.4 New drugs

Rising use of new drugs, including new psychoactive substances (NPS), sometimes called 'legal highs', is a new phenomenon. They are doing increasing harm to a growing number of people. The rise of these drugs counter-balances any slight decline in heroin/crack use seen in recent years. In nightclubs, 20 per cent of respondents to the Global Drug Survey carried out by Mixmag in 2012 reported that they had used NPS.¹¹⁹ The numbers of young people in the UK aged 15-24 who have taken a 'legal high' is estimated to be 670,000 (or 8.2 percent) – the highest in Europe.¹²⁰

¹¹⁵ United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

¹¹⁶ Ministry of Security and Justice, *Strong cannabis becomes a hard drug*, Government of the Netherlands, 2011

¹¹⁷ United Kingdom Focal Point, *UK Drug Situation 2012*, London: Department of Health, 2012 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf> (08/08/13)]

¹¹⁸ Swift W et al, *Analysis of cannabis seizures in NSW, Australia: cannabis potency and cannabinoid profile*, Sydney: National Drug and Alcohol Research Centre Sydney, 2013

¹¹⁹ Mixmag, *Global Drug Survey, 2012* [accessed via: <http://www.mixmag.net/words/features/mixmags-global-drug-survey-the-results> (08/08/13)]

¹²⁰ United Nations, *World Drug Report 2013*, Vienna: UN, 2013 [accessed via: http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf (08/08/13)] p80

About the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

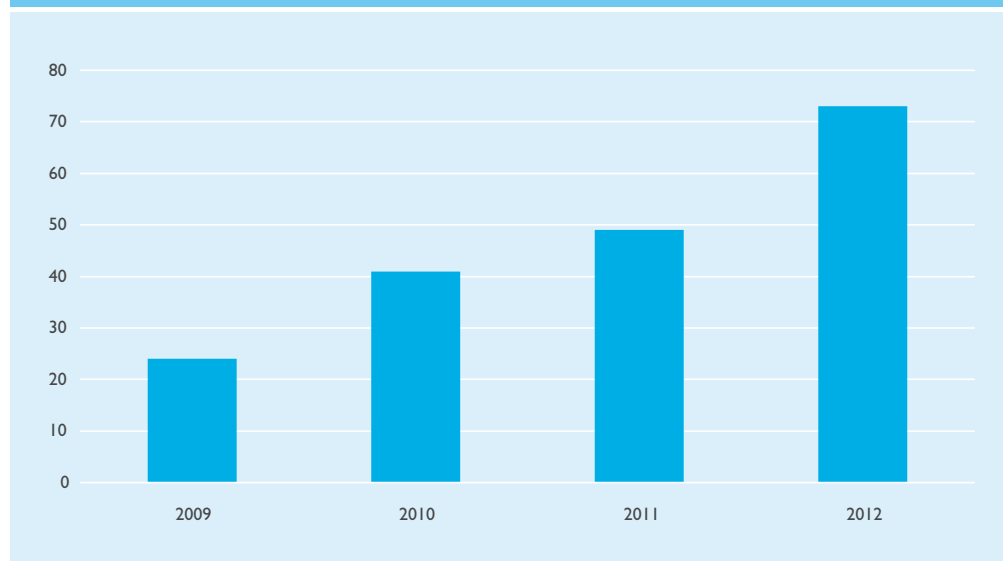
The EMCDDA exists to provide the EU and its Member States with a factual overview of European drug problems and a solid evidence base to support the drugs debate. Today it offers policymakers the data they need for drawing up informed drug laws and strategies. It also helps professionals and practitioners working in the field pinpoint best practice and new areas of research.

At the heart of the agency's work is the promotion of scientific excellence. To achieve its core task of providing sound and comparable information on drugs in Europe, the EMCDDA has developed the infrastructure and tools needed to collect country data in a harmonised way. These data are then fed by national drug monitoring centres (Reitox network) to the Lisbon agency for analysis, resulting in a variety of information products conveying the broader European picture.

Sold in 'head shops' on the high street and over the internet, these new drugs are often chemically similar to banned drugs and have the same effects. The slight molecular differences mean they can be sold as bath salts or research chemicals, provided they carry a caution against consumption. The result of this slight chemical difference means that new drugs are not covered under the A, B, C system of the Misuse of Drugs Act and therefore legal to produce, supply and possess.¹²¹

Such is the explosion in these substances, such as Salvia and Green Rolex, that the 251 uncontrolled drugs outnumber controlled substances like cocaine – of which there are 234. This means while 234 different drugs are subject to the ABC classification system, there are now 251 that are not.¹²²

Figure 12: New drugs detected each year by the European monitoring service¹²³



¹²¹ Misuse of Drugs Act 1971 [accessed via: <http://www.legislation.gov.uk/ukpga/1971/38/contents> (08/08/13)]

¹²² United Nations, *World Drug Report 2013*, Vienna: UN, 2013 [accessed via: http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf (08/08/13)] p59

¹²³ European Monitoring Centre for Drugs and Drug Addiction, *2012 Annual report on the state of the drugs problem in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2013 p26

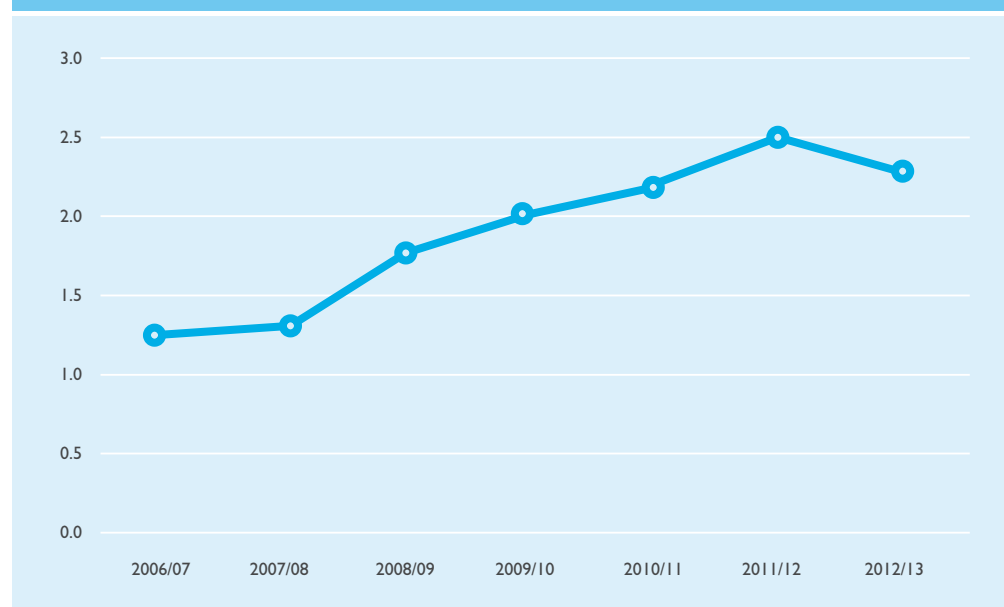
This situation will only increase given that NPS are emerging at the rate of one per week. According to the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) early warning system, there has been a dramatic rise in the number of new substances being detected (Figure 12).¹²⁴ Between 2005 and 2012, the early warning system identified 280 new psychoactive substances.¹²⁵

This rate of increase has been matched by the increase in the number of internet-based 'head shops'. The UK is now one of the leading hubs for the internet-based dealing of NPS. There are over 130 sites registered in the UK providing a range of legal highs. Internet sites selling NPS and shipping them to EU member states rose from 170 in January 2010 to 690 in January 2012.¹²⁶

The number of high street-based 'head shops' is uncertain but, according to the Angelus Foundation, which works with those affected by NPS, 'UKSkunkworks has 14 shops in and around London. Dr Herman has six shops in the North of England'. These shops openly sell an array of NPS, as well as cannabis paraphernalia.

The human cost is growing as a number of NPS are proving deadly. 6,486 people were treated in 2011/12 for abusing these drugs generally seen as 'club drugs', an increase of 39 per cent since 2005/06.¹²⁷ In 2010, 43 people in the UK died after taking now outlawed methcathinones, eight times more than the previous year.¹²⁸

Figure 13: Number of people reporting having used ketamine¹²⁹



¹²⁴ *Ibid*

¹²⁵ *Ibid*

¹²⁶ International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

¹²⁷ National Treatment Agency for Substances Misuse, *Club drugs: emerging trends and risks*, London: NTA, 2012

¹²⁸ Ghodse H et al, *Drug-related deaths in the UK: Annual Reports 2006–2012*, London: St George's University, 2012

¹²⁹ United Kingdom Focal Point, *United Kingdom drug situation 2012*, London: Department of Health, 2013

JOE'S STORY: Told by Joe in an interview with the CSJ

Joe is 33. He has no bladder and for the rest of his life will have to carry a catheter. Only one of his kidneys works and at 15 per cent of its potential. A further deterioration of five per cent would mean he requires dialysis.

At 24, Joe started using ketamine recreationally but eventually became dependent upon it. He estimates that his ketamine use led him to be admitted to hospital over one hundred times. 'All the doctors and nurses knew me', Joe told the CSJ. 'Ketamine rips the body', said Joe when explaining that he'd had more operations than any of the 'hard' drug users he had met in rehab.

Yet even with this repeated contact with the NHS over four years, for both major operations and minor complaints, Joe was never offered treatment to tackle his addiction. Instead the NHS services just patched-up the symptoms – at a cost of tens of thousands of pounds. Even after he had his bladder removed he was not told that he needed to give up drugs.

Eventually, when he did access a drugs treatment centre in London at his own asking, they said his drinking was not a problem, just ketamine. Joe told the CSJ that, after a month, he got drunk and used ketamine. This soon spiralled into heavy use which again required hospital treatment.

Joe was lucky enough that after attending a Narcotics Anonymous meeting he was sponsored privately to go to rehab, which enabled him to become alcohol and drug-free. He is now back to work and looking forward to his first holiday.

The tragedy for Joe, and indeed the taxpayer, is that in over a hundred trips to hospital and numerous costly operations, he was not offered the chance to beat addiction.

For poorer communities there are particular dangers because many new drugs are very cheap. The industrial solvent, *gamma*-Butyrolactone (GBL or 'G'), for example, is similar in its effects to alcohol. By way of illustration, we met the North West London Addiction Service who said that 'some of these drugs, like G, are 10 pence a hit – you don't need much money for a habit like that'.

Worryingly, despite the devastating impact they can have on people's bodies, the CSJ has heard that due to the name 'legal high', and the fact they can be obtained legally, some believe they are safe to use. The CSJ heard from Angelus, 'so many kids think NPS aren't dangerous like crack-cocaine because they can walk into a shop and buy them'.

Other substances, like ketamine (a horse tranquilliser), are being used more frequently, with the rate of use more than doubling from 2006/07 to 2011/12 (Figure 13).¹³⁰ The delay between people using these substances for the first time and developing a dependency means that the current treatment figures could be the start of a worrying trend.¹³¹

¹³⁰ 'Home Office, *Crime Survey for England and Wales*, London: Home Office, 2013'

¹³¹ National Treatment Agency for Substances Misuse, *Club drugs: emerging trends and risks*, London: NTA, 2012

Although club drugs do not share the ugly image of heroin, they can prove just as ruinous to a person's life. Ketamine, for example, can lead to permanent bladder damage requiring, at best, lifetime use of catheters and, at worst, blood poisoning and death.¹³²

The danger posed by the emergence of new drugs is great. Use of drugs like ketamine and gamma-Butyrolactone (GBL) can have severe health implications in a very short space of time. With increasing numbers of young people using these drugs, the potential cost to the NHS is great – not to mention the burden to a man in his twenties knowing he will always have to carry a catheter wherever he goes.

New drugs represent a paradigm shift in the way substances are viewed and obtained. They can be bought openly, either on the high street or delivered to the door via an internet order. It is young people who are those suffering most, increasingly taking them under the misapprehension that they are safer to use than other drugs which are controlled by the Misuse of Drugs Act. The consequences to date have been rising deaths, costs to the NHS and family tragedies.

1.5 Alcohol

'One in three people know someone with a drink problem that seriously affects their life.'

CSJ/YouGov Polling 2012 (1722 adults)

Alcohol addiction and abuse is taking an increasing toll on Britain despite a fall in overall consumption.¹³³ One in 20 adults are dependent drinkers and one in four drink to a hazardous level.¹³⁴ Although the number of people drinking every week has declined since 2002, the number of alcohol-related admissions to hospital has more than doubled in the same period (Figure 14).¹³⁵ Alcohol-related deaths have doubled since 1991 and liver disease is now one of the 'big five killers' alongside heart and lung disease, stroke and cancer.¹³⁶ The bill to the NHS is some £3.5 billion – or £120 per taxpayer per year.¹³⁷ This is a large figure but one that is dwarfed by the overall estimate of the cost to society of alcohol – £21 billion.¹³⁸

¹³² FRANK, *Ketamine* [accessed via: <http://www.talktofrank.com/drug/ketamine> (08/08/13)]

¹³³ North West Public Health Observatory, *Local Alcohol Profiles England*, Liverpool: PHE, 2012 ; ONS, *General Lifestyle Survey*, London: ONS, 2011

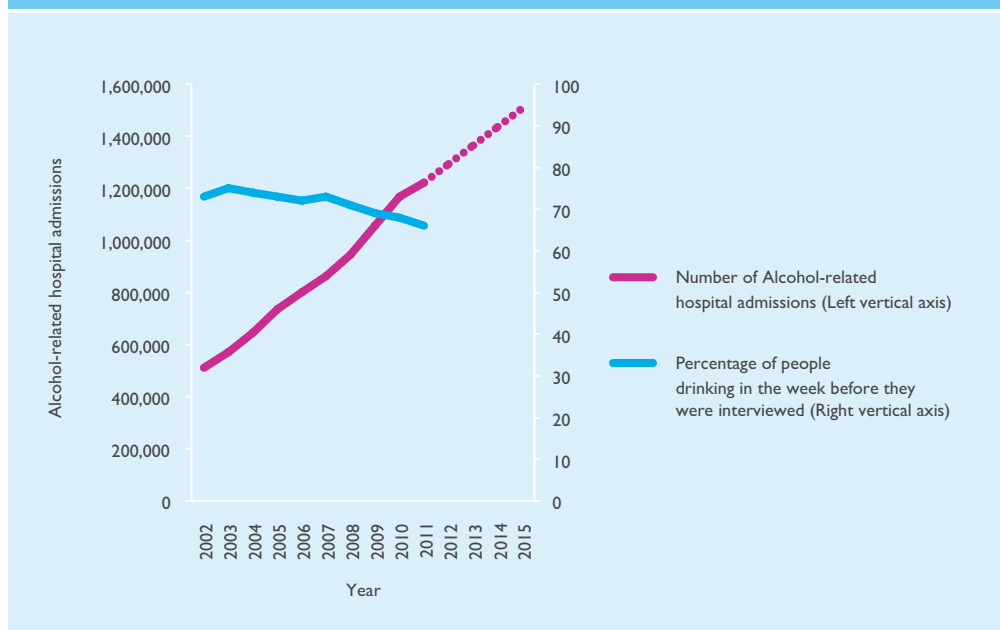
¹³⁴ Health and Social Care Information Centre, *Adult psychiatric morbidity in England: results of a household survey, 2007, 2009* [accessed via: <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf>]

¹³⁵ Health and Social Care Information Centre, *Statistics on Alcohol: England, 2013* [accessed via: <http://www.hscic.gov.uk/catalogue/PUB10932/alc-eng-2013-tab.xlsx> (08/08/13)]

¹³⁶ Health Protection Agency, *NHS Atlas of variation of healthcare for People with Liver Disease, 2013* p13 [accessed via: <https://docs.google.com/file/d/0B8ePB71dJorZ3JHnkZ1OTBZVDA/edit?pli=1> (22/08/13)]

¹³⁷ Health and Social Care Information Centre, *NHS Statistics on Alcohol*, Leeds: HSCIC, 2013 [accessed via: <https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2013/alc-eng-2013-rep.pdf> (08/08/13)]

¹³⁸ Home Office, *Government's Alcohol Strategy 2012*, London: Home Office, 2012

Figure 14: Percentage of people drinking every week and alcohol-related admissions¹⁴¹

1.5.1 Rise of the damaging drinker

There is a significant and growing minority dependent on alcohol and causing harm to themselves and costs to the taxpayer.¹⁴⁰ If current trends continue, some 1.5 million people will be admitted to hospital each year by the end of this Parliament (Figure 14). This matters as the cost of alcohol alone to the NHS was £3.5 billion in 2012 and will increase in line with trends.¹⁴¹

Despite this, treatment for alcohol problems is not adequate to match demand and is largely failing to address problem drinking. The CSJ has discovered from requests under the Freedom of Information Act that in some areas alcohol-related readmissions (the same person readmitted more than once in a year) have increased by between 16 to 40 per cent since the Coalition took power.¹⁴² Much like methadone maintenance, NHS treatment for alcohol abuse does not tackle the problem; rather it often enables people to continue in harmful behaviour.

Statistics on the slight decline in the number of people drinking each week masks the rising cost of alcohol which, like drug abuse, is worse in the UK than elsewhere in Western Europe. The UK rate of alcohol dependency amongst men and women is higher than all Western European countries other than Norway (Figure 15).¹⁴³

¹³⁹ Health and Social Care Information Centre, *Statistics on Alcohol: England, 2013* [accessed via: <http://www.hscic.gov.uk/catalogue/PUB10932/alc-eng-2013-tab.xlsx> (08/08/13)] ONS, General Lifestyle Survey, London: ONS, 2011

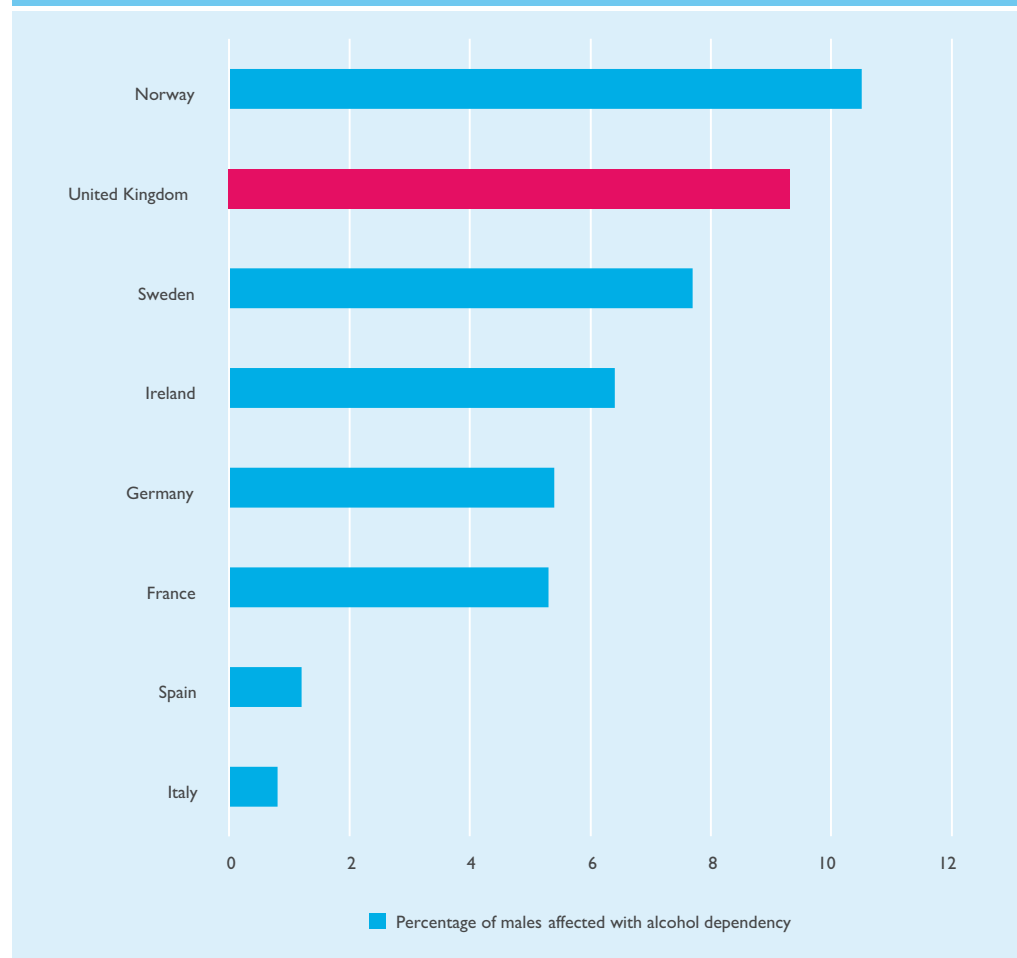
¹⁴⁰ The term 'alcoholic' is used less by medical professionals who prefer 'alcohol dependency'

¹⁴¹ National Treatment Agency, *Alcohol Treatment in England, 2011/12*, London: NTA, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/alcoholcommentary2013final.pdf>]

¹⁴² Freedom of Information replies to the CSJ to a selection of Primary Care Trust

¹⁴³ Rehm R and Shield K, *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe*, Canada: Centre for Addiction and Mental Health, 2012

Figure 15: Percentage of males affected with alcohol dependency in Western Europe ¹⁴⁴

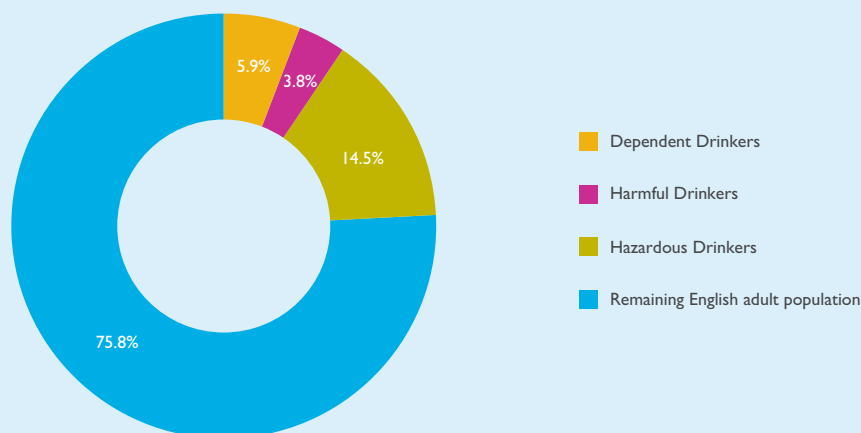


The families who live with a problem drinker are often the ones that suffer most. Currently more than one in five children lives with a parent who drinks hazardously (2.6 million) and nearly one in 16 lives with a dependent drinker (700,000).¹⁴⁵

Dependent drinkers are likely to have increased tolerance to alcohol, suffer from symptoms of withdrawal, and have lost some degree of control over their drinking. As dependency increases there may be withdrawal fits and drinking to escape from or avoid these symptoms.

¹⁴⁴ Rehm R and Shield K, *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe, Canada*: Centre for Addiction and Mental Health, 2012

¹⁴⁵ Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

Figure 16: Alcohol dependency in English adults¹⁴⁶

Concerningly, one in four adults is estimated to drink to a level which harms them in some regard (Figure 16).¹⁴⁷ Although not classed as dependent upon alcohol, this group is abusing alcohol in a way that is damaging both to themselves and society. This can lead to physical or mental health problems such as alcohol-related injury, inflammation of the liver or pancreas, or depression. In the longer term the person may develop high blood pressure, cirrhosis of the liver, heart disease, some types of cancer or brain damage because of their drinking. Heavy drinking can also lead to relationship problems, problems at work, college or school, and violence (Figure 17).¹⁴⁸

Furthermore, one in seven adults are hazardous drinkers who drink over the safe guidelines, either regularly or through less frequent sessions of binge drinking. Such consumption is associated with an increased risk of accidents and other risky behaviour (Figure 17).¹⁴⁹

Figure 17: Types of problem drinking and the consequences and symptoms¹⁵⁰

Hazardous drinking – 22–50 units/week for men and 15–35 women

Symptoms include: Being involved in an accident; becoming involved in an argument or fight; and, taking part in risky or illegal behaviour when drunk, such as drink-driving.

Harmful drinking – up to 50 units/week for men and 30 for women

Symptoms include: Depression; an alcohol-related accident, such as a head injury; acute pancreatitis (inflammation of the pancreas); high blood pressure (hypertension); cirrhosis (scarring of the liver); some types of cancer, such as mouth cancer and bowel cancer; and, heart disease.

¹⁴⁶ Health and Social Care Information Centre, *Adult psychiatric morbidity in England: results of a household survey, 2007, 2009* [accessed via: <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf>] p151

¹⁴⁷ *Ibid*

¹⁴⁸ Health and Social Care Information Centre, *Statistics on Alcohol 2013*, London, Office for National Statistics, 2013 and NHS Wales, 'Alcohol misuse, what are the impacts', [<http://www.wales.nhs.uk/sitesplus/888/page/43761>] (08/08/13)]

¹⁴⁹ Health and Social Care Information Centre, *Statistics on Alcohol 2013*, London, Office for National Statistics, 2013

¹⁵⁰ Alcohol Education Trust, *NHS and UK Chief Medical Officers' advice on units and drinking guidelines*, Frampton: Alcohol Education Trust, 2010; Health and Social Care Information Centre, *Statistics on Alcohol 2013*, London, Office for National Statistics, 2013 and NHS Wales, 'Alcohol misuse, what are the impacts', [<http://www.wales.nhs.uk/sitesplus/888/page/43761>] (08/08/13)]

Dependent drinking

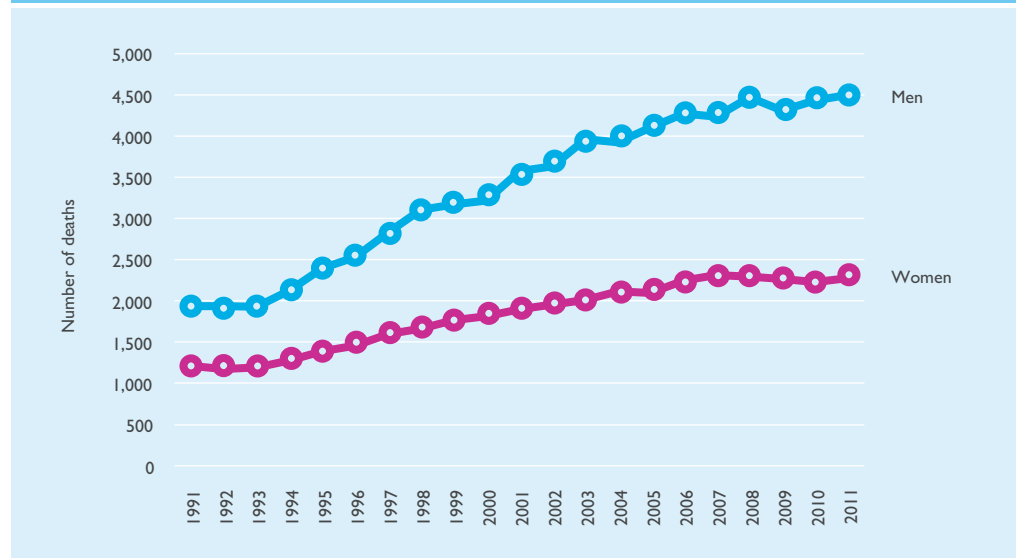
Symptoms include: Hand tremors ('the shakes'); sweating; nausea; visual hallucinations; seizures (fits) in the most serious cases; depression; anxiety; irritability; restlessness; and, insomnia.

NB: 1 pint of beer (4 per cent alcohol by volume – ABV) = 2 units; 1 large 250ml glass wine (12 per cent ABV) = 2 units

1.5.2 The costs of increasing alcohol abuse

The cost of alcohol abuse is significant and rising. Dr Stephen Ryder of Nottingham University Hospital told us that liver disease is now the fifth most common cause of death in the UK and the only one of the 'big five' (the others being heart and lung disease, stroke and cancer) that is rising. Despite advances in medical science and NHS spending, twice the number of people die from alcohol-related diseases than did 20 years ago (Figure 18). In 2012 there were 178,247 prescriptions for the treatment of alcohol dependence, an increase of 73 per cent since 2003.¹⁵¹

Figure 18: Alcohol-related deaths in England, 1991–2011¹⁵²



As well as the human cost, alcohol places a huge financial burden on the NHS, currently standing at £3.5 billion. This represents a 30 per cent increase since 2008.¹⁵³ One in 16 hospital admissions are alcohol-related and one in eight NHS bed-days are for alcohol-related diseases. As many as 70 per cent of attendances to Accident and Emergency Departments (A&E) in the early hours and 40 per cent of weekend attendances are caused by alcohol.¹⁵⁴

The impact of alcohol on A&E can include violent assaults, traffic accidents and psychiatric emergencies. Furthermore, at peak times in A&E Departments:¹⁵⁵

¹⁵¹ Health and Social Care Information Centre, 'Statistics on alcohol, England, 2013', [accessed via: <https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2013/alc-eng-2013-rep.pdf> (08/08/13)] p7

¹⁵² Office for National Statistics, *Age-standardised alcohol-related death rates*, London: ONS, 2013

¹⁵³ Health and Social Care Information Centre, *Statistics on Alcohol 2013*, London: National Statistics, 2013

¹⁵⁴ Alcohol Concern, *State of the Nation*, London: Alcohol Concern, 2012 [accessed via: <http://www.alcoholconcern.org.uk/assets/files/PressAndMedia/state.of.the.nation.pdf> (08/08/13)]

¹⁵⁵ Alcohol Concern, *State of the Nation*, London: Alcohol Concern, 2012 [accessed via: <http://www.alcoholconcern.org.uk/assets/files/PressAndMedia/state.of.the.nation.pdf> (08/08/13)]

- 40 per cent of all attendees have a raised blood alcohol level
- 14 per cent are intoxicated
- 43 per cent are problematic drinkers

Whatever the exact financial cost of alcohol to society, the estimates agree it stretches into the tens of billions. Beyond this financial cost however, is the rising level of human misery, from hospital admissions to deaths, alcohol is damaging increasing numbers of people. Worse, its effects are felt more in vulnerable communities and fuels a cycle of poverty.

1.5.3 The geography of alcohol harm

The problem of alcohol addiction and abuse is not spread evenly across the UK. The North/South divide is stark. Nearly one in four local authorities has a rate of harmful drinking significantly higher than the national average, 98 per cent of which are located in the North East, North West and Yorkshire and the Humber.¹⁵⁶ A snapshot reveals that some areas have more than three times the level of alcohol-related admissions and this is taking its toll in our most vulnerable communities. The table below, for example, shows that in 2010/11 three out of every 100 adult males in Manchester were admitted to hospital with an alcohol-related condition.

Figure 19: Alcohol-attributable admissions (males) to hospital in England per 1000 by local authority¹⁵⁷

Rank	Local Authority	Rate per 1000
1	Manchester	32.76
2	Burnley	32.45
3	Middlesbrough	32.14
4	Salford	31.92
5	Blackburn with Darwen	31.63
6	Liverpool	31.53
7	Hartlepool	29.82
8	Blackpool	29.50
9	Wigan	29.33
10	Sunderland	29.03

Alcohol, the most widely abused drug in Britain, causes the most harm, both financially and the cost in human lives. Underneath a picture of falling consumption lies a reality of increasing total harm, particularly to poorer communities – as hospital wards are stretched and alcoholics are trapped in dependency further by incapacity benefit.

¹⁵⁶ NHS, *NHS Statistics on alcohol, 2008*, London: The NHS Information Centre, 2008 [accessed via: <https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2008/alco-eng-2008-rep.pdf>]

¹⁵⁷ North West Public Health Observatory, *Local Alcohol Profiles England, Liverpool*: PHE, 2012. INSERT: [accessed via: http://www.lape.org.uk/downloads/LapeLADatasetNWPHEO_01_08_12.xlsx (22/08/13)]

CASE STUDY: Manchester and alcohol

Manchester is a thriving city. Recovering from post-industrial readjustments, it has a booming legal services sector and in 2010 was ranked the second best place to do business in the UK.¹⁵⁸ Yet there is another side to this town, in Manchester you are more likely to die early than anywhere else in the country, with alcohol as one of the driving factors.¹⁵⁹ Despite this, alcohol treatment services in Manchester are failing to break the cycle of alcohol abuse and dependence. With has the highest rate of alcohol-related admissions in England, Manchester; especially its deprived wards, has an acute problem with alcohol.¹⁶⁰ 'Frequent flyers' burden the health service, with some individuals visiting more than one hundred times a year. The cost to the nation of these personal tragedies is high.

The CSJ has learned through a freedom of information request that each year, approximately 800 individuals are readmitted to hospital in Manchester with alcohol-related symptoms. In other words, the same people are turning up at the hospital repeatedly. This shows that the treatment they are receiving does not work. This cycle costs the NHS in Manchester nearly £3000 per year, per individual.¹⁶¹ Statistics also show that there are approximately 870 individuals claiming incapacity benefit in Manchester 'whose main medical reason is alcoholism'.¹⁶² This amounts to nearly £4000 per year in incapacity benefit alone (not including other benefit costs such as housing benefit).

It is not possible to say that the 800 individuals in Manchester readmitted to hospital in that city constitute nearly all those 870 people claiming incapacity benefit for alcoholism. However the CSJ has heard that alcohol is a big problem in Manchester and that is it the same individuals from poorer backgrounds representing to various services. The Director of Public Health in Manchester told the CSJ that steps were now being taken to link the local GPs to the acute wards that see the same people representing again and again.

Peter, who runs a charity, Barnabus, working with homeless people with alcohol and/or drug problems said that despite the city's regeneration, more people were now struggling with alcohol dependency and housing problems. 'Alcohol is a bigger problem than before, especially with so many kids drinking at a younger age', Peter told the CSJ.

Like so many other parts of the country, there is a shortage of dry-houses – where someone who is trying to give up alcohol can be without other people drinking or using drugs around them. One housing association in Manchester told the CSJ that although they had modern, refurbished complex for those still drinking heavily, there was a 'gap in the market' for dry, transition accommodation.

Since the 2010 Drug Strategy the local authority has been more willing to use Barnabus, which is a third sector, Christian organisation. Similarly, NHS and community services are being integrated to tackle the 'frequent-flyer' alcoholic problem, and the Director of Health Manchester believes that services are now reformed to tackle the 'revolving door' of hospital admissions. Whether this will be more effective than sending an alcoholic to a rehabilitation unit remains to be seen.

¹⁵⁸ Cushman & Wakefield, *European Cities Monitor*, London: Cushman & Wakefield LLP, 2010

¹⁵⁹ Mortality Rankings, Public Health England, [accessed via: <http://longerlives.phe.org.uk/area-details> (08/08/13)]

¹⁶⁰ North West Public Health Observatory, *Local Alcohol Profiles England, Liverpool*: PHE, 2012

¹⁶¹ Reply to a Freedom of Information Request by the CSJ

¹⁶² North West Public Health Observatory, *Local Alcohol Profiles England, Liverpool*: PHE, 2012, *New Local Alcohol Profiles for England reveal the poorest suffer the greatest health harms from booze culture*, Liverpool: PHE, 2013 [accessed via: [http://www.lape.org.uk/downloads/Press%20Release%20Local%20Alcohol%20Profiles%20for%20England%20\(LAPE\)%202012.pdf](http://www.lape.org.uk/downloads/Press%20Release%20Local%20Alcohol%20Profiles%20for%20England%20(LAPE)%202012.pdf) (08/08/13)] and ONS, *Neighbourhood Statistics* [accessed via: http://www.neighbourhood.statistics.gov.uk/HTMLDocs/Images/Demography%20Local%20Profile_tcm97-130264.xls (22/08/13)]

chapter two

The consequences of drug and alcohol addiction and abuse

Most people agree that alcohol and drug abuse can cause poverty. 90 per cent of people think that having a parent addicted to drink or drugs is important when deciding whether a child is growing up in poverty.¹⁶³ Abusing substances can lead to family breakdown and child neglect, homelessness, crime, debt, and long-term worklessness. From its impact on children, through to consequences for those in later life, addiction destroys lives, wrecks families and blights communities. Tackling these problems is essential to achieving social justice and improving the lives of the most disadvantaged.

2.1 Addiction leads to child poverty and pushes families apart

Parental drug and alcohol abuse is associated with some degree of child neglect as parents struggle to prioritise the needs of their children. Issues range from the imminent danger of living around drug paraphernalia, to the conflicting demands on an addicted parent between their children and their habit. Faced with a craving to feed an addiction, drug and alcohol abusing parents face naturally conflicting demands between maintaining their habit and the demands of their children. As Jenny Peddar, a lecturer in social work, told the CSJ: 'the reality is feeding their addiction, not feeding their children.'

Children most dependent on their parents are particularly vulnerable. Annually 9000 mothers are admitted to hospital with alcohol-related miscarriages and 100 babies are born every month addicted to a substance that their mother was using during gestation, for example heroin.¹⁶⁴ Such problems continue after birth.¹⁶⁵

¹⁶³ Department for Work and Pensions, *Public Views on Child Poverty: Results from the first polling undertaken as part of the Measuring Child Poverty consultation*, London: DWP, 2013'

¹⁶⁴ NHS, *NHS Choices: Can I drink alcohol if I'm pregnant?* NHS [accessed via: <http://www.nhs.uk/cha/Pages/2270.aspx?CategoryID=54&SubCategoryID=130#close> (08/08/13)]; Dr Daniel Poulter, Parliamentary Undersecretary of State for Health Services, Written Parliamentary Answer: 8th November 2012 citing Hospital Episode Statistics (HES), The Health and Social Care Information Centre

¹⁶⁵ Manning et al, *Estimates of the number of infants living with substance misusing parents*, London: NSPCC, 2011 [accessed via: https://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/substance_misusing_parents_pdf_wdf85712.pdf (08/08/13)]; Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

- one in seven under-ones (110,000) lives with a substance abusing parent;
- more than one in five of all children (2.6 million) live with a parent who drinks hazardously;
- more than one in 20 (700,000) live with a dependant drinker;
- up to one in 40 live with a parent who is addicted to drugs; and,
- nearly one in 10 under-sixteens live with a parent who uses illicit drugs.

These are most likely to be underestimates as they are based on census data which under-records marginalised groups like drug addicts and relies on the honesty of interviewees in admitting alcohol intake.¹⁶⁶

This is an urgent problem – children of problematic drug users are seven times more likely to grow up with drug and alcohol problems themselves.¹⁶⁷

Some of the most explicit examples of the harm done to children by parental drug abuse are those where a child accidentally consumes a substance left in the home. Earlier in 2013 two parents were jailed after their child drank their state-supplied methadone.¹⁶⁸ These tragic circumstances were first raised by the CSJ in 2006 in a near identical case.¹⁶⁹ Yet seven years on, these tragedies are allowed to continue.

Methadone overdose in toddlers

Riley Pettipierre,¹⁷⁰ Jayden Lee Green,¹⁷¹ Aiden Cormack,¹⁷² all two years or younger, died after accidentally overdosing on their parents methadone. In the first case, methadone had been found in the child's beaker:

In all these cases, the parents had been given the heroin substitute to take home rather than consuming the methadone under supervision in the pharmacy. Patients are often given methadone to take home over the weekend as pharmacies are often closed on Sundays.

Beyond a child's immediate safety, parental drug or alcohol use can dramatically reduce the capacity for effective parenting and supporting children's education. Performance in school may suffer because parental problems dominate a child's thoughts and reduce concentration. In particular the children of parents who are addicted to drugs or alcohol are more likely to develop behavioural problems, experience low educational attainment, and are significantly more vulnerable to developing substance abuse problems themselves.¹⁷³ Of those children

¹⁶⁶ Cleaver, H., et al, *Children's Needs – Parenting Capacity*, London: HMSO, 2011 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf (08/08/13)]

¹⁶⁷ McKeganey N, 'Preteen Children and Illegal Drugs' in *Drugs: education, prevention and policy* 11:4, 2004

¹⁶⁸ BBC News, *Methadone beaker parents guilty of manslaughter*: 18 January 2013 [accessed via: <http://www.bbc.co.uk/news/uk-england-derbyshire-21064982> 08/08/13]

¹⁶⁹ Centre for Social Justice, *Breakdown Britain: Addictions*, London: CSJ, 2006

¹⁷⁰ BBC News, *Methadone beaker parents guilty of manslaughter*: 18 January 2013 [accessed via: <http://www.bbc.co.uk/news/uk-england-derbyshire-21064982> 08/08/13]

¹⁷¹ Daily Mail, *Welfare agencies missed 50 chances to save toddler who died of methadone overdose at hands of heroin-addict parents*, 4 September 2012. [accessed via: <http://www.dailymail.co.uk/news/article-2198174/Jayden-Lee-Green-Welfare-agencies-missed-50-chances-save-toddler-died-methadone-overdose.html> (08/08/13)]

¹⁷² BBC News, *Mother loses extradition appeal*, 24 June 2009 [accessed via: http://news.bbc.co.uk/1/hi/scotland/edinburgh_and_east/8117194.stm (08/08/13)]

¹⁷³ Cleaver H, Unell, I and Aldgate A, *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development* 2nd Edition, London: The Stationery Office, 2010 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf (08/08/13)]; Childrens Society, *Swept under the carpet: Children affected by parental alcohol misuse*, London: Alcohol Concern, 2010 [accessed via: http://www.childrensociety.org.uk/sites/default/files/tcs/swept_under_the_carpet_briefing_paper_oct_2010.pdf (08/08/13)]

that care for relatives with drug or alcohol dependency, 40 per cent miss school or show evidence of educational difficulties.¹⁷⁴

'Key causes of family breakdown here seem to be fathers' addiction (either alcohol or drugs) and domestic violence. Fathers' low confidence, poor self-esteem and sense of inadequacy due in part to either unrecognised or not-dealt-with dyslexia and/or poor parenting experiences and lack of a reliable male role model in their own childhoods.'

Anne McLaren, Project Manager at Fun in Action, in evidence to the CSJ

In too many cases, parental drug and/or alcohol abuse is so severe that the children of the addict can no longer reside with the parent/s. Those with wider family networks are taken in by relatives but too many have to be cared for by the local authority. Whilst free from the physical danger of living around an addict, the loss of a parent can severely impact upon a child's educational attainment and mental health.¹⁷⁵

A cohort of children who suffer greatly as a result of parental addiction are the those placed in local authority care. Of the 67,050 looked after children in England, possibly 61 per cent of cases involved some kind of parental substance abuse.¹⁷⁶ This disruption to family stability is of significant detriment to the children involved; only 15.5 per cent of looked-after children pass both English and mathematics GCSE, compared to 58.7 per cent of all other pupils.¹⁷⁷

2.1.1 Addiction drives families apart

When one person in a couple has an addiction to drugs and/or alcohol, it can put enormous strain on a relationship. The presence of a heavy drinker in a marriage, for example, increases the likelihood of divorce and family breakdown.¹⁷⁸ Consequent financial problems result from such breakdown and children suffer in particular.¹⁷⁹

¹⁷⁴ Dearden C & Becker S, *Young Carers in the UK: The 2004 report*, London: Carers UK and The Children's Society, 2004 [accessed via: <https://dspace.lboro.ac.uk/dspace-jspui/bitstream/2134/627/3/YCReport2004%25255B1%25255D.pdf> (08/08/13)]

¹⁷⁵ Cleaver H, Unell I and Aldgate A, *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development* 2nd Edition, London: The Stationery Office, 2010 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf (08/08/13)]

¹⁷⁶ Department for Education, *Statistical First Release: Children looked after in England (including adoption and care leavers) year ending 31 March 2012*, London: Department for Education [accessed on 25/06/13 via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167451/sfr20-2012v2.pdf.pdf (08/08/13)] and Cafcass, *Three weeks in November...three weeks on*, 2012 [accessed via: <http://www.cafcass.gov.uk/pdf/Cafcass%20Care%20Application%20Study%202012%20FINAL.pdf> (22/08/13)]

¹⁷⁷ Department for Education, *Statistical First Release: Outcomes for Children Looked After by Local Authorities in England, as at 31 March 2012*, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191969/SFR32_2012Text.pdf (29/04/13)]

¹⁷⁸ Ostermann J, Sloan FA, Taylor DH., 'Heavy alcohol use and marital dissolution in the USA', *Soc Sci Med*, 2005 Dec; 61(11) [Accessed via: <http://www.ncbi.nlm.nih.gov/pubmed/16139939>]

¹⁷⁹ Centre for Social Justice, *Fractured Families*, London: CSJ, 2013

This urgent issue affects millions in Britain. It is estimated that 1.5 million adults are affected by the drug addiction of a relative.¹⁸⁰ Many more are impacted by the alcohol abuse of a relative. As there are 2.6 million children living with a hazardous drinker, it is likely that wider figure for other family members affected is far larger, for example siblings and parents.¹⁸¹

The effects upon families are often highly traumatising. The ramifications of addiction within the family often involves: erratic behaviour; concern about the addict's health, both physical and mental; worry over the financial impact that the addiction is having on the family; the limiting of social life for the family; and, implications of ultimate family breakdown.¹⁸² The emotions often associated with addiction within the family can include anxiety, worry, depression, helplessness, anger and guilt.¹⁸³

Beyond the social cost, the financial cost to the family of an addict can be catastrophic. It has been estimated, for example, that the cost to a family of an opiate and/or crack-using relative is £9,497 per annum. These costs include the crime suffered by the family members, impact on the family's health and the resultant lost employment opportunities. This amounts to a cost to British families of approximately £1.8 billion.¹⁸⁴

The burden on families is further increased when parental addiction means they are no longer able to care for their children, often leaving relatives to take on the responsibility – this is called 'kinship care.' Although a better option than care, such children do have worse mental health outcomes than their peers.¹⁸⁵

The number of children in kinship care is significant. The most recent estimate is that in the UK there are more than 173,000 children being brought up by relatives other than their parents and nearly two-thirds (110,011) of these children have parents affected by alcohol or drug abuse, including nearly a quarter who abuse both.¹⁸⁶

Added to the consequences for the child involved, the economic cost of taking on the full-time care of a child can be substantial. Kinship care often incurs a huge personal cost and most kinship carers live in relative income poverty. Kinship carers find parenting children challenging. For many it is the second time in their lives and it can be tiring and physically demanding. Unsurprisingly, 73 per cent of kinship carers have long-term health problems or disabilities and a third say their lives are restricted by pain.¹⁸⁷

180 UKDPC, *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*, London: UKDPC, 2009 [accessed via: http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Adult%20family%20members%20and%20carers%20of%20dependent%20drug%20users_%20prevalence,%20social%20cost,%20resource%20savings%20and%20treatment%20responses.pdf 08/08/13]]

181 Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

182 UKDPC, *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*, London: UKDPC, 2009 [accessed via: http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Adult%20family%20members%20and%20carers%20of%20dependent%20drug%20users_%20prevalence,%20social%20cost,%20resource%20savings%20and%20treatment%20responses.pdf (08/08/13)]

183 Orford et al, 'Family members of relatives with alcohol, drug and gambling problems: a set of standardized questionnaires for assessing stress, coping and strain', *Addiction Abingdon England*, 100(11), 2005, pp1611-1624 [accessed via: <http://www.mendeley.com/catalog/family-members-relatives-alcohol-drug-gambling-problems-set-standardized-questionnaires-assessing-stress-coping-strain/> (08/08/13)]

184 UKDPC, *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses*, London: UKDPC, 2009 [accessed via: http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Adult%20family%20members%20and%20carers%20of%20dependent%20drug%20users_%20prevalence,%20social%20cost,%20resource%20savings%20and%20treatment%20responses.pdf 08/08/13]]

185 Nandy S, and Selwyn J, *Spotlight on kinship care*, University of Bristol, 2011

186 Nandy S, and Selwyn J, *Spotlight on kinship care*, University of Bristol, 2011

187 Buttle UK and University of Bristol, *The Poor Relations? Children and Informal Kinship Carers Speak Out*, Bristol: Buttle UK, 2013

Kinship carers, of whom over half are lone carers, have often foregone retirement or given up their jobs. Young carers miss out on further education and job training and are the poorest of all. Added to the burden, 60 per cent of carers must manage difficult contact with the children's parents, who are often in the throes of active addiction.¹⁸⁸

The economic cost of being a kinship carer is significant. Just 36 per cent of kinship carers are currently working which contrasts starkly with the 75 per cent who were working before taking on the children.¹⁸⁹ Of those kinship carers who have had to stop work, 86 per cent said they would have liked to stay in work.¹⁹⁰ As nearly two-thirds of kinship care cases involve parental substance misuse, the welfare cost of drugs and alcohol are stark.

2.2 Addiction leads to welfare dependency and worklessness

'Part of recovery means being willing and able to work, to earn a living, pay bills and make a positive contribution to the lives of your kids'.

Mark Gilman, NTA's Strategic Recovery Lead in evidence to the CSJ

The role played by addiction in leading to worklessness is all too familiar. Ignoring addiction traps people in poverty. A dependent drinker is twice as likely to claim state benefits. That dependent drinkers and drug addicts are more prevalent in the benefit population is not surprising considering the symptoms and behaviour surrounding dependency which make it difficult to achieve and sustain employment.¹⁹¹

The numbers trapped in poverty by addiction are sizeable. Of the 200,000 in drug treatment in 2011 in England, only 18 per cent of those were in employment.¹⁹² In Scotland, that figure is 12 per cent and this percentage will likely be lower for the estimated 52,000 drug addicts in Scotland.¹⁹³

Beyond the all too familiar tragedy of unemployed street drinkers, young people are also prevented from taking work by their drug use. Approximately 70 per cent of young people not in education, employment, or training (NEET) report using drugs compared with 47 per cent of their peers.¹⁹⁴ Some will turn to drugs from the boredom of unemployment but others will be prevented from working by their drug use.

¹⁸⁸ Gautier A and Wellard S, *Giving up the day job*, London: Grandparents Plus, 2012

¹⁸⁹ Buttle UK and University of Bristol, *The Poor Relations? Children and Informal Kinship Carers Speak Out*, Bristol: Buttle UK, 2013

¹⁹⁰ Gautier A and Wellard S, *Giving up the day job*, London: Grandparents Plus, 2012

¹⁹¹ Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010

¹⁹² Department for Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department for Health, 2012 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf>]

¹⁹³ Scottish Government, *The Road to Recovery*, Edinburgh: The Scottish Government, 2008; United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

¹⁹⁴ New Philanthropy Capital, *Getting Back On Track*, London: New Philanthropy Capital, 2009

LEE'S STORY: given to the CSJ by a faith-based homeless charity on the South Coast

We met Lee on a Sunday night. He was hunched in a doorway and had been drinking heavily. After chatting, Lee invited us back to his flat which was in a poor state.

Lee was a trained carpenter, but had been out of paid employment for over 2 years. He was a skilled and had built much of the furniture in his own flat during periods of being clean from drinking.

His rent was paid through housing benefit, and he was in receipt of employment support allowance, having been signed off work. Lee was still capable of working – he had been doing voluntary carpentry work for a charity – but didn't feel capable of dealing with the pressure of a full-time job.

As well as alcoholism, Lee was anxious and fearful of getting back into work, as he had previously suffered bullying in the workplace.

Good support in isolation

Many of the 'support' systems in place for Lee were effective in isolation – he was quickly seen and prescribed an alcohol-replacement drug by his local GP to support him going dry.

The local hospital had a new ward specifically designed for those recovering from addictions. They provided an excellent service to Lee, but he would not otherwise have been able to access this service had we not been available to drive him to the hospital.

These services did their part effectively, but they were addressing symptoms rather than the cause. There was a noticeable lack of co-ordination or concerted effort to manage Lee through the various stages and processes of rehabilitation back into society, so we took a lot of this on ourselves.

Untapped potential

We have since lost contact with Lee. At the time, we tried to get involved in helping Lee to turn his life around. It was a massive task, and a challenge which initially required virtually full-time care and assistance – as well as Lee's commitment to come off drink, which would waver. Lee's drinking had distanced him from any friends or family who could help.

Most of the people we meet on the streets in Portsmouth have skills or experience working in many different sectors. We are aware that most are not readily employable – either through struggling with addictions, or needing to update their skills and qualifications. However we meet people who are engaging, bright and have untapped potential!

Substance abuse and dependency costs the welfare system vital resources. Addiction means up to 420,000 people are on welfare rather than in work, with a further 100,000 carers picking

up the pieces, not able to work.¹⁹⁵ This represents a colossal waste of potential given that there were 529,000 vacancies in July, 2013.¹⁹⁶

The cost of this failure is a staggering £3.32 billion per year in welfare payments. It is estimated that £1.7 billion in benefits a year go to addicts, while the welfare costs of looking after the children affected is estimated to be £1.62 billion.¹⁹⁷ This is a subject about which the public feels strongly, with 74 per cent believing that addicts who refuse treatment should lose their benefits.¹⁹⁸

Figure 20: Estimated numbers of people on main benefits who are dependent drinkers and opiate and crack users, by Government Office Region and benefit, England¹⁹⁹

Type of benefit	Dependent Drinkers	Opiate/Crack Users
Disability Living Allowance	29,400	24,766
Incapacity Benefit	99,200	86,869
Income Support	93,200	145,594
Job Seekers Allowance	26,500	65,668
Main benefits	159,900	266,798

The CSJ has heard, however, that current reforms to the welfare system may be drawing a previously hard-to-reach group of addicts into treatment. For some addicts, a 'nudge' is required before they seek treatment. This can be the negative effects upon their own health, getting arrested, or the prospect of losing their children. The CSJ has also heard that for some who had refused treatment before, reforms to the welfare system under the current Government have led them to come forward for help with their addiction.

More rigorous conditions on welfare benefits have meant that some are no longer able to maintain an expensive habit. One local authority commissioner of addiction treatment said some addicts receiving welfare benefits had been able to maintain a relatively comfortable living standard and would not engage in treatment.²⁰⁰ She told the CSJ that with the reforms to welfare, some were starting to realise they could no longer maintain such a lifestyle and continue their drug taking. As a consequence they were now willing to address their addiction.

Considering that 70 per cent of those entering drug-treatment in Scotland funded their habit with welfare benefits, the potential effect may be to boost recovery and reduce the welfare

¹⁹⁵ Hay G and Bauld L, *Population estimates of problematic drug users in England who access DWP benefits: A feasibility study*, London: DWP, 2008; Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010

¹⁹⁶ Office for National Statistics, *Labour Market Statistics: July, 2013* [accessed via: <http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/july-2013/statistical-bulletin.html#tab-Summary-of-Labour-Market-Statistics-published-on-17-July-2013> (08/08/13)]

¹⁹⁷ Gyngell K, *Breaking the Cycle*, London: CPS, 2011; United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012 [accessed via: <http://www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf> (08/08/13)]

¹⁹⁸ YouGov Polling for the CSJ

¹⁹⁹ Hay G and Bauld L, *Population estimates of problematic drug users in England who access DWP benefits: A feasibility study*, London: DWP, 2008; Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010. These estimates are several years out of date and do not take account of subsequent welfare reforms

²⁰⁰ A care manager working on behalf of a local authority in evidence to the CSJ

bill.²⁰¹ As Shirley Berry of the Glasgow-based Findlay Family Network told the CSJ, tougher conditions have meant that some addicts, who had previously refused to engage in treatment, have decided to address their personal expensive behaviour. She described how some people are addressing personal health issues like substance abuse because their benefits were no longer stretching as far as before.

'The welfare reforms are meaning that there are people coming to the surface who are realising something needs to change for them. For example, we have started working with a Mum who has addiction problems, who we have been trying to engage for two years. She was able to manage before, but not happily. We are having some good engagement with people like her, which we wouldn't have had otherwise.'

Shirley Berry – Findlay Family Network, Glasgow in evidence to the CSJ

Yet there are still elements of the welfare system, such as the advisor's and/or claimant's incomplete awareness of support available, that aggravate the transition into recovery. There is specific support available through JobCentre Plus and local treatment services to help those with substance abuse problem into employment.²⁰² However those struggling with addiction are put off moving into independence by the perceived risks involved. James, who is two months clean and sober, told the CSJ 'It's scary, not being on benefit. If you get a job, it's up to you. If you're short, you get in with some dodgy lender. Then that's pressure to relapse.'

'Liam, who's in recovery, was living in emergency accommodation, was concerned that he and his girlfriend might get into debt with their rent if they took on paid employment and then lost some of their benefit entitlements.'

Professor Jo Neale in evidence to the CSJ

The Coalition has done much to tailor support to help those with drug and alcohol problems through treatment and into work, for example it has removed conditionality for those in residential treatment. Now the Government must go further in boosting awareness of such schemes. This will insure that people like Lee get the help they need to get their lives back on track.

201 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

202 Department for Work and Pensions, *Drug or alcohol dependency – new support from Jobcentre Plus*: DWP, 6 June 2011 [accessed via: <http://www.dwp.gov.uk/adviser/updates/drugs-strategy/> (08/08/13)]

2.3 Drugs, alcohol and the criminal justice system

The impact of substance abuse in fuelling crime and reoffending is stark. Between a third and half of new prisoners are estimated to be problem drug users in England and Wales and over half of offenders link their crime to their drug problem.²⁰³ Nearly half of Scottish prisoners reported being under the influence of drugs at the time of their offence.²⁰⁴

At the end of March 2012, 14 per cent of men and 18 per cent of women in prison were serving sentences for drug offences but a wider group blame their crime on their drug problem.²⁰⁵ Shoplifting, burglary, vehicle crime and theft can all be linked to drug abuse.²⁰⁶

Drug and alcohol abuse are clearly associated with crime. For example, 81 per cent of people arrested who used heroin and/or crack at least once a week said they committed an acquisitive crime in the previous 12 months, compared with 30 per cent of other people arrested. One third of this group reported an average of at least one crime a day, compared with 3 per cent of other offenders.²⁰⁷

The consequences of alcohol-related crime are grave as well. The human misery includes: damaged or stolen property; reduced productivity; emotional and physical strain; cost to health services; and, loss of human life.

Alcohol dependency and abuse is a major factor in the journey that leads to offending. Alcohol abuse is strongly related to crime, including domestic abuse, anti-social behaviour, public disorder, sexual assault and motoring offences.²⁰⁸

Victims estimated their assailant to have be drinking in:²⁰⁹

- half of violent incidents,
- two-thirds of woundings; and
- over one third of domestic abuse incidences.

‘Addiction gets people into debt and, temporarily, allows them to escape their problems. One recovering heroin addict told us “I would never open an envelope. I’d just put it straight in the bin...”’

Professor Jo Neale in evidence to the CSJ

203 UK Drug Policy Commission, *Reducing drug use, reducing reoffending*, London: UKDPC, 2008; Prison Reform Trust *Bromley Prisons Briefings Factfile*, London: Prison Reform Trust, 2010

204 Scottish Prison Service, *Prisoner Survey 2011*, Edinburgh: Scottish Prison Service, 2011

205 Ministry of Justice, *Offender Management Statistics Quarterly Bulletin, October to December 2011*, Table 1.3a, London: Ministry of Justice, 2012

206 Ramsay M, *Prisoners’ drug use and treatment: seven studies*, Home Office Research Findings 186, London: Home Office, 2003

207 UK Drug Policy Commission, *Reducing drug use, reducing reoffending*, London: UKDPC, 2008

208 Cheshire Probation, *Evaluation of the use of Alcohol Treatment Requirements and Alcohol Activity Requirements for offenders in Cheshire* [accessed via: <http://www.cph.org.uk/wp-content/uploads/2012/08/evaluation-of-the-use-of-alcohol-treatment-requirements-and-alcohol-activity-requirements-for-offenders-in-cheshire.pdf> (08/08/13)]

209 Flatley J, Kershaw C, Smith K et al, *Crime in England and Wales 2009/10*, London: Home Office, 2010

Within the prison population, the influence of alcohol is apparent. One third of sentenced men are severely dependent on alcohol and another third are hazardous drinkers.²¹⁰ Over a fifth of prisoners drank alcohol every day in the four weeks before custody.²¹¹

Reoffending is similarly aggravated by problem drinking. People drinking each day before custody have a higher rate of reconviction, with 62 per cent reconvicted within a year after release compared with those who drink less (49 per cent). These prisoners are also less likely to have been employed during the same period than those who drink less frequently (24 per cent compared with 34 per cent).²¹²

2.3.1 Substance abuse leads young people to offend

The effects of substance abuse upon young people who offend and reoffend are particularly stark.²¹³ Nearly half of offences committed by 18–24 year-olds were driven by alcohol – so called ‘crimogenic needs.’ Of those that abuse more than one type of drugs (poly-use) 71 per cent were reconvicted of an offence within a year of being discharged from custody.²¹⁴

The influence of alcohol in youth offending is an increasing problem. The number of young offenders who got drunk everyday has increased by a factor of five since 1979. Currently 40 per cent of young offenders got drunk every day, up from eight per cent in 1979.²¹⁵

2.4 Debt and addiction

The interaction between severe personal debt and addiction is perhaps an obvious one; each can lead to the other in a predictable way. To an addict concerned with feeding a habit, stable finances to meet basic needs are low on the list of priorities.

Beating addiction enables individuals locked into debt to find a way out. As addicts’ lives stabilise and drug use ceases, the ability to manage money, pay bills and deal with paperwork increases.

Essential for a sustained recovery from substance dependency is taking personal financial responsibility. Recovery is a long-term process, and vulnerability to relapse can be heightened by issues like personal debt.

2.5 Conclusion

Drug and alcohol addiction trap many in poverty and fuel a cycle of deprivation. The consequences for addicts themselves are often severe as they are at risk of losing of children, jobs, health, morale, and liberty. For families and society, the consequences are equally dire.

210 Prison Reform Trust, *Alcohol and reoffending: who cares?*, London: Prison Reform Trust, 2004

211 Prison Reform Trust, *Alcohol and reoffending: who cares?*, London: Prison Reform Trust, 2004

212 Ministry of Justice, *Compendium of reoffending statistics and analysis*, London: Ministry of Justice, 2010

213 Ministry of Justice, *A Compendium of Research and Analysis on the Offender Assessment System, 2006-2009*, London: Ministry of Justice, 2009

214 Ministry of Justice, *Compendium of reoffending statistics and analysis*, London: Ministry of Justice, 2010

215 Young People in Focus, *Fact File 1: Young Adults Today*, Brighton: Young People in Focus, 2011 [accessed via: <http://www.barrowcadbury.org.uk/wp-content/uploads/2011/04/Young-People-in-Focus-Young-Adults-in-CJS-Substance-Misuse-FACT-FILE-2011.pdf> (08/08/13)]

The horrors experienced by the infant children of addicts and the wider effects of neglect felt by children see the innocent have their life chances damaged. Similarly families are driven apart by substance abuse, broken by lies, theft and irresponsible behaviour. Other family members give up work to care for children because their parents are not fit to fulfil their responsibilities.

Wider society also suffers from the effects of drugs and alcohol with welfare costs exceeding £3 billion. From maintaining addicts and alcoholics who are unable to work, through to caring for their children, society picks-up the heavy cost of this failure. Added to this is the danger of violent crime to the public, half of which is fuelled by alcohol. The frequency of reoffending by substance abusers is testament to both the influence of alcohol and the failure of treatment prisoners receive.

Consequently, government has a pressing duty to help addicts repair their lives and achieve independence from drugs and alcohol, to support families to beat addiction, and to help communities rebuild.

chapter three

Barriers to Britain's recovery

3.1 The barriers to success

In 2007 the CSJ identified a broken system of drug addiction treatment which trapped tens of thousands on state-supplied heroin substitutes – a system not far from giving an alcoholic state-supplied vodka or other strong drink. Despite a pledge from the Prime Minister to address this national scandal, more remains to be done.²¹⁶ Substitute prescribing is still the only addiction treatment received by too many struggling with heroin addiction.²¹⁷ This stagnation has been compounded by a disappointing lack of culture change. The CSJ has heard how many of the same people now tasked with delivering recovery are the same people who previously relied on maintaining addicts in their dependency.²¹⁸

Part of the failure to address addiction has been the dilution of the aim that an addict's treatment should aspire for them to lead a drug-free life.²¹⁹ Since that declaration, there has been a disappointing lack of progress in promises made, despite the efforts of many committed reformers in Parliament, from the Prime Minister down. This inertia is manifested in the treatment both drug addicts and alcoholics currently receive and in the outcomes used by the drugs and alcohol payment-by-results pilots.²²⁰

Beyond addressing current addicts, the Government has also failed to address the woeful lack of drug and alcohol prevention education received by children. The subject is still poorly addressed in many schools and, shamefully, the ineffective *FRANK* is still the Government's flagship prevention policy.

Nor has the Government dealt as effectively as required with the supply of drugs. Drugs are freely available and their availability is increasing. New drugs are entering the market at the

216 The Guardian, *David Cameron shifts drug addicts treatment to live-in schemes*, 6 August 2010

217 Department of Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012 [accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf> (08.08.13)]

218 Evidence to CSJ – 05/02/13

219 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

220 Department of Health [accessed via: <https://www.gov.uk/government/news/drug-and-alcohol-recovery-pilots-supporting-material-published> (08.08.13)]

rate of one per week and now outnumber 'traditional drugs.' Currently, the law is not capable of keeping up.²²¹ Despite the surge in new drugs, the Government's response, temporary banning orders, have only been used to ban nine substances in three years.²²²

New routes of supply are also rendering enforcement methods obsolete and the UK is becoming a leading hub for the dealing of internet drugs.²²³ Before an individual had to get access to a dealer to obtain drugs, now Ebay-like sites selling drugs have removed this barrier and DHL or Royal Mail act unwittingly as delivery agents. The CSJ has heard that school-age children are increasingly having drugs delivered in this way.²²⁴

By maintaining the distinction between alcohol and drug strategies, the Government is hindering its own response to the problems flowing from the abuse of both these substances.

For example, despite strong rhetoric in the Drugs Strategy 2010 on the effects of alcohol abuse, the Government's 2012 Alcohol Strategy has shied away from tackling the issue. Despite alcohol's place as the most widely used drug in Britain, government policy backed away from its pledge to tackle the availability of super-cheap, super-strong alcohol. The introduction of a minimum unit price for alcohol was advocated by the Prime Minister, and would have gone some way to tackling the problem, but it has recently been dropped as a commitment.²²⁵

Rather than a minimum unit-price on alcohol, the CSJ has advocated a 'treatment tax.' The effect of both would be to tackle super cheap, super strong alcohol but a tax would benefit taxpayers (who pay the alcohol-related costs to the NHS, police and welfare) rather than retailers. The proceeds would also then also been directed into funding effective rehabilitation.

While it is of great importance that some in government have focused on the importance of recovery much more needs to be done to help people become drug free and achieve full recovery.

3.2 A combined alcohol and drug strategy

At present alcohol and drugs policies are drawn from separate strategies: the *Drugs Strategy 2010* and the *Alcohol Strategy 2012*.²²⁶ The separation of alcohol and drugs strategies prevents drug and alcohol abuse being tackled effectively. As will be seen later, part of the paucity of alcohol abuse treatment stems from the inequality in services for drug addiction compared to alcoholism. While half of the opiate and crack addicts in England are in treatment, only one-sixteenth of alcohol dependants are being helped.²²⁷

221 International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

222 Home Office, *Temporary class drug order for benzofury and NBOMe compounds – letter to ACMD* [accessed via: <https://www.gov.uk/government/publications/temporary-class-drug-order-for-benzofury-and-nbome-compounds-letter> (08.08.13)]

223 International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

224 Youth worker in the North East in evidence to the CSJ

225 Home Office, *The Government's Alcohol Strategy*, London: Home Office, 2012 and Hansard, 17 July 2013 : Column 1113 [Accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130717/debtext/130717-0001.htm#1307172000005>]

226 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010; Home Office, *Alcohol Strategy*, London: Home Office, 2012

227 National Treatment Agency, *Alcohol Treatment*, 2012; Department for Health, *Statistics from the National Drug Treatment Monitoring System*, London: DH, 2012 [Accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf>] and National Institute of Clinical Excellence, *Alcohol-use disorders*, London: The British Psychological Society and The Royal College of Psychiatrists, 2011 [accessed via: <http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf> (09/08/13)]

In 2007, the CSJ called for a combined addiction strategy, attempting to get alcohol addiction treated with the same level of concern as addiction to illicit drugs.²²⁸ Sadly this disparity is still the case, as the Children's Commissioner noted in 2012, social workers do not treat alcohol abuse on a par with other substances, to the detriment of children.²²⁹

The mismatch between funding for treating drug dependency compared with alcohol is shown in Figure 22 (below), namely that half of the 300,000 problem drug users in England get some form of treatment but only 109,000 of the 1.6 million (less than ten per cent) of the dependent drinkers received help.²³⁰

Richard Johnson, director of drugs and alcohol rehabilitation centre ANA, told the CSJ that 'alcohol has not had the level of focus that drugs like heroin and crack-cocaine have, partly due to its entrenched status in society.' Until recently, the National Treatment Agency for Substance Misuse, had only a limited remit for alcohol dependency despite the fact it is the most widely abused substance.²³¹

3.2.1 Re-structuring efforts to tackle addiction

There has been some progress with the continued work of the Home Office Drugs and Alcohol Unit and mention of the harmful use of abuse of alcohol in the *Drug Strategy* 2010, however further action is required to tackle these issues effectively.²³²

As part of a fundamental shift of focus from fatalistic negative management and maintenance to a positive recovery oriented policy' the CSJ deemed an adequate response to addiction required 'a combination of independence from existing departmental interests and a high level of commitment'.²³³ This would have been led by a 'Second Chance Unit within the Cabinet Office that could provide the strategic lead'.²³⁴ To manage the allocation of treatment resources, the CSJ proposed a 'National Addiction Trust' responsible to the Second Chance Unit to replace the existing National Treatment Agency.²³⁵

Much of the CSJ's concern about having drugs and alcohol policy contained in separate strategies in the disparity in the way that the two were, are still are, treated. This was because we were concerned that:²³⁶

'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

228 Centre for Social Justice, *Breakthrough Britain: Addictions*, London: Centre for Social Justice, 2007

229 Children's Commissioner, *Silent Voices*, London: Department for Education, 2012

230 National Treatment Agency, *Alcohol Treatment*, 2012; Department for Health, *Statistics from the National Drug Treatment Monitoring System*, London: DH, 2012 [Accessed via: <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf>] and National Institute of Clinical Excellence, *Alcohol-use disorders*, London: The British Psychological Society and The Royal College of Psychiatrists, 2011 [accessed via: <http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf> (09/08/13)]

231 Alcohol Concern, *Guidance for User-Led Commissioning*, London: Alcohol Concern, 2008

232 Home Office, *Drug Strategy 2010*, London: Home Office, 2010

233 Centre for Social Justice, *Breakthrough Britain: Addictions*, London: Centre for Social Justice, 2007

234 *Ibid*

235 *Ibid*

236 *Ibid*

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.'

CSJ, *Breakthrough Britain*, 2007

3.3 Reducing Demand

3.3.1 Prevention

Despite widespread rhetorical agreement that prevention is better than cure, the Government has done little to unlock prevention as a means of addressing Britain's drug and alcohol problem. England ranks ninth out of 35 for early drunkenness (young children getting drunk for the first time) amongst European countries, with Scotland sixth and Wales eighth.²³⁷ Furthermore, young people are using new substances which are not being picked up by official surveys. The Government, however, has persisted with the ineffectual *FRANK* campaign and has done little to advance drug and alcohol prevention in schools.

Official statistics are missing many of the problems young people in communities across Britain are experiencing. Use of Nitrous Oxide, for example, is second only to cannabis use among 16–24 year olds.²³⁸ Yet until a year ago, it was not recorded in official statistics. Consequently, despite reports of heavy use across the country – official statistics ignored the problem and failed young people.

'Official stats just aren't picking up the new drugs people are using – G [GBL], and a range of other harmful drugs, just are not showing up.'

Annette Dale-Perera, Directions and Addictions and Offender Care

The CSJ has heard that communities, particularly those in the poorest areas, are seeing young people abuse new drugs in increasing amounts. Annette Dale-Perera, Director of Addictions and Offender Care in Central and North West London NHS Foundation Trust, confirmed to the CSJ that young people are increasingly using substances that are not recorded by official statistics. Official statistics, therefore, are failing to reveal a rising trend in use of substances other than traditional drugs.

Jenny, a youth worker who focuses on drugs and alcohol in Middlesbrough, told the CSJ how drug use amongst young people is changing:

The CSJ also heard from Anne-Marie, a recovery worker in Edinburgh, who described the increase use of 'legal highs' by young people. 'The kids are using these things which aren't banned and they think they're ok, but really it's strong stuff.'

237 World Health Organisation, *Status Report on Alcohol and Health in 35 European Countries*, Copenhagen: WHO, 2013 [Accessed via: http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf] World Health Organisation, *Status Report on Alcohol and Health in 35 European Countries*, Copenhagen: WHO, 2013 [Accessed via: http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf]

238 Home Office, *Drug Misuse: Findings from the 2012/13 Crime Survey for England and Wales*, London: Home Office, 2013

'We're seeing kids sniff glue at levels not seen since the early 1990s, they're taking pills they find in their parents medicine cabinets, they're buying new drugs off the internet.'

Jenny, substance misuse youth worker in Middlesbrough

3.3.1.1 FRANK

Young people are being let down by a lack of effective prevention programmes. As the CSJ has previously argued, the flagship drugs and alcohol prevention programme, *FRANK*, is shamefully inadequate. The *FRANK* website and media campaign have long been at the heart of prevention policy, despite there being a paucity of evidence as to its impact in reducing the numbers of young people abusing drugs and alcohol. Although the Government correctly identified the need for effective drugs and alcohol education in schools in its *Drug Strategy*, little has been enacted to alter the ineffectual status quo.

In the *Drug Strategy 2010* the Government stated that 'all young people need high quality drug and alcohol education so they have a thorough knowledge of their effects and harms and have the skills and confidence to choose not to use drugs and alcohol'.²³⁹

To achieve this objective the Government committed to 'provide accurate information on drugs and alcohol through drug education and targeted information via the *FRANK* service'.²⁴⁰ As recently as June 2013, the Crime Prevention minister reaffirmed this reliance: 'the *FRANK* website...has been updated and relaunched and is widely used as a source of information – particularly...by young people'.²⁴¹

The CSJ, however, has heard how the *FRANK* campaign is wholly inadequate in terms of preventing young people from abusing drugs or alcohol. Despite national trends indicating a decline in use of some drugs by under-18s, this masks an increasing problem within the most vulnerable neighbourhoods. Jenny, who works with young people who have abused substances in Middlesbrough, told the CSJ that none of the young people that she works with had used *FRANK*.

The futility of campaigns like *FRANK* has been demonstrated, yet the Government persists in championing this moribund service. The European Monitoring Centre for Drugs and Drug Addiction found that 'studies found that media campaigns had no effect on reduction of use and a weak effect on intention to use illicit substances'.²⁴² Revealingly, a survey conducted by national treatment provider, Addaction, found that only one in ten children would call the 'FRANK' helpline to talk about drugs.²⁴³

²³⁹ Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

²⁴⁰ Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

²⁴¹ Hansard, House of Commons debate, 6 June 2013, c287WH [accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130606/halltext/130606h0001.htm> (08.08.13)]

²⁴² European Monitoring Centre for Drugs and Drug Addiction, *Mass media campaigns for the prevention of drug use in young people*, European Monitoring Centre for Drugs and Drug Addiction, 2013

²⁴³ Addaction, 'One in five young people say they think parents have taken drugs, according to Addaction commissioned survey', October 2008 [accessed via: <http://www.addaction.org.uk/news.asp?section=253&itemid=297&search> (08.08.13)]

3.3.1.2 Prevention in schools

Prevention and interventions in England remain low. Personal, Social and Health Education (PSHE), which addresses matters like resistance to risky behaviours around drug and alcohol abuse, is not a statutory subject, meaning that schools are free not to teach it.

Recent studies have shown that the subject of drugs, alcohol and tobacco is covered once a year or less by more than 60 per cent of schools from Key Stages Two to Four (Ages seven – 11) and 74 per cent of schools covered it once a year or less at Key Stage One (Ages five – seven).²⁴⁴

It is impossible to say whether those schools delivering drug and alcohol education are using programmes that are proven to work since the Department for Education does not monitor the programmes or resources that schools use to support their teaching.²⁴⁵ However a small survey of local authorities conducted by the Home Affairs Select Committee found that none of the schools examined delivered the most effective programmes.²⁴⁶

Despite the aspiration of the *Drugs Strategy 2010* that schools will be enabled to 'work with local voluntary organisations, the police and others to prevent drug or alcohol abuse', the CSJ has heard this is not always happening and of schools failing to report the use and dealing of drugs on their premises for fear of it harming their reputation. One drugs-prevention co-ordinator at a local authority in the South East told the CSJ 'schools are so afraid for their reputation that they won't admit there's a problem with drugs.'

PAT'S STORY: Pat is a mother from Teesside who took action after her daughter was offered drugs at school. She told her story to the CSJ

"My daughter came home one day and told me she'd been offered drugs at school. When I informed the school, they did action appropriately as an isolated incident, however indicated that the school does not have a wider problem which is not what the children themselves were saying. On further discussion privately with teachers at my daughters school then with other local schools, they shared a fear; that any school who admits they have a problem ends up with a bad reputation, which means incidents are not always recorded as accurately as they could be. All this to look good during Ofsted inspections and not deal with the real issues our young people are facing in a place where they should be safe at all times.'

After a great effort by Pat, local schools now welcome in trained facilitators to deliver drugs prevention education, this has also opened up dialogue to the families of those children, improving their own understanding of risk-taking behaviour – even re-assessing their own use of cigarettes, alcohol and drugs at home.

However, if each area does not have an individual like Pat, the current system whereby schools are not directed to deliver prevention mean that many young people will continue to be at risk.

244 Formby E, "It's better to learn about your health and things that are going to happen to you than learning things that you just do at school": findings from a mapping study of PSHE education in primary schools in England, *Pastoral Care in Education*, 29 (3), 2011, 161–173

245 Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012

246 Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012

On alcohol too, prevention education is failing young people. England has one of the highest rates of early drunkenness in Europe – nearly half of all pupils have drunk alcohol, including one in nine 11-year-olds, and one quarter report being drunk at least once.²⁴⁷ This is despite the Chief Medical Officer's recommendation that childhood should be alcohol-free until 15 years of age.²⁴⁸

Ofsted highlight the importance of effective alcohol education at Key Stage Three (11–14 year olds) and points to current failures in timing and quality of alcohol education. Troublingly, one in five pupils learn nothing about drugs, alcohol, or tobacco until after the age of 14. This is despite Ofsted's recommendation that the evidence shows this is too late in a child's development to be effective.²⁴⁹

According to the CSJ Alliance of poverty-fighting charities, alcohol abuse amongst young people has increased in recent years, including large quantities of alcohol being consumed in conjunction with other drugs. Phil, a drugs worker from Freedom Social Projects in Barnstable, North Devon, told the CSJ how 'situations of complex poly drug use have increased – alcohol is increasing more than just drug issues'. Similarly, Lawrie, of abstinence-based charity Hope North East in Middlesbrough told the CSJ how:

'Alcohol is now the biggest problem around here, especially among young people.'

Lawrie, Hope North East, Middlesbrough

3.3.2 Treatment and Recovery

The treatment system remains alarmingly poor at moving addicts into full recovery. It is still largely failing in its ambition to move more addicts from dependence upon state-supplied opiates to drug-free lives. The ambition that rehabilitation and abstinence from drugs and alcohol is the best way to maintain recovery has yet to firmly take hold among all those delivering treatment.

As highlighted the by the CSJ in 2007, under the last Government treatment had become little more than a dispensing service for state-supplied opiates. This fatalistic system trapped thousands in state-sponsored and long-term dependency and meant very few addicts become drug free.

In a welcome and radical move, the Coalition Government recognised this problem in its 2010 strategy, stating that the policies that had gone before had focussed 'primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency'.²⁵⁰

247 World Health Organisation, *Status Report on Alcohol and Health in 35 European Countries*, Copenhagen: World Health Organisation, 2013; Ofsted, *Not yet good enough: personal, social, health and economic education in schools*, Ofsted, 2013

248 NHS Choices, *Should my child drink alcohol?* [accessed via: <http://www.nhs.uk/chq/pages/2595.aspx?categoryid=62&subcategoryId=6608/08/13>]

249 Ofsted, *Not yet good enough: personal, social, health and economic education in schools*, Ofsted, 2013

250 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010, [Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf]

Since then, however, too little has changed across our treatment system – the chance of full recovery is still a distant dream for thousands of addicts. By failing to specify that 'recovery' means becoming drug-free, treatment services continue to lack ambition for those they seek to help.

This failure has been compounded by the reduction in funding of residential rehabilitation for addicts. Despite being shown to be the most effective treatment for addiction, figures obtained by the CSJ under the Freedom of Information Act have revealed that 55 per cent of local authorities have cut these services. This is contrary to the wishes of the Prime Minister and the counter to the aims of the *Drugs Strategy*.²⁵¹

This is also in contrast to public health measures and ineffective methadone programmes which have been preserved by the NHS ring-fence. The former pooled treatment, which has historically funded these services, has now formed part of the ring-fenced public health grant.²⁵²

After promising rhetoric and three years in Government, crucial reforms to create a life-changing addiction recovery service have been left on the shelves by too many who could have made a difference.

3.3.2.1 Definition matters

Full recovery from drug addiction and alcohol dependency, whereby the aim of treatment is to enable an addict to become drink and drug free, is tragically not an option for many in addiction treatment. The term 'recovery' has entered the mainstream lexicon of addiction treatment in the UK but the way it is used in documents has led to debilitating confusion.

By not specifying that every person in treatment should be given the chance to become clean and sober, a vacuum has been created. Rather than aspiring for every addict to lead a full life, free from drugs, the definition of recovery in use now means providers can discharge someone as 'in recovery' even if they are known still to be using drugs. Not everybody will achieve a drug-free life, however too many are not given the chance to even try.

In its early days in office, this Government correctly identified the problem of too many addicts being trapped by a broken treatment system:

'One of the ways to collapse the drugs market is to have a more effective treatment system. In this country particularly, we have spent too much time on heroin replacement and methadone rather than on trying to get people clean and clear up all the things in their lives that perhaps cause them to take drugs in the first place.'

David Cameron, *The Guardian*, 29th June 2011

251 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010, [Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf]

252 Public Health England, *Public health Grants to Local Authorities 2013-14 and 2014-15*, [assessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190640/Public_Health_Grants_to_Local_Authorities.pdf (08/08/13)]

The Coalition Government stated in its *Drug Strategy* that:²⁵³

Recovery is an individual, person-centred journey

'Recovery involves three overarching principles– wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support. This means that local services must take account of the diverse needs of their community when commissioning services.

Our ultimate goal is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition.

Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. Medically-assisted recovery can, and does, happen. There are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime. We will continue to examine the potential role of diamorphine [pure heroin] prescribing for the small number who may benefit, and in the light of this consider what further steps could be taken, particularly to help reduce their re-offending.

However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change. We will ensure that all those on a substitute prescription engage in recovery activities and build upon the 15,000 heroin and crack cocaine users who successfully leave treatment every year free of their drug(s) of dependence.'

The CSJ has heard concerns about the mixed message in the second paragraph which states both that 'our ultimate goal is to enable individuals to become free from their dependence' and 'supporting people to live a drug-free life is at the heart of our recovery ambition'. The former too often means that the latter is not the ambition for addicts, due to the manner in which 'free from dependence' is defined – namely it does not mean drug free. The two metrics for success as Public Health England (formerly National Treatment Agency) states are:²⁵⁴

Treatment completed – drug free: The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.

Treatment completed – occasional user: (not heroin and crack) – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be

253 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010, [Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf]

254 National Treatment Agency, *Treatment Outcomes Profile (TOP) The protocol for reporting TOP A keyworkers guide 2010 Gateway 5.5.3*, London: National Treatment Agency, 2010

using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.

These are the two potential discharge codes by which addicts leave treatment and which are used to gauge whether treatment is successful. Yet these outcomes are flawed and the CSJ is convinced that they are an inappropriate way to judge the success of addiction treatment.

The result of this system meant that 29,855 people were discharged last year as 'free of dependency' but of those, 8,045 'may be an occasional user of a drug on which they are not dependent e.g. cannabis.'²⁵⁵ They may also be taking a variety of other illegal drugs. Furthermore, of the 29,855, it is not expected that they should abstain from alcohol. At best then, it can be said that of the 185,428 adults 'effectively engaged in treatment for 12 weeks or more, or if leaving treatment did so free of dependency' only 11.8 per cent of those left drug-free.²⁵⁶

Both outcomes lack ambition and prevent the delivery of recovery. The first outcome 'Treatment completed – drug free' still means someone can be discharged as a successful outcome if they are taking 'legal highs' or alcohol. The second outcome is more egregious, as it allows someone to be discharged from treatment despite the fact they might be using illicit drugs like ecstasy, amphetamines, cannabis and any other drug that is not an opiate or crack-cocaine.

The CSJ has heard from those who have successfully overcome addiction that using mind altering substances, either illicit drugs, NPSs, or alcohol, prevents an addict from confronting their dependence. People in recovery have consistently argued that it is doubtful whether someone can leave addiction treatment 'successfully' if they are still using drugs or alcohol.

'I did treatment when I was 23 and it got me off heroin. I thought great, no more heroin, I'll just take E's [ecstasy] and drink. Then on holiday I had a drink, got drunk, did some coke [cocaine], and ended up taking heroin to calm down. For the next 20 years I was in and out of heroin and prison. Now I'm clean and sober, I can work and see my kids.'

Scott, 43 years old, in evidence to the CSJ

'I went to treatment and got off heroin when I lost my job, it wasn't that hard. So I thought my problem was solved. I started to party again, drinking and that. Then I was drinking every morning. Eventually I lost another job. Finally went to proper rehabilitation and now I don't drink or take drugs and am back working. I'm now nine months clean and sober.'

Trevor, in evidence to the CSJ

255 National Treatment Agency, Facts and Figures – What do we mean by successfully completing treatment? [accessed via: <http://www.nta.nhs.uk/facts.aspx> (08/08/13)]

256 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012

The ambiguity surrounding the definition of recovery has allowed some providers of addiction treatment to claim they are delivering recovery. Those that have been discharged 'free from dependence' but still using other drugs are re-presenting to treatment services – their 'occasional use' of other drugs having spiralled back into dependence. One rehabilitation provider told the CSJ:

'...they're coming back around. People that had been got off heroin but effectively told a bit of cannabis or bottle of wine is ok. They end abusing those then often eventually back on to heroin.'

3.3.2.2 Double prescribing

Natalie, 31, from Birmingham, in evidence to the CSJ

'I thought "if I can get on methadone, everything will be ok," nine and a half years later, I was still on it.'

Natalie first started using heroin at 19 but by 20 had decided that she wanted to stop. She had heard about methadone as a treatment for heroin addiction and went to a GP to ask about it.

The GP put her on a methadone prescription and onto benzodiazepines. Over the course of the next nine years, Natalie moved around the Midlands and between GPs and drugs services. When a new GP stopped her methadone, she went to the local drugs service which put her on back on it.

Whilst being prescribed methadone by the local service, she was also receiving benzodiazepines from her GP through a 'shared care arrangement'. Neither the GP nor the local drug service knew that the other was prescribing to Natalie.

Although she would be required to give urine samples before collecting her methadone to prove she was not using other drugs, Natalie said the tests were easy to beat. In this way, Natalie was able to collect enough methadone for seven days – over 1000 ml. 'I would sell extra methadone or I could save it for a rainy day, when I couldn't score other drugs', she told the CSJ.

Natalie went through eight GPs and several drug services. None of these knew her previous history and would meet her request to be issued with a methadone prescription. During nine years of methadone 'treatment', her life became one of despair which only more and more drugs could alleviate, be they prescribed or from the street.

12 years on, clean, sober and working after attending a residential rehabilitation centre, whenever she meets addicts still using drugs but looking for help, Natalie tells them 'don't go on methadone, it's worse than heroin.'

The prescribing of opiates, like methadone, and other medications, by GPs under shared care arrangements is also undermining the Government's efforts to build recovery and potentially distorting the figures for addicts discharged as 'free of dependency'. Shared care occurs, for example, when a community drugs service and a GP see the same patient. A drugs service might discharge a client as 'free from dependency', however due to ongoing needs, they are referred to a GP or possibly a prescribing nurse. These medical professionals will often put the client back onto a substitute prescription without that being recorded by the Government's data monitoring system. Similarly, a GP might be prescribing strong pain killers whilst unknown to him, the drugs service is also prescribing methadone.

GP Dr Chris Longstaff described to the CSJ how some GPs are not willing to engage effectively with certain client groups, for example heroin addicts, and will write a prescription as it is the fastest way to end a consultation. 'They do not want to engage with patients who have complex social problems; the result is the further medicalisation of a social issue.'

3.3.2.3 Residential treatment: failure to back what works

In his first year as Prime Minister, David Cameron committed to tackling addiction by focussing on full recovery. He placed a particular emphasis on one such viable alternative – residential rehabilitation:

'The last government became too target obsessed. It was all about how many addicts are in touch with treatment agencies, and this, in too many cases, really meant the addict was talking to someone and maybe getting some methadone, which is a government authorised form of opium, rather than heroin. It did not really address the problem – that [the addict] had a drug habit... I would like to... try to provide – difficult though it will be given the shortage of money we have been left – more residential treatment programmes. In the end, the way you get drug addicts clean is by getting them off drugs altogether, challenging their addiction rather than just replacing one opiate with another.'

David Cameron, *The Guardian*, 6th August 2010

This undertaking was welcome – residential rehabilitation is known to be a particularly effective intervention. Jo Neale, professor of public health told the CSJ working group:

'Residential treatment seems to be particularly good at allowing individuals to establish routines, find meaningful ways of spending time and develop crucial independent living skills; community rehabilitation seems less suited to achieving this.'

Research has shown that abstinence-based residential treatment of addiction is much more successful than the community-based prescribing of substitute medication, the best units having a 60 per cent success-rate at getting people to leave dependency-free.²⁵⁷ However, this is received by only two per cent of those in treatment, while 49 per cent receive prescribing

²⁵⁷ National Treatment Agency, *The Role of Residential Rehabilitation in an Integrated Treatment System*, London: National Treatment Agency, 2012 – though this is based on a flawed comparison of residential treatment which usually involves abstinence and therefore is more likely to help someone in their journey to full recovery

as treatment.²⁵⁸ This lack of quality treatment received by so many addicts explains why the national figure for leaving 'free of dependence' is only 11.5 per cent.²⁵⁹

Consequently, the cost benefits of residential rehabilitation are clear. The cross-party Home Affairs Select Committee reported after its lengthy review into drugs policy that residential rehabilitation was cost effective:

*'Although it is expensive when compared to treatment entirely in the community, it is cost-effective when compared to the cost of ongoing drug addiction.'*²⁶⁰

The value for money given by residential rehabilitation is illustrated by examining the costs of the current system and its failings. For example, drug users and their dependants are estimated to receive nearly £3.3 billion a year in welfare benefits.²⁶¹ The employment prospects of an addict who completes a programme are increased by a miniscule three per cent under the current £854 million treatment system.²⁶² The most effective residential rehabilitation units get a far higher proportion of their clients who complete the programme into education, training, voluntary work or employment, and yet less than ten per cent of the budget is spent on such units.²⁶³

Far from improving, and despite the Prime Minister's pledge, the position of residential treatment is increasingly under threat. Currently only two per cent of those entering treatment receive residential rehabilitation and research undertaken by the CSJ has revealed that this has been cut in 55 per cent of local authorities.²⁶⁴ Given the high rates of effectiveness of residential treatment this represents a failure to deliver the necessary shift in addiction treatment.

CSJ freedom of information requests reveal that the amount spent on residential treatment programmes has actually fallen since the Coalition entered office, whilst the number of those in receipt of long-term substitute prescriptions, like methadone, has risen. Whilst the latter may represent an increase due to the advent of Public Health England, the former has always been backed by local authorities and remains so. It would appear that as local authorities have begun to develop their public health services (methadone) they are reducing funding to effectively tackle addiction through rehabilitation.

Consequently, it is unsurprising that the number of people entering residential rehabilitation fell by five per cent between 2010/11 and 2011/12 so that only 4026 of England's 197,110 addicts were in residential rehabilitation.²⁶⁵

258 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012 Vol. 1: The Numbers*, London: National Treatment Agency, 2012

259 *Ibid*

260 House of Commons Home Affairs Select Committee, *Drugs: Breaking the Cycle*, London: House of Commons, 2012

261 Gyngell K, *Breaking the Cycle*, London: CPS, 2011, p22; United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012, p219. Calculation: £1.7 billion in welfare payments to addicts (CPS) and £1.6 billion (UK Focal Point). These figures are extrapolations and forthcoming data from the Department for Work and Pensions should clarify the extent of welfare payments made to opiate and crack users.

262 National Treatment Agency, *Drug Treatment Funding*, [Accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08/08/13)]

263 Ashton M, 'NTORS: The most crucial test for addiction treatment in Britain yet' in *Drug and Alcohol Findings*, 2, 1999 [accessed via: http://findings.org.uk/docs/Ashton_M_12.pdf]; National Treatment Agency, *The Role of Residential Rehabilitation in an Integrated Treatment System*, London: National Treatment Agency, 2012; McCartney D, 'LEAP and the Recovery Community in Edinburgh' in *Addiction and Recovery in the UK*, in J Roth and D Best (eds) Oxford: Routledge, 2013 pp57–72

264 National Treatment Agency, *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 – 31 March 2012 Vol. 1: The Numbers*, London: National Treatment Agency, 2012

265 Department of Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2012; Department of Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department of Health, 2011

Case Study: Kickstart, Sheffield

Kickstart helped adults overcome addiction by bringing order and hope into the chaos of an addict's life. The charity supported its clients to overcome their addiction, stay clean and sober, and eventually to flourish in mainstream society. The charity, based in Sheffield, worked with the clients whilst they remained within their own families and communities. Sadly, it has now closed down after a disappointing re-tendering of drugs services.

Through a minimum 12-week day care provision (Monday–Friday, 0900–1700) Kickstart equipped its clients with the tools needed to transform their lives, become abstinent and stop negative behaviour patterns. Clients participated in one-to-one key worker contact sessions, group work and art therapy, and attended evening support groups and aftercare sessions as required. Kickstart endorsed the principle that 'substance abuse is not the problem, but a poor solution to a deeper problem' – a solution that results in diminished self-esteem and subsequent withdrawal from the community.

Though there was a 12-week course, people could join at any time and stay for as long as they need. Nobody was pushed to move on until they were completely well, even when the funding had run out. Nor did Kickstart 'cherry-pick' its clients, accepting all who came.

Keyworkers were involved in helping clients with all areas of their life, including benefits, housing, dentist and doctors' appointments, etc. Each client's final care plan included a plan for their moving-on, which included education, training and work experience. Another programme also worked with the families of former addicts.

Despite delivering a successful service, Kickstart, which by 2012 was two-thirds funded by the Sheffield Drug Action Team (DAT) lost its funding and had to close its doors. The DAT re-tendered all services and Kickstart lost out. Instead two national providers were brought in to deliver the type of therapeutic interventions delivered by Kickstart.

Kickstart's success can be seen with the 20 per cent decline in the number of problematic drug users (heroin/crack) from 4,997 to 4,017 in Sheffield in the period 2006/07 to 2010/11, compared to a national average of 9 per cent.²⁶⁹ With the services of Kickstart withdrawn in 2012, it remains to be seen whether this progress will continue.

One drug worker, based in a centre run jointly by the NHS and a national provider of drugs treatment, described to the CSJ how hard it is to send an addict to residential rehabilitation.

*'I've got 40 on my books on methadone. Many need rehab but the commissioners and providers are dragging their feet. One woman has been on methadone for years. For over a year she's been ready for rehab. She has done everything asked of her to prove she wants to get clean and go to rehab but they won't spend the money. It's tragic. She wants to work.'*²⁶⁶

²⁶⁶ Drug worker in Hampshire in evidence to the CSJ (20/07/13)

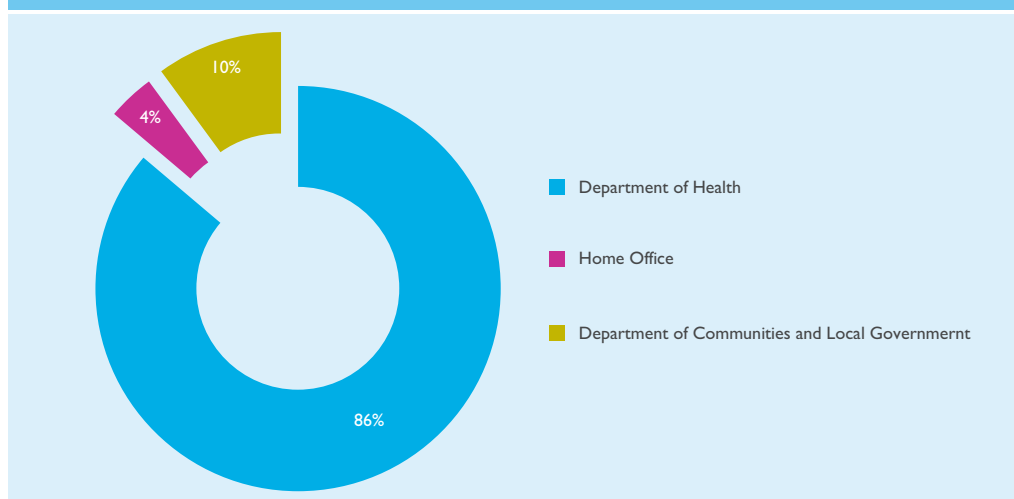
Such examples correspond with a rise in the number of people receiving long term substitute prescriptions. Of the 146,660 opiate users in prescribing treatment in 2011/12, 30 per cent had been on a substitute prescription for four years or more.²⁶⁷ This represents a 28 per cent increase since 2009/10.²⁶⁸ Far from getting more people into recovery, more is being done to maintain people in their dependence.

The failure of this strategy appears to have had much to do with the way in which funding for services has, until very recently, been split between the NHS – which has accounted for about half of the money for addiction services – and local authorities who have received money from the Department for Communities and Local Government, the Ministry of Justice and the Home Office.

Central government spends approximately £450 million each year on drug treatment, via the pooled treatment budget, this is being protected under Public Health England and the NHS ring-fence. This is mainly spent on measures designed to insulate the general population from the effects of addiction, for example HIV. Needle exchanges and methadone clinics absorb a large part of the funding, and while keeping addicts healthier than they otherwise might be if left to their own devices, they do not effectively tackle addiction. Residential rehabilitation, which does tackle addiction, comes mainly from local authority budgets set aside for supporting vulnerable people.

Although the NHS ring-fence has largely protected the public health aspect of the drugs and alcohol funding, the remainder, part of which does more to tackle addiction, has been significantly reduced. Nationally, this meant a reduction by 55 per cent of local authorities in their spending on rehabilitation.²⁶⁹ Thus, despite being the most effective treatment, residential rehabilitation (funded mainly from DCLG) accounts for less than 10 per cent of drug treatment spend (Figure 21). Such an allocation of resources reveal how most addicts want to become drug-free, as frequent studies have shown. One recent study of people trying to overcome heroin addiction found: 'Without a doubt, one of the most common hopes discussed by our study participants was to be drug-free'.²⁷⁰

Figure 21: Origins of funding for drugs treatment²⁷¹



267 Department of Health, Deposited Paper DEP2013-1196 in response to PQ 164324 [accessed via: http://data.parliament.uk/DepositedPapers/Files/DEP2013-1195/164324_-_continuous_prescriptions_-_opiate_use.xls (10/7/13)]

268 *ibid*

269 Replies to freedom of information requests submitted by the CSJ

270 Royal Society of Arts, *The everyday lives of recovering heroin users*, London: Royal Society of Arts, 2012

271 National Treatment Agency [accessed via: <http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf> (08.08.13)]

From the above it is clear that protecting the spending on the pooled treatment budget (PTB) will secure the harm reduction services, whilst cuts to local authority-run social services are resulting in a decrease in the already microscopic funding of residential rehabilitation.

Drug Treatment on Teesside

'What would help your children?' the CSJ asked parents and other family members of drug addicts and alcoholics at a support group meeting. 'Residential rehab, not methadone', was the near unanimous reply.

The parents and grandparents who spoke to the CSJ all have children who are drug addicts or alcoholics. When asked about the treatment services in the Teesside area, they told the CSJ that they were ineffectual. Family members felt shut out from the treatment of their child. 'It's like, they're the professionals, they know what's best and you should butt out. The worker in the room decides the treatment for the addict, based on what the addict tells them.'

In many cases, the family members said that the addicts were using all kinds of drugs, making no progress, but would lie to drug workers to get more methadone, either to use themselves or to sell on. The family members were not given the opportunity to contribute to the drug workers' decisions.

Although the family members wanted their children to attend a residential rehabilitation centre, where they become abstinent from drugs, they were resigned. 'They won't pay for that. They pay for a big building to give out methadone but not rehab.'

The consequences of drugs treatment policies on Teesside can be seen in national prevalence statistics with the number of opiate and/or crack users in Middlesbrough increasing by 12 per cent since 2006/07.²⁷²

Despite this, only 2.5 per cent of Middlesbrough's £4.9 million drug treatment budget was spent on residential rehabilitation.²⁷³ Worse, half the residential rehabilitation monies came from the now unring-fenced social services contribution. Meanwhile, the type of services received by addicts, as described by their parents to the CSJ, is protected under the NHS ring fence.

Even in areas where the PTB has made a contribution to residential rehabilitation, this has been slashed by local areas since the Coalition took office. In 2009/10 Sefton, for example, spent £437,000 of its £6 million drugs treatment fund on residential rehabilitation with over half the contribution coming from the PTB (though some of this was within a hospital rather than a rehabilitation centre).²⁷⁴ In 2010/11 this had been reduced by 60 per cent.²⁷⁵

272 National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via: [http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority\[0\].xslm](http://www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xslm) (08/08/13)] and National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2006/07* [accessed via: http://www.nta.nhs.uk/uploads/north_east_prevalence_data_0607doc.pdf (22/08/13)]

273 Safer Middlesbrough Partnership, *Adult drug treatment plan 2010/11* [accessed via: <http://www.nta.nhs.uk/regional-northeast-middlesbrough.aspx> (08/08/13)]

274 Safer Middlesbrough Partnership Adults Part 4, *Adult drug treatment plan 2010/11* [accessed via: <http://www.nta.nhs.uk/regional-northeast-middlesbrough.aspx>]

275 *Ibid*

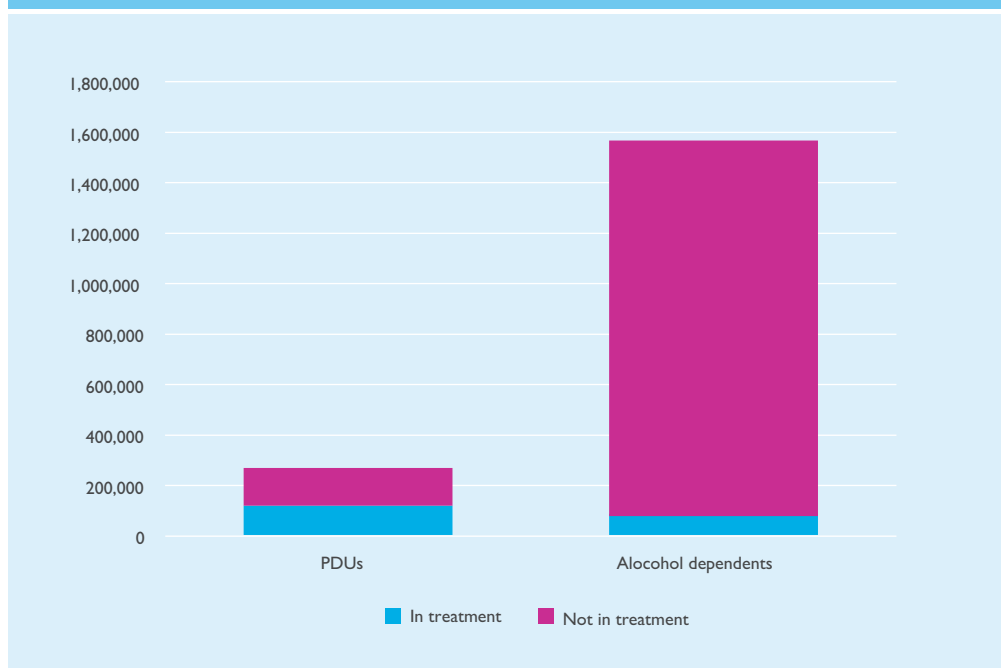
3.3.2.4 Alcohol treatment – breaking the cycle?

Despite being the most widely abused drug and costing society more than other drugs combined, the treatment available for those who are alcohol dependent is dwarfed by the help available to drug addicts. In terms of availability and quality, alcohol treatment is inadequate to the demand.

In spite of its prevalence in society, fewer than six per cent of dependent drinkers receive specialist treatment.²⁷⁶ Although it is estimated that for every pound invested in specialist alcohol treatment, £5 is saved on health, welfare and crime costs,²⁷⁷ the average PCT²⁷⁸ expenditure on alcohol services is just 0.1 per cent (£600,000) of their annual budget. This is in stark contrast to the 0.5 per cent or £2.7 million spent by each PCT on treating drug addiction.²⁷⁹

The lack of treatment for those abusing alcohol is worrying, especially when compared to those receiving drug treatment. Despite there being five times as many alcohol dependants as other drug addicts, nearly twice as many drugs addicts receive treatment (Figure 22).

Figure 22: Number of heroin and/or crack users and their numbers in treatment versus alcohol dependents and their numbers in treatment²⁸⁰



Alcohol treatment, although more effective than drug treatment, is too sparse and ineffective, as seen by the increasing burden on the health service. Yet despite the rising cost of alcohol to society, the UK is one of only five nations in Europe that does not aim to help those entering

²⁷⁶ Alcohol Concern, *Investing in Alcohol Treatments: reducing costs and saving lives*, London: Alcohol Concern, 2010

²⁷⁷ National Treatment Agency, *Review of the effectiveness of treatment for alcohol problems*, London: National Treatment Agency, 2006

²⁷⁸ Now CCGs have replaced PCTs the CSJ has heard things are much the same

²⁷⁹ Alcohol Concern, *Investing in Alcohol Treatments: reducing costs and saving lives*, London: Alcohol Concern, 2010

²⁸⁰ National Treatment Agency, *Review of the effectiveness of treatment for alcohol problems*, London: National Treatment Agency, 2006

treatment for problems with alcohol to stop drinking.²⁸¹ As was shown in Chapter One by the increase in the number of readmissions to hospital for alcohol abuse, this unresolved issue is deteriorating.

Current statistics show that of the 108,906 people who received treatment for alcohol abuse, only 33 per cent left alcohol-free. This is far from good enough, and half the rate for the best rehabilitation centres. Much of this is attributable to the system which provides the treatment.²⁸²

At present, most alcohol treatment is carried out by the NHS and the advice it provides on its website represents a lack of ambition for those it is seeking to help. For harmful drinking 'you will first have to make the decision about whether you want to reduce your alcohol intake (moderation) or give up drinking alcohol altogether (abstinence).'²⁸³

Rather than encouraging harmful drinkers to give up alcohol, the NHS advice lamely notes: 'Abstinence will obviously have a greater health benefit, although moderation is often a more realistic goal, or at least, a first step on the way to abstinence.' Instead of attempting to prevent alcohol-harm to all alcohol misusers through abstinence, the only attempt to encourage abstinence is limited to those already suffering liver damage or heart disease, those on incompatible medication, or women planning to, or already, pregnant.²⁸⁴

Even for the seriously ill, patients can choose which treatment to take, even if it may be the most ineffective. As the CSJ heard:

'Putting someone with cirrhosis in a controlled drinking programme is madness, it may be all that can be achieved, but it is terrible to start out with that approach.'

Dr Stephen Ryder, Nottingham liver and pancreatic cancer service in evidence to the CSJ

However for individuals whose substance abuse repeatedly leads them into contact with state services, the successful use of abstinence as a goal from treatment can be seen in examples within the UK and abroad. The pioneering Family Drug and Alcohol Court in Soho requires addicted parents to be clean and sober before deciding to restore custody of their children.²⁸⁵

281 Rehm et al, *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe*, Canada: Centre for addiction and mental health, 2012 p78

282 National Treatment Agency for Substance Misuse, *Alcohol Treatment*, 2013 [accessed via: <http://www.nta.nhs.uk/uploads/alcoholcommentary2013final.pdf> (22/08/13)]

283 NHS Choices, *Alcohol misuse – Treatment* [accessed via: <http://www.nhs.uk/Conditions/Alcohol-misuse/Pages/Treatment.aspx> (08.08.13)]

284 NHS Choices, *Alcohol misuse – Treatment* [accessed via: <http://www.nhs.uk/Conditions/Alcohol-misuse/Pages/Treatment.aspx> (08.08.13)]

285 Nuffield Foundation & Brunel University, *The Family Drug & Alcohol Court (FDAC) Evaluation Project*, Brunel University, 2011

International Comparison: Enforcing Sobriety in South Dakota – 24/7

Problem

South Dakota had a burgeoning prison population fuelled by alcohol abuse, harming families, children, communities and the taxpayer. When the programme was introduced, South Dakota had one of the highest drink driving rates in the USA and almost three-quarters of those involved in fatal crashes had an increased blood-alcohol level.²⁸⁶ Whilst judges frequently ordered recidivists to abstain from alcohol as a condition of probation, there was no effective programme in existence to ensure compliance.

The 24/7 Sobriety Program was established in 2005. The program uses breath tests, monitoring bracelets, urinalysis and drug patches to monitor offenders with addictions.

Solution

The impetus for the 24/7 Project began in the early 1980s in Bennett County, a rural area in South Dakota with a population of 3,500 and a shocking level of both alcohol consumption and worklessness.

The county prosecutor, Larry Long, convinced his local judge to take a more interventionist approach in dealing with alcohol-related offenses, primarily driving over the limit and domestic abuse. Offenders were required to present themselves twice daily to the sheriff's office to demonstrate that they had not consumed alcohol by submitting to breathalyzer tests. Anyone who failed the test or did not turn up was immediately incarcerated.

In 2004, the newly-elected Attorney General Long was appointed by the Governor of South Dakota to a task force charged with examining incarceration rates in South Dakota. Long believed from experience that alcohol abuse and drug-related offenses fuelled much of the problem.

The Bennett County programme was implemented as a pilot project in three counties in South Dakota, with judges in those counties requiring, as a condition, that defendants abstain from alcohol.

Every defendant arrested for a second or subsequent drink-driving offense was required to submit to a breath test between the hours of 0700 and 0900 and 1900 and 2100 at the local sheriff's office. The judges agreed to immediately revoke bail of anyone who failed to present for a scheduled test or whose test revealed that they had consumed alcohol. Having seen the success of the programme, judges began using it for domestic abuse cases and drug offences.

In 2007, South Dakota made the programme officially state wide. The State Attorney General was charged with the responsibility of co-ordinating efforts amongst the state and local government agencies to find and implement alternatives to prison for drink-driving and other offences involving alcohol, cannabis, or other controlled substances.

Participation in the programme has also been extended, for example to those with substance issues who are on bail, serving a suspended sentence, or as a requirement to regaining custody of children in care.

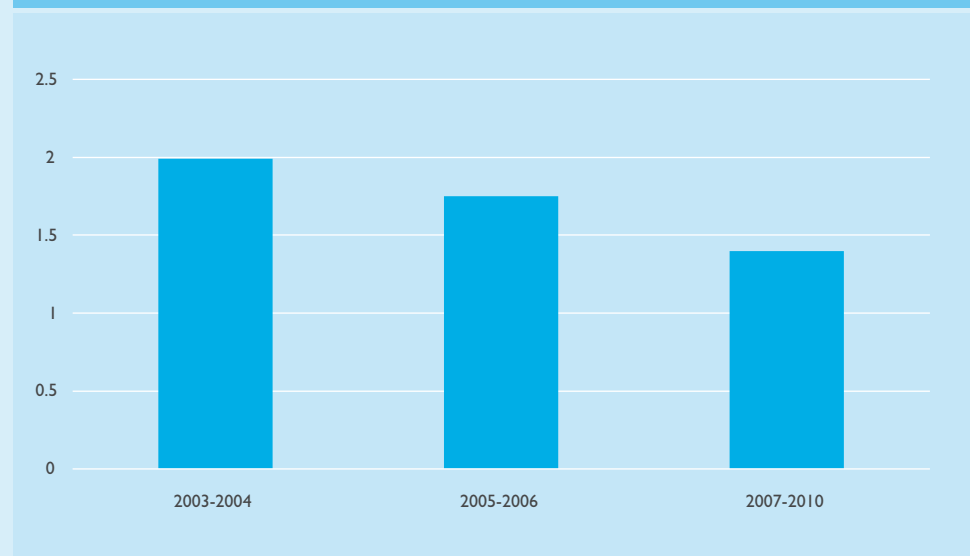
286 National Partnership on Alcohol Abuse and Crime, *South Dakota 24/7 Sobriety Project*, [accessed via: http://www.alcoholandcrime.org/images/uploads/pdf_tools/sd_program.pdf (08.08.13)]

Results

Counties that have the programme have seen a 12 per cent reduction in repeated drink driving arrests and a nine per cent drop in domestic abuse arrests.²⁸⁷

Since 2005, the prison population has decreased in South Dakota, saving taxpayers about \$75 per day per person and allow offenders to maintain jobs, live with their families, and contribute to their communities. Millions have been saved every year in prison costs because the programme has helped reduce the daily jail population by almost 100 people in the state's two largest counties.²⁸⁸

Figure 23: South Dakota Alcohol-Involved Motor Facilities compared to USA average where 1 is the average²⁸⁹



Road deaths have also been reduced. From 2006 to 2007, alcohol-related traffic deaths in South Dakota declined by 33 per cent, the highest decrease in the nation.²⁹⁰ In a year where the U.S. had a four per cent decline in drink-driving deaths, South Dakota outperformed every other state.²⁹¹

In 2013, South Dakota's 24/7 Sobriety Program was selected as one of the ten best criminal justice innovations in the United States. It has been praised by the Association of Prosecuting Attorneys, the U.S. Department of Justice's Bureau of Justice Assistance, and the Centre for Court Innovation.²⁹²

3.3.2.5 Tackling housing needs to build recovery

A further way in which treatment is undermined and recovery hindered is the approach to housing by many local authorities. Some councils spend thousands of pounds sending

²⁸⁷ Kilmer, B, Efficacy of Frequent Monitoring With Swift, Certain, and Modest Sanctions for Violations: Insights From South Dakota's 24/7 Sobriety Project in *Read American Journal of Public Health* 103(1) 2013 pp37–43 [accessed via: <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2012.300989>]; journalCode=ajph]

²⁸⁸ *Ibid*

²⁸⁹ Humphreys K, *An Evidence-Informed Approach to Alcohol Problems in Britain*, 12 March 2013

²⁹⁰ National Highway Traffic Safety Administration, *Traffic Safety Facts 2008*, Washington DC: US Department of Transport, 2009, p165

²⁹¹ National Partnership on Alcohol Abuse and Crime, *South Dakota 24/7 Sobriety Project*, [accessed via: http://www.alcoholandcrime.org/images/uploads/pdf_tools/sd_program.pdf (08.08.13)]

²⁹² Rapid City Journey, *South Dakota's sobriety program gets national recognition*, 8 February 2013

people to rehabilitation centres (sometimes for as long as six months to a year) only then to re-house them in council accommodation in which drug and alcohol abuse is known to be rife.

The CSJ heard John's story. He graduated from rehabilitation and, being homeless, wanted to go into a 'dry' house to begin his reintegration into society. The only accommodation made available was in a house with people who would otherwise have been 'sleeping rough'. Many were in active addiction and/or dependent drinkers. After a day or two staying there, John gave in and got drunk with some of the residents. This story is all too typical.

In freedom of information requests submitted by the CSJ, fewer than one third (27 per cent) of local authorities confirmed that monitored dry housing was available for people in recovery from substance abuse separate to that for people who drink and/or take drugs.

People entering full recovery are extremely vulnerable. This work is then threatened when people move from the protective environment of rehabilitation and are placed in council accommodation with others still using drugs and alcohol – often because there is no dry council accommodation available. This needless risk is dangerous for addicts and senseless for taxpayers. As one council, which does provide supported, dry accommodation, told the CSJ:

'It's [dry housing] important if you want to sustain the recovery of someone you've invested time and money in to get them well.'

Too many local authorities are also inflexible. Local commissioners often pay for residential treatment for an addict for a certain time but will not extend it, even for a few days – even if move-on housing is not available. So having spent thousands of pounds on sending someone through rehabilitation, local authorities have been known to cut the support before they have secured accommodation. If an addict is sent to a rehabilitation centre in a different local authority to that which is funding the treatment, the 'host' local authority has no obligation to house him. The result can be an addict who is clean and a sober, but is not from the local area, is forced on to the streets on the same day he leaves rehabilitation.

The result of this short-termism is a loss to the taxpayer as relapse becomes considerably more likely. It can also be a tragedy for those involved.

MIKE'S STORY

Mike, who had been funded through rehabilitation by his local authority, had funding up until Tuesday. The housing he had arranged to move into (with the help of the rehabilitation centre), to progress his transition into the community, was not available until the following Monday.

Despite having invested thousands of pounds in Mike's treatment, the local commissioner would not pay a couple of hundred pounds for the extra week in the rehabilitation centre (charged at less than the national average). By making Mike effectively homeless, even for a day or two, the local authority risked Mike's recovery. Going from the protective environment in which he had become drug-free, to the streets of a city.

By forcing him on to the streets or into living with people who might be using drugs, at a very vulnerable stage in his journey against addiction, the local authority risked a human tragedy for Mike, a financial tragedy for the taxpayer.

Anger, but not surprised, at the situation, the rehabilitation centre chose to accommodate Mike for the remaining time. However, this solution is not financially viable for all treatment providers and delays someone else's recovery.

3.3.2.6 Need for culture-change to deliver recovery

Another barrier which has prevented the wholesale culture change needed to deliver recovery has been employment law. This has resulted in the same workers who used to dispense methadone being transferred to services now trying to help people off methadone and into recovery. As one authority involved in sector told the CSJ:

'In my opinion, one of the biggest barriers to recovery is the current workforce. I have watched as multi-million pound treatment systems have been de-commissioned and re-commissioned at great public expense without any sustainable improvement in service quality.'

Employment law regulations, designed to protect workers from large corporate buy-outs, are instead holding back effective charities from delivering recovery for thousands in need of help. The transfer of undertakings (firms/charities etc.) is governed by The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), which stem from a European Union Directive. This means that when a group of employees are transferred to a new employer as a block their terms and conditions cannot be downgraded.

The effect of TUPE has been to stifle the voluntary sector in its attempts to take on work done currently either by private firms or local authorities.²⁹³ CSJ Alliance members have told us how small charities cannot afford to take on contracts to run existing state services which come with expensive staff, even though the charities believe they can do the work better for a lower cost to the taxpayer.²⁹⁴

293 Centre for Social Justice, *Breakthrough Britain II: Voluntary Sector*, London: Centre for Social Justice, 2013 [forthcoming]

294 MyTime, in evidence to the CSJ 12/03/13

‘One of the challenges of retendering, particularly when TUPE applies, is to ensure that the leadership, management and one-to-one client contact brings about the changes envisaged at the point of re-tendering services or whole systems.’

Mark Gilman, NTA Strategic Recovery Lead, in evidence to the CSJ

When a contract to deliver drug and alcohol treatment services comes up for re-tendering, the staff will often be transferred to a new provider. The result is often that an effective organisation which wins a contract is forced to take on the staff from the current provision. These workers are often trained to dispense a prescription rather than deliver, for example, cognitive/behavioural therapies that are part of effective, abstinence-based interventions.

Organisations like the Ley Community, which attribute their success to their specialist staff in whom they have invested, are dissuaded by TUPE from bidding for contracts to deliver treatment services. Although highly expert, with good results, smaller organisations cannot risk taking on the staff which would be transferred to them under TUPE. As a large, national treatment provider told the CSJ:

‘We can afford to take on the staff of a less effective services. Either they are retrained, which can take some time, or they end up leaving. We’ve got the resources to do that ... small providers can’t do that. They can’t take the TUPE burden.’

Large, national treatment provider in evidence to the CSJ

The dilemma faced by a successful organisation is either to ‘manage-out’ underperforming staff, which can be very costly, or spend a great deal of time and money re-training staff who may well be resistant to change. Large, national charities can afford to do this more than smaller organisations with a local knowledge.

Accordingly effective organisations are discouraged from applying for contracts that could deliver services for better value than existing providers. This means that fewer addicts are successfully treated and the tax-payer is funding an inefficient treatment service and burdening an already stretched criminal justice system.

3.3.3 Social workers ill-equipped to tackle addiction

Despite being the main point of intervention for many families affected by substance abuse, often social workers are inadequately trained to handle this issue. This is surprising as 62 per cent of all children subject to care proceedings and 40 per cent of children on the child protection register involve parental substance abuse.²⁹⁵ However, social workers are

²⁹⁵ Children’s Commissioner, *Silent Voices*, London: Children’s Commissioner, 2012

not required to have an understanding of addiction. This situation has not altered since *Breakthrough Britain* first drew attention to this.²⁹⁶

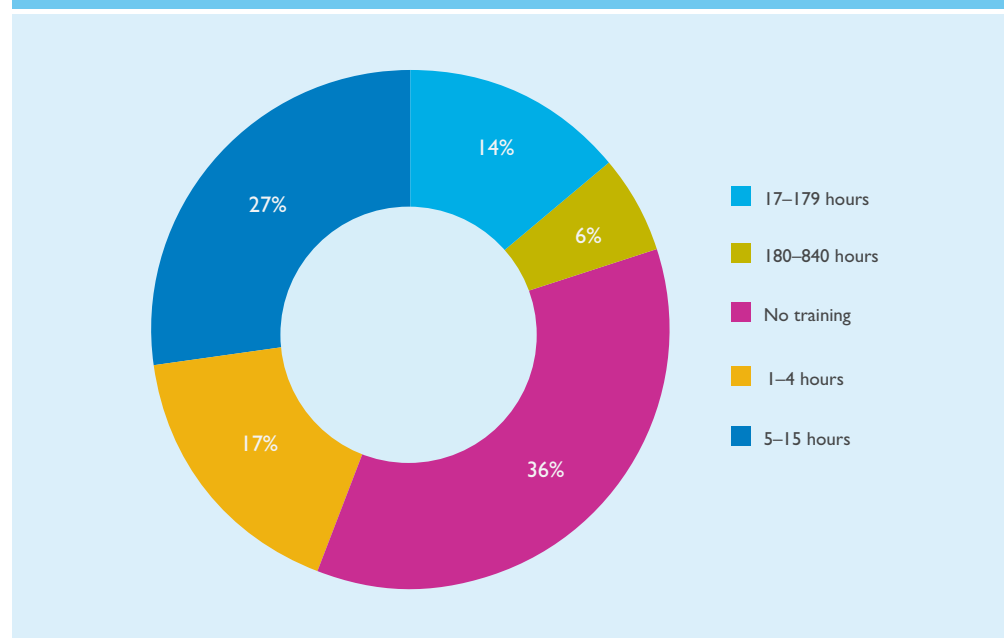
Most social workers undertake an undergraduate degree in social work before applying for jobs at local authorities in social work. There is currently no requirement for universities to have addiction as part of the curriculum.²⁹⁷ The result is that it is possible, and indeed common, for people to become fully qualified and practicing social workers without having an insight into addictions.²⁹⁸

The CSJ heard from Jenny Peddar, senior lecturer at Portsmouth University, that 'social workers are often the first people into a home where substance abuse is occurring, a rigorous knowledge of addiction is essential to be able to work with families facing multiple challenges'.

A recent study of nearly 300 newly qualified social workers found that over 60 per cent did not feel adequately prepared to identify substance-use problems and associated risks, or discuss the types of support available. It found that:²⁹⁹

- Over a third of social workers do not receive any training on substance use during training.
- Of those who do, the majority have received less than two days; and,
- Many social workers who specialise in children have no guidance on what or how to ask about substance abuse.

Figure 24: Percentage of social workers who get substance abuse training³⁰⁰



296 Centre for Social Justice, *Breakdown Britain: Addictions*, London: CSJ, 2006

297 Skills for Care, National Occupational Standards (NOS) [accessed via: http://www.skillsforcare.org.uk/developing_skills/National_Occupational_Standards/NOS_introduction.aspx (08.08.13)]

298 Jenny Peddar of Portsmouth University in evidence to the CSJ

299 Forrester & Galvani, 'How well prepared are newly qualified social workers for dealing with substance use issues? Findings from a national survey in England', *Social Work Education*, 2011 30:4 [accessed via: <http://www.tandfonline.com/doi/abs/10.1080/02615479.2010.504981#preview> (08/08/13)]

300 University of Bedfordshire, *From the front line: alcohol, drugs and social care practice. A national study*, University of Bedfordshire, 2011

Those commissioning and directing the priorities for social work education regard insight into substance abuse as part of the risk management process rather than crucial issues that need to be addressed as fundamental to other concerns.³⁰¹

Social workers are often the first trained professionals to encounter substance abuse and its consequences. The responsibility of social workers to ensure the safety of children means that knowledge of addiction is essential given its prevalence in society. Currently, however, too many social workers do not have adequate knowledge of this subject and as a result, children are in unnecessary danger.

3.3.4 Drugs in Prison

The Drug Strategy committed the Government to 'creating drug-free environments in prison and ... [increasing] the number of drug-free wings, where increased security measures prevent access to drugs.'³⁰² This is an absolutely necessary measure. Instead of being centres of recovery providing rehabilitation, in too many prisons the problem of addiction in prison is getting worse.

The lack of effective treatment to date is evident and demonstrates why reform is needed. In 2010–11, 38 per cent entered local prisons with a drug problem and nearly one third of whom estimate they will leave prison still abusing drugs, this included one quarter of young offenders.³⁰³

Worryingly, however, despite its ineffectiveness in tackling addiction, prisoners are receiving more methadone than ever before. The number of prescriptions has nearly trebled since 2007 to 33,198 in 2011/12.³⁰⁴ The worst practices of endless methadone-maintenance prescribing highlighted in civilian drugs treatment in *Breakthrough Britain* now appear throughout the prison estate. The HM Chief Inspector of Prisons for England and Wales observed that 'It was noticeable that large numbers of prisoners received methadone maintenance treatment without regular treatment reviews.'³⁰⁵

The CSJ heard from a GP and pharmacist how lax approaches to prescribing meant that prisoners were being prescribed strong painkillers, including opiates.

'It keeps the prisoners happy and the wings quiet. It doesn't tackle the problem at all in the long term.'

Pharmacist in North East in evidence to the CSJ

301 University of Bedfordshire, *From the front line: alcohol, drugs and social care practice. A national study*, University of Bedfordshire, 2011

302 Home Office, *Drug Strategy 2010*, London: Home Office, 2010

303 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

304 Hansard, Written Answers, 3 December 2012 [accessed via: <http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121203/text/121203w0003.htm> (08.08.13)]

305 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

'I went to a prison and the amount of prisoners on strong painkillers was incredible.... I then see people come out, who might be on heroin but now they're addicted to pregabalin too.'

GP in Buckinghamshire in evidence to the CSJ

As well as the increased supply of prescribed opiates, the interdiction of illicit drugs in prison has not yet effectively disrupted the trade. Between 17 to 42 per cent of prisoners report that it is easy to obtain illicit drugs.³⁰⁶ Many prisoners are introduced to highly addictive drugs when in prison. One survey revealed that one third of prisoners who had ever used heroin reported first using it in prison.³⁰⁷

Alcohol abuse, similarly, is too familiar in the prison estate. In some prisons, alcohol is readily accessible and alcohol-related incidences are increasing in some prisons.³⁰⁸ A recent report into HMP Lincoln, for example, found that alcohol is widely available, with prisoners telling inspectors how easy it was to procure alcohol.³⁰⁹

Compounding the availability of alcohol is the lack of alcohol recovery services currently in prison – despite the fact that 22 per cent arrive in prison with a drinking problem and 19 per cent expect to leave as such. Just under half of prisons inspected have no alcohol-related services or programmes available.³¹⁰ The Inspectorate found that at every stage in prison, the needs of prisoners with alcohol problems are less likely to be either assessed or met than those with illicit drug problems. Services for alcohol users were very limited, particularly for those who did not also use illicit drugs.³¹¹

Despite the aggravating role in crime and reoffending played by alcohol and drugs, treatment efforts have been inadequate and supply too liberal. The present Government needs to ensure that drug-free wings and recovery units serve to tackle this problem. This is imperative for taxpayers and those caught in the cycle of substance abuse and reoffending.

3.4 Restricting Supply

3.4.1 Enforcement

In 2010 the Government, as part of its strategy to tackle the drugs problem, pledged to restrict the supply of illicit substances.³¹² Following this there has been an increase in the enforcement of laws controlling 'traditional' drugs (Figure 28). However the emergence of new drugs and

306 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

307 Ministry of Justice, *Compendium of reoffending statistics and analysis, SPCR Sample 1, Wave 1 questionnaire tables* London: Ministry of Justice, 2010

308 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

309 HM Chief Inspector of Prisons, *Report on a full unannounced inspection of HMP Lincoln*, HM Chief Inspector of Prisons for England and Wales, 2012

310 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

311 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010-11*, London: The Stationery Office, 2011

312 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

a new route of supply – the internet – are proving too fast for the Government's current classification system, and its response has thus far been inadequate.

The 2010 Drug Strategy outlined a tough approach to the enforcement of drug laws, stating 'we will not classify drug problems at a local level as anti-social behaviour – drug dealing and drug possession is a crime'.³¹³ This has been reflected in the continued rise in arrests for drugs offences. This increase has included cannabis, the harshest sanctions for which, court sentence or caution, have increased by 30 per cent since 2007.³¹⁴

Figure 25: Rise in the number of arrests for drug offences 2003/04 to 2010/11³¹⁵



As part of its strategy, the Government has overseen the creation of Police and Crime Commissioners (PCCs) in an attempt to re-orientate the response to crime to a local level.³¹⁶ PCCs have the power to set police priorities and direct or withdraw police funding for specific operations.³¹⁷ Whilst enforcement of drug laws has increased under the Coalition, there is a danger, identified by the Home Affairs Select Committee, that certain PCCs may downgrade drugs as a priority.³¹⁸ One PCC has already stated this as her intention.³¹⁹ This also risks the geographic displacement of the drugs trade which may impact more severely on particularly vulnerable areas.³²⁰

³¹³ Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

³¹⁴ United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

³¹⁵ United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

³¹⁶ Home Office, *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Lead a Drug Free Life* London: Home Office, 2010

³¹⁷ Association of Police and Crime Commissioners [accessed via: <http://www.apccs.police.uk> (08.08.13)]

³¹⁸ Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012 [accessed via: <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmha/184/184.pdf> (08.08.13)]

³¹⁹ Northumberland Police and Crime Plan [accessed via: <http://www.northumbria-pcc.gov.uk/sites/default/files/plans/pcp/Police&CrimePlan2013-2018.pdf> (08.08.13)]; *Chronicle Live*, 'Low-level drug use 'not a priority'', 1 April 2013

³²⁰ Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012

3.4.1.2 Renewed sources of supply

Given that nearly all the heroin found on Britain's street comes from Afghanistan, it is essential to consider the possible effects on Britain from the NATO withdrawal from that country.³²¹ The disruption caused by the Soviet invasion of Afghanistan in 1979 led to a boost to the supply of heroin to Europe and helped bring about the heroin epidemic of the early 1980s.³²² When the soldiers leave, it is essential that the UK remains engaged in the development of Afghanistan, otherwise more heroin may end up on streets in Britain's cities.

Benoit Gomis of foreign affairs think-tank Chatham House told the CSJ that 'the presence of ISAF forces has done little to counter the production and export of heroin'. Indeed despite the presence of NATO forces, the production of heroin has increased opium poppy cultivation rose 18 per cent from 2011 to 2012.³²³

However, Gomis emphasised the comparative success of development policies compared to eradication of crops. Given this, it is imperative that Britain, when it withdraws combat forces, does not cease its efforts to help develop Afghanistan's state and economy. To this end, it is encouraging that the Foreign Secretary has pledged to maintain the UK's £178 million annual contribution to the development of Afghanistan.³²⁴

Given the long-term nature of development policies, heroin will still be produced in Afghanistan for some time to come and any internal disruption could lead to a boost in supply. With much focus moving to new drugs, and the existing heroin population ageing, it is imperative that Britain remains live to this danger and not dismiss heroin as yesterday's problem.

3.4.2. New drugs and the internet

If not checked, the rapid emergence of New Psychoactive Substances (NPS or 'legal highs') may eclipse traditional substances. As has been shown in Chapter One, there are now more uncontrolled drugs, like New Psychoactive Substances (251) than controlled substances (234). This means while 234 different drugs are subject to the ABC classification system, there are now 251 that are not. This situation will only increase given that NPS are emerging at the rate of one per week.³²⁵

In its strategy the Government declared it would 'introduce a system of temporary bans on new 'legal highs' whilst health issues are considered by independent experts'.³²⁶ This process involves the temporary banning of a substance suspected to be harmful by the Home Secretary for one year whilst the Advisory Council of the Abuse on Drugs conducts analysis.

321 Department of Health, *United Kingdom Drug Situation 2011 EDITION*, London: Department of Health, 2011

322 UKDPC, *Drugs Policy*, London: UKDPC, 2007

323 United Nations Office on Drugs and Crime & Islamic Republic of Afghanistan Ministry of Counter Narcotics, *Afghanistan Opium Survey 2012*, 2012, United Nations Office on Drugs and Crime & Islamic Republic of Afghanistan Ministry of Counter Narcotics, 2012

324 The Rt Hon William Hague MP, Quarterly Statement on Afghanistan, 2013 [accessed via: <https://www.gov.uk/government/speeches/quarterly-statement-on-afghanistan> (08.08.13)]

325 European Monitoring Centre for Drugs and Drug Addiction, *2012 Annual report on the state of the drugs problem in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2012

326 Home Office, *Drugs Strategy 2010*, London: Home Office, 2010

If it is found to be harmful, the substance will be added to the A, B, C classification system, based on its suspected harm.³²⁷

The United Nations argues that 'it has generally been observed that when a NPS is controlled or scheduled its use declines shortly thereafter'.³²⁸ This occurred in the United Kingdom when mephedrone was banned along with other methcathinones, in 2009. This saw a decrease in use of mephedrone by 31 percentage points amongst clubbers and a reduction in the number of associated deaths.³²⁹ It cannot be concluded, however, that the system of temporary banning is working as only nine have been banned since the Coalition came to power.³³⁰ In the same period, approximately 160 new substances have appeared.³³¹

3.4.2. Online dealing

Another key problem is the use of an alternate supply chain – the internet. Increasingly, the internet is now being used to buy drugs and efforts to disrupt this supply are not proving adequate. Whilst traditional drugs are being traded over the internet, the market in New Psychoactive Substances (NPS) particularly benefits from online sales.³³² Factories producing NPS can take orders online and post them from China to any address in the UK.³³³

This threatens to fundamentally change the way drugs are supplied. No longer is it necessary for young people to know a dealer on a street corner. All that is necessary is a debit card and a knowledge of how to use the internet. Mainstream delivery companies deliver to any street in Britain without knowing the contents of what is being delivered. One youth worker in the North East told the CSJ, 'this is really scary. They're buying stuff off the net with their bank cards – children's bank cards – and their parents have no idea'.

In the 2010 Strategy, the Government acknowledged the problem of the way drugs are bought over the internet and pledged to tackle the problem.³³⁴ Yet by 2013, we learned that the UK was one of the leading hubs for the internet-based dealing of NPS. There are over 130 sites registered in the UK providing a range of legal highs. Internet sites selling NPS and shipping them to EU member states rose from 170 in January 2010 to 690 in January 2013.³³⁵

When the CSJ asked all police forces in England, Wales, and Northern Ireland for information, via a freedom of information request (FOI), on the number of enforcement operations aimed

327 Home Office, Abuse of Drugs: Temporary Class Drugs [Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98007/temporary-class-drugs.pdf]

328 United Nations Office on Drugs and Crime, *World Drug Report 2013*, Vienna: United Nations, 2013

329 United Kingdom Focal Point, *United Kingdom drug situation*, London: Department of Health, 2012

330 European Monitoring Centre for Drugs and Drug Addiction, *2012 Annual report on the state of the drugs problem in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2012; Home Office website: Temporary Banning Orders; Home Office, *First 'legal high' to be banned under new powers* [accessed via: <https://www.gov.uk/government/news/nbome-and-benzofury-to-be-banned> (08.08.13)]

331 European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2013, p26

332 International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

333 This is South Wales, 'Depressed man tried to buy heroin online', 21 December 2012; APPG Drugs Policy Reform, *Toward a safer drug policy*, 2013 [accessed via: https://docs.google.com/file/d/0B0c_8hkDJu0DODg3UXpfa2U05Fk/edit?usp=sharing&pli=1 (08.08.13)]

334 Home Office, *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Lead a Drug Free Life* London: Home Office, 2010, p16

335 International Narcotics Control Board, *Report of the International Narcotics Control Board*, Vienna: United Nations Office, 2013

at internet-based dealing, none were able to produce figures.³³⁶ It would suggest that the Government's pledge to restrict supply in this area is not being pursued as firmly as required.³³⁷

Whilst legal high vendors based on the internet may not worry too much about prosecution, until Temporary Banning Orders are placed on their products a far more dangerous problem has developed.

There are sites, like the *Silk Road*, which are hosted on the so called 'Dark Web', which is also used by those that supply pornographic images of child abuse. As well as 'legal highs', these sites sell traditional drugs like heroin and crack-cocaine and use a virtual currency that is virtually untraceable.

The Dark Web

The Dark Web (or Deep Web) is a side of the internet which the likes of Google cannot search. It represents the majority of webpages and enable illegal and immoral trading to occur; for the most part unchallenged. Anonymity is one of the features desired by the Dark Web. As one software supplier, which enables access to the Dark web, says:³³⁸

'Tor protects you by bouncing your communications around a distributed network of relays run by volunteers all around the world: it prevents somebody watching your Internet connection from learning what sites you visit, and it prevents the sites you visit from learning your physical location.'

There are websites not accessible through search engines such as Google or Yahoo – one estimate put the indexing of web pages at 0.25 per cent.³³⁹ Much as the 99.75 per cent is only accessible through password-protected firewalls, pages requiring manual inputs, or specially downloaded software.

Many legitimate sources, including Governments, use the Dark Web, however it is also the lair of groups like 'thieves, hucksters, predators, child pornographers, terrorists, drug cartels.'³⁴⁰

The marketplace for drugs has always been a cash business due to the anonymity provided to buyers and sellers. This reliance on cash has previously limited the ability of drug dealers to conduct business online as there was no easy way to conduct transactions anonymously due to the records kept by electronic payment methods such as credit cards. This has changed with the creation of the Bitcoin, an online currency that operates somewhere between casino-chips and pounds sterling. It allows account holders to buy, apparently without a trace, anything they want from websites like the *Silk Road*, up to and including heroin.³⁴¹

336 One force, Lancashire Constabulary, did respond to confirm that no specific operations had targeted the online sale of drugs, but that use of the internet did arise in occasional cases

337 Freedom of Information requests to Police Forces in England and Wales: It is shocking that the police do not keep easily accessible data in this area (note: an FOI can be declined if the answer will take more than 18 hours to collate)

338 Tor Website [accessed via: <https://www.torproject.org> (08.08.13)]

339 Bergman, M, 'White Paper: The Deep Web: Surfacing Hidden Value', *The Journal of Electronic Publishing*, 7(1), 2001

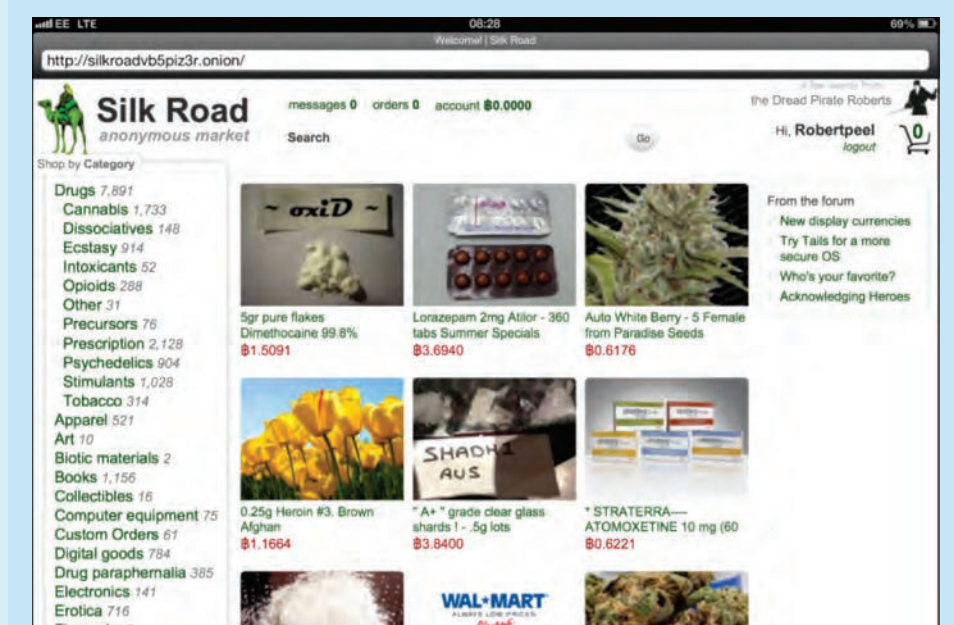
340 The Economist, *Difference Engine: Happy anniversary?*, 12 Aug 2011

341 Chen A, *The underground website where you can buy and drug imaginable*, 2011 [accessed via: <http://gawker.com/5805928/the-underground-website-where-you-can-buy-any-drug-imaginable> (08.08.13)]

The Silk Road

Described as the 'underground eBay-like site which has become the core marketplace for buying and selling drugs online' and 'Amazon – if Amazon sold mind-altering chemicals'; the *Silk Road* is a website facilitating a new drugs trade.³⁴² This trade however has remained largely untouched by enforcement agencies and consequently, almost as easily as one might order a book from Amazon, one can order drugs and have them delivered by post. The Royal Mail and DHL have become the latest unknowing vehicles.

Figure 26: A screen shot from the Silk Road showing 0.25g of heroin for sale for One Bitcoin or approximately £66.00.



Bitcoin

Bitcoin is a wholly virtual currency operated and managed by a network of individuals running special open-source software similar to the BitTorrent network. Part of the untraceable nature of sites like the *Silk Road* lies in the manner in which the purchase is made. The network uses sophisticated algorithms to produce currency, verify and process transactions, as well as prevent fraud, all without a central banking authority.

The nature of the currency, held in electronic wallets which can easily be created or assigned new identities, means that tracing individual transactions to individual people is exceedingly difficult, especially if the initial Bitcoins were purchased by a user with cash. Furthermore, sites like the *Silk Road*, take extra steps to ensure users' anonymity by requiring users to access the site through software specifically designed to mask their identity and location, as well as by encrypting users' records and deleting all identifying transaction logs upon the completion of successful transactions.

342 The Guardian, *Silk Road: the online drug marketplace that officials seem powerless to stop*, 22 March 2013

3.4.3 Super cheap, super strong alcohol

While some argue that the problem of alcohol abuse is declining as fewer people drink each week, the reality – as shown in chapter one – is that the cost of dangerous alcohol use is rising.

3.4.4 2012 Alcohol Strategy

Last year the Government set out its plans to tackle problem alcohol use. These developments would address general levels of drinking for reasons of law, order and public health. There were also important implications for the limiting of heavy drinking.

'We need to get to grips with the problem of super cheap alcohol that's fuelling violence on our streets and causing mayhem in our accident and emergency units and damaging the health of the country and I think this minimum unit pricing is a big part of the answer. It's mad when you can buy cans of lager for 25p or 2 litres of cider for less than £2.00, so we need to deal with that and this shows a radical government rolling up its sleeves and getting on with the job.'

David Cameron, *Telegraph*, 23rd March 2012

The Government argued that the problem of one million alcohol-related crimes, of 1.2 million alcohol-related admissions to hospital a year, high levels of 15-16-year-old binge drinking, and the £21 billion annual cost to society had been caused by:³⁴³

- Cheap alcohol being too readily available;
- The failure of previous governments in extending licensing hours;
- A lack of challenge to individuals who drink and cause harm to others.

3.4.5 Minimum Unit Pricing

At the core of its response to these problems was the Government's commitment to introduce a minimum unit price for alcohol. It was recommended that this be introduced through primary legislation at a rate of 45p a unit on the grounds that this would lead to:³⁴⁴

- An estimated reduction in consumption across all product types of 3.3 per cent;
- A 5,245 reduction in the number of crimes per year;
- A reduction in 24,600 alcohol-related hospital admissions;
- 714 fewer deaths per year after ten years.

This was, broadly, a position that the CSJ endorsed. In *Breakthrough Britain* we argued for the taxation on alcohol to better reflect the cost of consumption, which is currently borne by the taxpayer. The increased tax-take '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.'³⁴⁵

343 Home Office, *The Government's Alcohol Strategy*, London: Home Office, 2012.

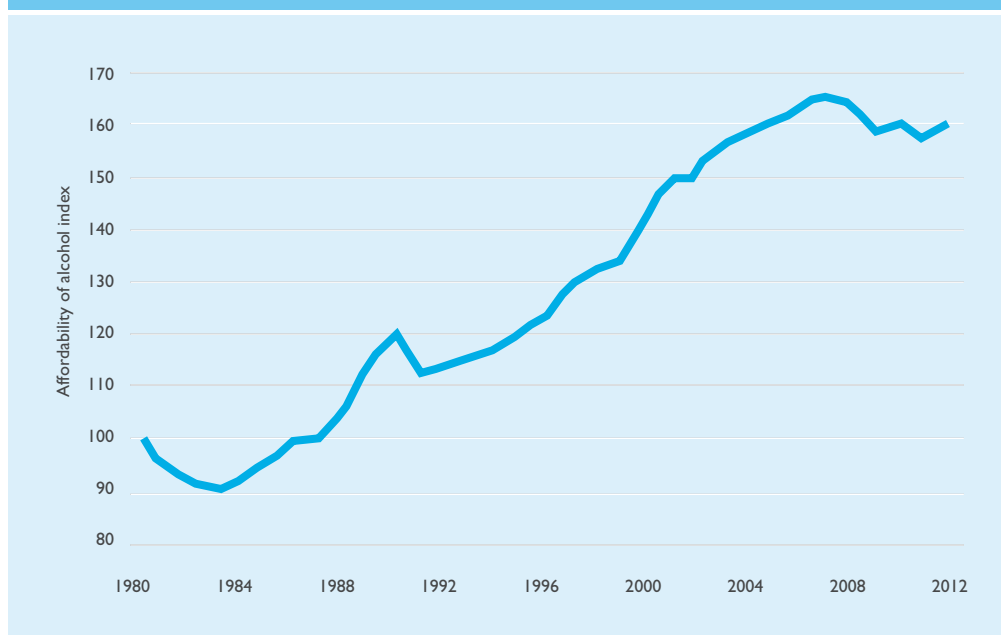
344 Home Office, *A consultation on delivering the Government's policies to cut alcohol fuelled crime and anti-social behaviour*, London: Home Office, 2012.

345 Centre for Social Justice, *Breakthrough Britain: Addictions*, London: Centre for Social Justice, 2007.

A higher price for alcohol, if established in such a way as to allow money to flow to preventative and intervening services (rather than drinks companies) would have been an invaluable tool in combating the effects of serious drinking. Recent research from Canada, beyond that considered by the Government in its consultation, has shown the positive impact that a minimum unit price can have.³⁴⁶

Alcohol is now more widely available than ever. Historically, it is the most affordable it has ever been and liberalised licensing laws mean it is available for sale for longer and in more venues than ever before. The effect of this has been to increase supply of this most widely used drug. Despite a small reduction in affordability during the recession, it would appear to be becoming more affordable once again.

Figure 27: Alcohol affordability index: 1980 (=100 per cent) to 2012³⁴⁷



However, the Government has rowed back on its commitments to tackle alcohol pricing. The Crime Prevention Minister announced in July 2013 that plans for a minimum unit price were to be scrapped.³⁴⁸ Justifying the decision in Parliament, Jeremy Browne MP said, 'a person without the means to buy Chablis, and who therefore had to drink a cheaper bottle of white wine every evening, would be affected'.³⁴⁹

Such statements do not accord with public health signals warning of heavy drinking. NHS guidelines state that 'men should not regularly drink more than 3-4 units of alcohol a day.

³⁴⁶ Institute of Alcohol Studies, *Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol*, Canada: Institute of Alcohol Studies, 2013

³⁴⁷ Office for National Statistics, *Statistics on Alcohol: England, 2013* [accessed via: <https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2013/alc-eng-2013-rep.pdf> (08.08.13)]

³⁴⁸ Hansard, 17 July 2013 : Column 1113 [accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130717/debtext/130717-0001.htm#13071772000005> (08.08.13)]

³⁴⁹ Hansard, 17 July 2013 : Column 1117 [accessed via: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130717/debtext/130717-0001.htm#13071772000005> (08.08.13)]

Women should not regularly drink more than 2-3 units a day' and advises that the average bottle of wine contains 10 units.³⁵⁰ The Crime Prevention Minister said of the minimum unit price however, that it would interfere with a person's ability to have a bottle of cheap white wine per night – equivalent to five times the recommended daily intake of a woman.³⁵¹

This climb-down represents a missed opportunity to disrupt the supply of cheap, strong alcohol which is fuelling addiction. The types of alcohol that would have been affected by the legislation were only used to get very drunk, very quickly:

'Does anyone enjoy a small amount of White Cider?...anything brewed with the suffix 'Extra' or 'Super' is entirely brewed and marketed for the harmful or hazardous drinking market. Most [of my patients] will drink until they run out of money. If they drink less, they live longer. If it's more expensive, they will drink less.'

Dr Stephen Ryder, Nottingham liver and pancreatic cancer service in evidence to the CSJ

3.5 Conclusion

Despite promises made in opposition to move to an ambitious treatment system, many barriers remain to tackling drug and alcohol addiction and abuse in Britain. From the continuance of thousands parked on methadone, to the wide availability of drugs – particularly from new sources, and a weak approach to alcohol, the Coalition Government needs to go further to deliver on a promising start.

Separate strategies, an ambitious definition of recovery, and effective reform of employment law are all needed to ensure that central Government plays its part in Britain's recovery. Action is also needed to address the self-defeating reduction in funds from residential rehabilitation by local authorities. By protecting the methadone-maintenance system with the NHS ring-fence, but excluding local authority funds for rehabilitation, the drive for full recovery is imperilled.

The Government must also take steps to address the growing supply of drugs across the internet and ensure its response to alcohol abuse is coherent.

350 NHS Choices, *Your health, your choices* [accessed via: <http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx> (08.08.13)]

351 NHS Choices, *Your health, your choices* [accessed via: <http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx> (08.08.13)]

chapter four

The new commissioning landscape

4.1 Introduction

There are several significant challenges which threaten to undermine the Government's attempts to deliver recovery from addiction. Reform to the drug and alcohol treatment system in England presents opportunities but also carries risk. Constant among them is the lack of ambition to get addicts drug-free.

The danger is two-fold. Firstly, the Government's health reforms are seeing drugs and alcohol addiction treatment commissioning merged into a larger organisation with a much broader remit, Public Health England (PHE).³⁵² Drugs and alcohol recovery programmes now have to compete in the same health category with concerns like obesity and sexual health.³⁵³ Despite the disproportionate welfare and criminal costs of drugs and alcohol addiction and abuse, there is a threat that recovery services may lose out.

The second cause for concern with PHE is that, despite the abolition of the National Treatment Agency and the focus on recovery within the Drugs Strategy, many of the commissioning personnel have remained in their old role with a new title. It therefore remains to be seen whether a change in culture has been brought about or whether this merely represents a re-branding exercise.

In conjunction with these reforms, GPs now have more say over which services are commissioned for their patients. This is important as for many addicts their GP is the first professional contact. Whilst GPs have good knowledge of the local population and services, some have historically been associated with writing prescriptions for substitute medication for addicts rather than challenging the addiction and encouraging a move to recovery.

352. Department of Health, Improving outcomes and supporting transparency, London: DH, 2012 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193619/Improving-outcomes-and-supporting-transparency-part-1A.pdf] (08/08/2013)]

353. *Ibid*

This lack of ambition for full recovery is also reflected in the way the Government is testing its recovery pilots. There are eight payment-by-results (PbR) schemes aimed at finding the most effective ways to help addicts recover.³⁵⁴ Yet these pilots do not have as their main aim the ambition to help addicts become drug-free. By not making 'drug-free' a gateway payment (one which is necessary to achieve before payment) the CSJ has heard concerns that the focus on beating addiction has been blurred and the project is at risk of failing those suffering from addiction.³⁵⁵

Furthermore, the introduction of Police and Crime Commissioners (PCCs), who now have control over a large portion of former drug and alcohol treatment funding, may not decide to invest in tackling addiction. The independence afforded to PCCs presents exciting opportunities for innovation and it is essential that they invest in tackling the drivers of crime. For example, rather than follow popular cries for more uniformed officers that deal with the effects of crime, PCCs should be investing in rehabilitation and education schemes that prevent crime.

This chapter considers the potential impact of each of these reforms in turn.

4.2 Public Health England

In recognition of the wider societal and welfare costs of addiction, previous administrations had regarded it as more than a health issue. However, responsibility and funding for treating addiction was transferred on 1st April 2013 from local partnerships that reported to central government, to local arms of Public Health England within local authorities by virtue of the Health and Social Care Act 2012.³⁵⁶

Previously, central government funded and directed the work of 149 local drug and alcohol partnerships (Drug (and Alcohol) Action Teams – D(A)ATs). Now local authorities are free to invest in whatever programmes they deem to be the most effective in delivering recovery.³⁵⁷ This presents excellent opportunities for innovation. However there are also concerns that the move, without the right leadership, risks a return to a narrow public health approach to treatment which keeps addicts in dependency, reliant on state-supplied substitutes in an attempt to reduce harm.

The National Treatment Agency for Substance Misuse (NTA) was abolished in April 2013, a decision called for by the Centre for Social Justice in 2007.³⁵⁸ The majority of funding for drugs and alcohol services will now lie with Directors of Public Health based within local authorities. These directors are members of Health and Wellbeing Boards which will develop and deliver strategy for improving public health within local authorities.³⁵⁹

354 Department of Health Website [accessed via: <https://www.gov.uk/government/news/drug-and-alcohol-recovery-pilots-supporting-material-published> (08/08/2013)]

355 *Ibid*

356 Health and Social Care Act 2012

357 National Treatment Agency, *Transition to Public Health England*, 2011 [accessed via: <http://www.nta.nhs.uk/uploads/ntaactionplan1112.pdf> (08/08/13)]

358 Centre for Social Justice, *Breakthrough Britain: Addictions*, 2007

359 Department of Health, *Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies* [accessed via: <http://healthandcare.dh.gov.uk/jsnas-jhws-guidance-published/> (08/08/2013)]

The consequences for the treatment of drug and alcohol addiction will be significant because although the former NTA funding constitutes a third of the funding of PHE, the remit of the new public health body includes many more issues.

The functions of the NTA have now been subsumed within Public Health England (PHE) which, in addition to drugs treatment, is responsible for issues such as:³⁶⁰

- 'Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol;
- Reducing the burden of disease and disability in life by focussing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency; and
- Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics'.

These reforms have seen the focus and funds once specified for tackling drug and alcohol abuse subsumed within local authority public health units. The absorption of the former National Treatment Agency (NTA) funding into Public Health England (PHE), together with the advent of Police and Crime Commissioners (PCCs), has seen funding once dedicated to tackling drugs and alcohol subsumed within larger budgets tasked with more mainstream concerns like smoking and crime reduction.

Strong leadership will be required to ensure that short-term concerns, bolstered by sectional interest groups, do not lead to the degradation of services aimed at tackling addiction. Should this be permitted, some have warned, the knock-on effects of this will be a rise in the cost to society of drug and alcohol abuse. Wendy Dawson, of the Ley Community addictions rehab, told the CSJ that:

'If addiction is seen purely as a health issue, like diabetes, it ignores the associated welfare dependency and possible criminality, commissioners will not give it the priority it needs.'

Former specific funds for drugs and alcohol treatment are now available to tackle a range of other issues.³⁶¹ Although former drug and alcohol treatment money makes up over one third of the PHE budget, drugs and alcohol outcomes are subsumed within other priorities like obesity, and fitness. Specific drugs and alcohol criteria by which local authorities will be judged represent only three of 66 Public Health Outcomes.³⁶² This disparity is displayed in Figures 28 and 29.

³⁶⁰ Public Health England Website [accessed via: <https://www.gov.uk/government/organisations/public-health-england/about> (08/08/2013)]

³⁶¹ Department of Health, *Improving outcomes and supporting transparency*, London: DH, 2012 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193619/Improving-outcomes-and-supporting-transparency-part-1A.pdf (08/08/13)]

³⁶² Department of Health, *Improving outcomes and supporting transparency*, London: DH, 2012 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193619/Improving-outcomes-and-supporting-transparency-part-1A.pdf (08/08/2013)]

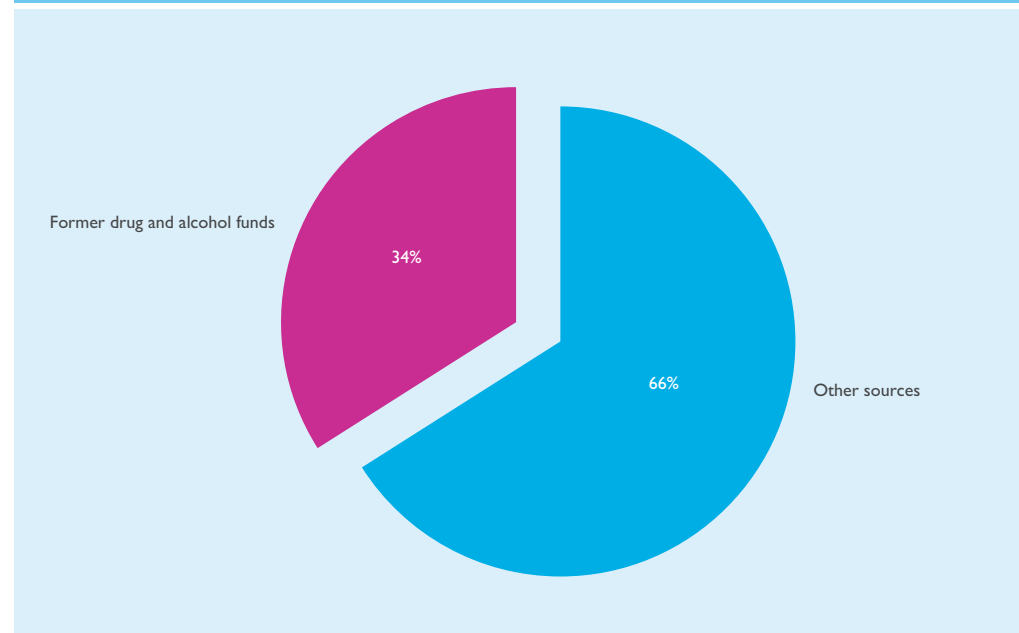
'Unless they [Directors of Public Health] know what they're doing, the inevitable consequence of this will be disinvestment from drugs and alcohol services.'

Fiona Dunwoody of One North East London told the CSJ

As well as the small number of alcohol and drug outcomes, three outcomes that are represented lack ambition to get addicts free from drugs. They are:³⁶³

- The successful completion of drug treatment (this does not equate to not abusing all drugs and alcohol).
- People entering prison with substance dependence issues who are previously not known to community treatment.
- Alcohol-related admissions to hospital.

Figure 28: Proportion of Public Health England budget which comes from drugs and alcohol offices, 2012



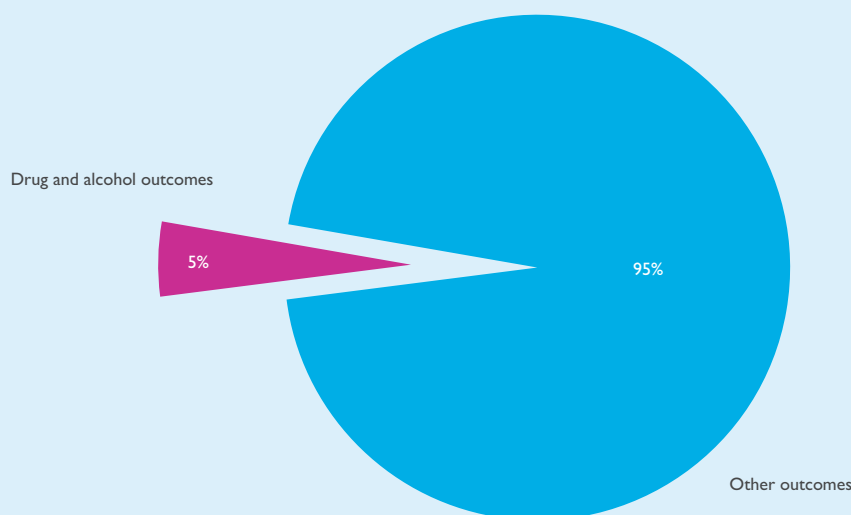
Within the new public health commissioning framework, there is no statutory requirement for drug and alcohol treatment providers to sit on Health and Wellbeing Boards (HWBs) and consequently there is a danger that those making the decisions will become detached from the effects of addiction on society.³⁶⁴ Compounding this, the 14-page statutory guidance for HWBs contains only one reference to drugs and alcohol and located in a footnote on the last page.³⁶⁵

³⁶³ *Ibid*

³⁶⁴ McKenney, Prof. N., in evidence to CSJ

³⁶⁵ Department for Health, *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*, [accessed via: <https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf> (08/0813)]

Figure 29: Proportion of Public Health indicators specific to drugs and alcohol, 2013–2014



How addiction recovery programmes will now be commissioned

Each local authority now employs a Director of Public Health tasked with improving the health and well-being of the area's population as measured by the public health outcomes determined by Public Health England at the Department of Health.³⁶⁶ Each Director is accountable for delivering the Health and Wellbeing Strategy set by the local Health and Wellbeing Board (HWBs).³⁶⁷ This strategy is determined after a Joint Strategic Needs Assessment (JSNA), to which drugs/alcohol services and interested parties should contribute.

The influence of GPs on HWBs will be strong as Clinical Commissioning Groups (CCGs) are statutory members of HWBs. This brings a danger that a strong medical focus will dominate the approach to tackling addiction. Speaking to the CSJ Professor Neil McKegeeny cautions that:³⁶⁸

'Even if Health and Wellbeing Boards maintain funding to drugs and alcohol services, they may do so only on the strict public health terms i.e., methadone-maintenance and needle exchange but not recovery.'

³⁶⁶ National Treatment Agency for Substance Misuse, *Transition to Public Health England*, 2011 [accessed via: <http://www.nta.nhs.uk/uploads/ntaactionplan1112.pdf> (08/08/13)]

³⁶⁷ NTA, *Transition to Public Health England*, 2011 [accessed via: <http://www.nta.nhs.uk/uploads/ntaactionplan1112.pdf> (08/08/13)]

³⁶⁸ McKegeeny, N., in evidence to CSJ

The preference of GPs for prescribing drugs to tackle what is often more of a social problem is a threat to the Government's attempts to get more addicts into recovery. This troubling practice can be seen in Blaneau Gwent where GPs prescribe enough antidepressants to supply one in six of its population.³⁶⁹ GPs can currently only refer to existing, community-based drugs agencies and do not have the option to send an addict to, for example, residential rehabilitation. They are only permitted to refer to locally-approved services. Speaking directly about prescribing methadone to a heroin addict, one GP told the CSJ:

*'If I have someone in front of me, asking for help, the only thing I can realistically do is give them a methadone prescription. It's not the answer to their problems, but it might make their lives a little easier.'*³⁷⁰

GP Dr Price, told the CSJ how the extent of knowledge of addiction amongst GPs is often based on a one-day training course based-around prescribing methadone and other heroin substitutes. This course is taken by GPs to enable them to take on work prescribing substitute medication. This medical bias means that many GPs are ignorant of the wider work with addicts, such as in a residential rehab for example, relating to education, social skills, and therapy.

If GPs realise the benefits of tackling the causes of addiction, rather than to just alleviate the symptoms, then the potential for good from GP commission is great. With co-ordination between PHE, CCGs and local authorities, rates of addiction could be dramatically reduced.

Public Health England, then, has much to do to ensure that the new treatment structures that came online in 2013 are fit to enable Britain to tackle its addiction crisis. Without a focus on getting addicts drug free, there is a risk that methadone maintenance will be the only treatment for opiate addiction.

4.3 Police and Crime Commissioners

4.3.1 Police and Crime Commissioners and Treatment

The introduction of elected Police and Crime Commissioners (PCCs) in England and Wales in November 2012 has far-reaching implications for drug and alcohol services. With PCCs being given control of funds that were once dedicated solely to tackling addiction, there is no guarantee that addiction services will continue to receive the same level of funds. If PCCs are convinced of the effectiveness of such expenditure, there is the chance they could increase. However with budgetary pressures acting upon PCCs, there may well be a temptation to reduce the level of funding in this critical area.

PCCs now determine local policing priorities, potentially sit on Health and Wellbeing Boards, and allocate funding for community safety activity. Their budgets include the former £123

369 Easton, M, BBC Magazine, 'The Unbearable Sadness of the Welsh Valleys', 2013 [accessed via: <http://www.bbc.co.uk/news/magazine-23028078> (08/08/13)]

370 Edinburgh-based GP in evidence to the CSJ

million Drug Intervention Programme (DIP), that dealt with drug treatment for offenders, providing interventions for drug-misusers in the criminal justice system.³⁷¹ This represents 10 per cent of former drugs and alcohol treatment funding which can now be used for any purpose the PCC decides.

The discretion afforded PCCs means that they have the ability to invest more than ever in those programmes which reduce crime. This presents real opportunities to those organisations which can demonstrate their impact on offending. Given the links between crime and substance abuse, PCCs will be wise to invest in organisations that effectively and efficiently help people become drug-free and sustain their recovery. The key task for such organisations is to prove to PCCs that they are effective and therefore represent a sound investment.

Andy Winter, who provides abstinence-based treatment at the Brighton Housing Trust told the CSJ that the:

'PCC has been very positive about my stance on substance misuse issues locally...I am aware that she has much higher expectations regarding accountability on DIP money and this can only be a good thing.'

In constrained financial circumstances, providers of treatment will have to ensure substance misuse remains prominent is the focus of PCCs. There is a danger that resources will be used in the short term to plug gaps in other services, leading to long-term increases in drug and alcohol-related crime.³⁷² The Director General of the Crime and Policing Group at the Home Office wrote to Local Authority Chief Executives and the Mayor of London in February 2011 explaining that:

'ministers intend that other funding streams, including Drug Intervention Programme grants will be consolidated with Community Safety Funding for PCCs in 2013/14 and 2014/15 and thus provide them with a significantly larger unringfenced budget overall'.³⁷³

Not only is the budget for drugs and alcohol vulnerable to being spent in other areas, it is also being reduced. Despite the NHS 'ring-fence', no protection has been afforded to the former Drug Intervention Programmes (DIP). To date it has decreased 27 per cent, from £123 million in 2012/13 to £90 million in 2013/14.³⁷⁴

Commissioners will therefore need to be fully briefed on the wider impact of decisions which they might take.³⁷⁵ Rosanna O'Connor, now head of drugs and alcohol at Public Health England, told the CSJ about how crucial active engagement in substance abuse from PCCs will be:

371 Home Office, Community Safety Fund, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/143831/community-safety-fund.pdf 08/08/13]

372 DrugScope, *Police and Crime Commissioners – A briefing for the drug and alcohol sector*, London, DrugScope, 2012

373 Home Office, Community Funding Letter, 2011 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97891/community-safety-funding-letter.pdf 08/08/13]

374 Home Office, Community Safety Fund, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/143831/community-safety-fund.pdf 08/08/13]

375 Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012

*'clearly the linkages between these groups and local drug commissioning groups are key to the impact drug treatment has on reducing reoffending and will be of keen interest to PCCs.'*³⁷⁶

With the pressures of election cycles, some of those we interviewed in the course of our research are concerned that PCCs will respond to calls to invest in visible, uniformed officers at the expense of other areas of critical spending, such as addiction services. That PCCs are aware of the importance of tackling addiction is essential. Providers have a crucial role to play convincing them of this by demonstrating the effectiveness of their programmes in cutting offending.

4.3.2 Police and Crime Commissioners and enforcement

PCCs so minded may choose to use their independence to allow their areas to be seen as 'soft on drugs' and therefore become destinations for drug abusers from around the UK and their suppliers. As the Home Affairs Select Committee has warned, 'there is a risk that significant variations in the local approach to drugs could lead to geographical displacement of the drugs trade within the UK'.³⁷⁷

The danger of creating 'drug-friendly zones' where low-level supply and possession is allowed is already happening in parts of England. In Northumberland the PCC has decided that low-level drug use is not a priority for local police.³⁷⁸ The Northumberland Police and Crime Plan emphasises that it will prioritise organised crime but not the enforcement of drug laws below this level, for example lower level supply and possession. One Tyneside-based treatment provider told the CSJ 'if this acts as a green light to people to come here for drugs, it will undo years of work.' This de facto decriminalisation invites drug abusers to congregate in one area acting as a draw for suppliers.

4.4 Payment by Results

A further reform which has considerable potential to help tackle addiction by rewarding and driving effective practice is payment-by-results. Yet as presently constituted the drugs and alcohol Payment by Results (PbR) pilots do not reflect best practice. Instead success is being judged on a range of outcomes which do not emphasise helping people become drug free. The failure to focus on helping addicts become drug-free means the PbR pilots reflect the persistent lack of ambition in the treatment system it is seeking to improve upon. This flawed design has resulted thus far in poor results for these pilot projects.

PbR is seen by the Coalition Government as a key mechanism for public service reform including the drug and alcohol sector, and will test this approach to examine suitability for

³⁷⁶ Rosanna O'Connor, Head of Delivery, NTA now head of drugs and alcohol at PHE in evidence to the CSJ (15/02/13)

³⁷⁷ Home Affairs Select Committee, *Breaking the Cycle*, London: House of Commons, 2012

³⁷⁸ Northumberland Police and Crime Plan [accessed via: <http://northumbria-pcc.gov.uk/sites/default/files/plans/pcp/Police&CrimePlan2013-2018.pdf> (08/08/13)]

national use by Public Health England.³⁷⁹ The eight areas began their work in March 2012 and will report at the end of 2013. Rather than being paid on activity, 'providers are now rewarded for the outcomes achieved for the individual'.³⁸⁰ The aim of the programme is 'to test whether such an approach can help more people to break the cycle of dependence and achieve long-term recovery, with recovery having an impact not only for the individual, but also for their families and communities too'.³⁸¹

A Snapshot of the Drugs and Alcohol Recovery PbR Pilots³⁸²

Enfield has included more outcomes than those already mandated. As well as focusing on improved health and wellbeing, 'freedom from dependency', reduced offending and employment, training and education, it has included extra measures: 'Within the Health and Wellbeing domain include interventions relating to sexual health, child safeguarding, hospital presentations, mental health, smoking and other cardio-vascular disease prevention initiatives'.³⁸³

Wigan is continuing a PbR programme begun in 2009. 'In its first 3 years, a third of all people leaving the service did so either employed or in education, thus providing them with a foundation on which to build a new life outside of addiction'.³⁸⁴

Kent sees payment 'based on identifying and reducing risks not just around substance misuse, but other risk factors that affect the individuals, the people around them and the wider community incorporating education, training and employment, mental health, housing, safeguarding issues and criminal activities'.³⁸⁵

Wakefield will be delivering its PbR through its ARC project which sets 'out to achieve the locally agreed metrics for employment, training and education through three areas, each incorporated into daily service delivery. These include meaningful activities, in-house accredited education and externally accredited education. Meaningful activities include in house activities in Music, Art, Healthy Lifestyles, Mindfulness and Mutual Aid'.³⁸⁶

379 Home Office, *The Drugs Strategy 2010*, London: HMG, 2010 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf] (08/08/13)]

380 Department of Health Website [accessed via: <https://www.gov.uk/government/news/drug-and-alcohol-recovery-pilots-supporting-material-published>] (08/08/13)]

381 Department of Health Website [accessed via: <http://recoverypbr.dh.gov.uk/2012/03/08/go-live/>] (08/08/13)]

382 With thanks to Addiction Today for its original article 'Payment by results: Resisting Reform' [accessed via: <http://www.addictiontoday.org/addictiontoday/2011/07/breaking-the-habit-pbr-pilots.html>] (08/08/13)]

383 Enfield DAAT, *Payment by Results (PbR) for Drug Recovery Pilot*, [accessed via: <http://www.enfield.gov.uk/downloads/file/5889/daat-payment-by-results-for-drug-recovery-information-for-professionals>] (08/08/13)]

384 Department of Health Website *From our pilots* [accessed via: <http://recoverypbr.dh.gov.uk/2012/10/12/wigan3/>] (08/08/13)]

385 Department of Health Website *From our pilots* [accessed via: <http://recoverypbr.dh.gov.uk/2012/11/02/kent3/>] (08/08/13)]

386 Department of Health Website, *From our pilots* [accessed via: <http://recoverypbr.dh.gov.uk/2012/11/19/wakefield3/>] (08/08/13)]

Oxford is only working with some addicts in its area. It admits 'those who do not choose to work towards recovery can engage with the Harm Minimisation service, where a consultant-led medical team provide Opiate Substitution Therapy in a wide variety of setting including GP (shared care) practices'.³⁸⁷

Stockport had a PbR scheme running before the pilot's were even announced. It was set up in 2009 and therefore predates the 2010 strategy. The pilot has stated 'the majority of existing service users are satisfied with the service they are receiving, and will continue with their current treatment service'.³⁸⁸

Bracknell, in its most recent report said, 'although there have been some teething problems the Bracknell Forest Payment by Results pilot is still progressing well. Booking in regular reviews can prove challenging and with ever-growing caseloads we are trying very hard to make sure that people attend these reviews'.³⁸⁹

The results of the PbR schemes, as presently constituted, show that more needs to be done to ensure they focus on helping addicts into full recovery. The best residential rehabilitation centres have a 60 per cent success rate for getting addicts drug and alcohol free while the existing national success rate of all government-monitored programmes for getting addicts 'free of dependency' is 14 per cent.³⁹⁰ After a year the PbR pilots, all had worse rates of success than the existing treatment system, at 11 per cent leaving drug-free.³⁹¹

The design of the pilots is potentially responsible for failure. Firstly, it should be noted that the pilots do not aim to get someone drug-free; only 'freedom from dependence' which does not equate to abstinence from all drugs like cocaine, cannabis and alcohol. As seen in chapter 3, abstinence is regarded as the most effective goal by those that have the most success in treating addiction. As the CSJ heard from Jon Smith at the Bridge rehab in Birmingham, 'you need to get off drugs before you start the real work of recovery, even if you're off heroin, all the time you can retreat to something like cannabis or alcohol, you can't begin to tackle your deeper problems'.

Furthermore, the stated 'results' measured by the PbR pilots extend beyond becoming free of dependency on drugs and include issues like housing and the more nebulous 'quality of life'. This has diluted the goal of helping someone become free of their dependence and sustaining their personal development. Such dilution of aim has led to the poor results as PbR programmes are most effective when they have a focus.³⁹² The CSJ heard from Criminal

387 Department of Health Website, *From our pilots* [accessed via: <http://recoverypbr.dh.gov.uk/2012/07/20/oxford/> (08/08/13)]

388 Stockport Metropolitan Borough Council, *Payment by Results*, [Accessed via: http://www.stockportdrugsandalcohol.org/sto-content/uploads/2012/04/6241_PaymentbyResultsService_Leaflet_x500printed.pdf]

389 Department of Health Website, *From our pilots* [accessed via: <http://recoverypbr.dh.gov.uk/2012/10/22/bf3/> (08/08/13)]

390 National Treatment Agency for Substance Misuse, *The Role of Residential Rehab*, Department of Health, 2011. It should also be noted that 'freedom from dependency' is not the same as abstinence aimed for by residential clinics and therefore the true figure is likely to be an even larger gap in favour on residential treatment

391 Department of Health, *Performance of Payment by Results pilot areas: April 2012 to February 2013*, London, Department of Health, 2013

392 Russell Webster in evidence to CSJ

Justice and Recovery Payment-by-Results expert, Russell Webster, that the 'more outcomes, the more costly they are to measure and the greater potential for providers to focus on individual targets rather than long term recovery'.

Other pilots focus their 'results' more around housing and education without necessarily dealing with the addiction or its root causes, this risks the addiction resurfacing when support is withdrawn.³⁹³ As CEO of Action on Addiction (who do not run any pilots) told the CSJ, 'we were concerned by reports from some supposedly PbR arrangements that the outcomes were singularly un-ambitious'.

The design of the drug and alcohol pilots contrasts substantially with other government PbR schemes. The outcome for the Work Programme is clear, namely to get people into sustained employment.³⁹⁴ Similarly the Transforming Rehabilitation PbR schemes run by the Ministry of Justice aim to curtail reoffending.³⁹⁵ This clarity of purpose contrasts with the drug and alcohol recovery pilots which have nine national outcomes under three headings: free from drug(s) of dependence, reduced offending and, health and wellbeing.³⁹⁶ The commissioners in one pilot site, Enfield have set a total of 21 payment targets.³⁹⁷ Whilst all are important, they currently do not prioritise the necessary aim to help addicts become drug-free.

The CSJ has heard several other critiques from experts in the field of addiction and recovery. Some pilots, for example Oxford, have not included certain groups of addicts, such as those receiving GP prescribed methadone. The recovery or otherwise of these addicts will not form part of the PbR results in that area, despite being some of the toughest people to work with.³⁹⁸ It is unclear how the Government intends PbR to tackle addiction if some addicts are excluded.

As mentioned above in the discussion of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), some of the pilots do not involve change of commissioning personnel – leaving many people in charge of reform who, whatever the 2010 Drugs Strategy might hope, are not trained to deliver recovery.³⁹⁹

'You call up [the new department] and yet the same people answer the phone.'

Wendy Dawson of the Ley Community in evidence to the CSJ

393 Diedre Boyd of Addiction Today in evidence to the CSJ (30/04/13)

394 DWP, *Helping people to find and stay in work* [accessed via: <https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/managing-the-work-programme> (08/08/13)]

395 Ministry of Justice, *Transforming Rehabilitation* [accessed via: <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation> (08/08/13)]

396 NHS, *Payment by results*, [accessed via: <http://www.nta.nhs.uk/healthcare-pbraspx> (08/08/13)]

397 Russell Webster in evidence to the CSJ and Enfield Council [accessed via: http://www.enfield.gov.uk/downloads/file/5889/daat-payment_by_results_for_drug_recovery-information_for_professionals (08/08/13)]

398 Diedre Boyd of Addiction Today in evidence to the CSJ (30/04/13)

399 *Ibid*

Furthermore, the capital requirements excluded many smaller providers from bidding to run the pilots. Nick Barton of Action on Addiction told the CSJ, 'our main concern about PbR is the capital needed to manage the risk and the question of attribution'. This has excluded many of the smaller, innovative providers such as Acorn Treatment in Stockport from running the PbR pilot which is happening.

With a proven track record of helping people become drug and alcohol-free, Acorn hoped to bid to run the PbR pilot in Stockport. Due to the potential financial burdens imposed by the contract, Acorn did not feel able to take on the project. The result of this is that one of the best providers of addiction rehab, with extensive local knowledge, was prevented from bidding to deliver recovery for a community in need. John Hopkins of Acorn regretted that 'it's such a shame, we know we could have done a lot of good for people, getting them off drugs and into work'.⁴⁰⁰

It is concerning that this flagship scheme to deliver recovery from drug and alcohol addiction does not have that outcome as its main objective.

As was seen in Chapter 3, the need to establish that services aim to help addicts become drug free is crucial for their success. Without this aim, services can become fatalistic and condemn addicts to a life on drugs and alcohol. A statutory requirement for PbR payment to be made only if an addict becomes 'drug free', so-called 'gateway payments', would ensure all addicts received the best help to turn their lives around and begin contributing.

4.4 Conclusion

As set out in *Breakthrough Britain I*, sweeping reform to the drugs and alcohol treatment system was desperately needed. Previously, too often addicts were maintained in their dependence rather than helped to lead drug-free lives. It is essential that if the reformed services discussed above are to fulfil their full potential that they invest in services which focus on helping addicts to achieve full recovery.

⁴⁰⁰ John Hopkins in evidence to the CSJ

chapter five

Conclusion

This report has identified the barriers to tackling addiction and over the next year we will scour the country looking for ways in which those barriers can be removed.

Some recommendations are already self-evident, and indeed supported by those in power; what is urgently needed is the political will to see reforms through.

Those in treatment deserve the opportunity to achieve full recovery and become drug-free. With HIV threatening the nation in 1980s, Britain undertook bold measures – including the introduction of needle exchanges and the expansion of methadone programmes – to prevent an epidemic. Today, Britain has record low rates of HIV compared to western European nations like France or Italy. Similarly bold action is now needed to transform a system which protects broad public health to one that restores people's lives.

As we have seen, a great deal of alcohol dependency is effectively left untreated – despite the fact that it has an effect on a far greater number of families than any other drug. Helping to drive this has been an increase in the supply of cheap alcohol more abundant than at any time in recent history. This escalating problem requires urgent attention.

There is also a pressing need to tackle the rising tide of new drugs and so-called 'legal highs', the full dangers of which are not yet fully understood. Similarly, government and police must take immediate steps to tackle the new supply routes for drugs that are opening on the internet and radically changing the nature of the drug trade.

People who are dependent on drugs and alcohol are almost always dependent on other services too. These are people trapped outside the mainstream of society who, without assistance, will remain trapped. The tragedy of the present system is not that it does not intervene, it is that it often does so ineffectively. Too often heroin addicts are given alternative addictions. Too often alcoholics are given health services to help them recover from alcohol-sustained injuries but not services to help them beat addiction. In our next report, the CSJ will ask how the country can develop an addiction strategy which offers addicts a way out of the trap in which they find themselves and how more people can be helped to avoid the trap.

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