the state of the nation report

addicted britain

december 2006

About the Addiction Working Group

The Addiction Working Group's composition draws on a wide range of expertise in the field of drugs and alcohol addiction – involvement does not imply membership of the Conservative Party. The Group will report in the middle of next year June 2007. It will then present the Conservative Party with a set of options and recommendations for policy change while acknowledging what government on its own can and cannot effect. Further details of the membership of the working group are to be found in the final appendix.

Kathy Gyngell (Chair) is a Research Fellow at the Centre for Policy Studies
David Burrowes MP (Deputy Chair) is Member for Enfield Southgate since 5 May 2005 General Election
Professor Chris Cook is a consultant psychiatrist specialising in alcohol misuse with Tees, Esk & Wear Valleys NHS Trust.
David Partington is Director of the International Substance Abuse & Addiction Coalition,
Camila Batmanghelidjh, 'Woman of the Year' 2006, founded and runs Kids Company
Andy Horwood is Director of Doyle Training & Consultancy Ltd
Shaun Bailey runs 'My Generation' a youth community initiative on the North Kensington estates.
Russell White is a researcher with the Social Justice Policy Review
Rebecca Smith is Parliamentary Assistant to David Burrowes

Contents

PART TWO - SHATTERED LIVES, COLLATERAL DAMAGE

Foreword by Iain Duncan Smith

This Report documents the nature and full extent of alcohol and drug addictions in the UK. 8.2 million people in the UK have and alcohol disorder and over 350,000 children live in households headed by drug addicted families. A worrying development is that children as young as 11 are drinking and taking drug. Over 45% of 14 to 15 year olds have consumed more than 5 drinks on a single occasion in the last thirty days.

Government needs to invest money to improve drug rehabilitation for addicts rather than focusing its attention on short- term initiatives and political objectives. Addicts do not want replacement drugs but want a break from their cycle of addictions. The voluntary sector is carrying out great work in tackling drug addictions and support must be given for these organisations to carry out their work.

My thanks to Kathy Gyngell, and his committee, all of whom have worked incredibly hard to produce a detailed account of the reality of addiction in Britain today.

Rt Hoi Iain Duncan Smith MP

Foreword by Kathy Gyngell, Chairman of Addiction Working Group

The task of assessing the scale and nature of the problem of addiction in Britain today and of reviewing the government's policies in this field is a daunting one. The sources of evidence are multiple and new information comes into the public domain on almost a daily basis. Yet much relevant research has hardly been communicated beyond academic confines and the odd civil servant. Despite this there remains much that we do not know about drug using behaviour and its prevalence in the population.

The experience, insights and expertise of the members of the Addiction Working Group's have proved crucial in facing this challenge. Each of us has direct knowledge of the 'coal face' of addiction, either professionally, personally or both. Our combined 'work experience' in this field - Camila Batmanghelidjh's with children, Chris Cook's with treating alcoholism and psychiatric illness, Dave Partington as a drugs counsellor and founder one of the first residential rehabilitation centres in the country, Andy Horwood as a former substance misuse worker and Drugs Action Team coordinator and Shaun Bailey as a 'detached' youth drugs intervention innovator - is considerable. It has meant that our consultations and investigations have been informed by practical realities rather than by political orthodoxies, received wisdom or overly philosophical debate. Having David Burrowes, one the brightest, most committed and caring of the new intake of Conservative Members of Parliament, as the Deputy Chair has been and is invaluable. We owe much to Russell White, our researcher for much of the period, whose research initiative, analysis and speed of delivery have been exemplary and to Andy Horwood who has brought to bear his specialist research skills about this complex area of policy administration.. Rebecca Smith has organised our hearings at Portcullis House with great efficiency making each occasion a memorable and positive experience.

All members of the group have contributed to our process, by advising, researching and writing; by opening doors and providing contacts and by meeting a huge range of witnesses including former and recovering addicts, ex offenders, homeless, substance misuse workers, treatment providers, counsellors, lobbyists, academics and research and policy experts. This has provided a rich and invaluable source of evidence only some of which I could include in writing this interim report. A full analysis of it is not yet complete and this report should be read as 'work in progress'.

Acknowledgements

Since the group was established last February, we have spoken to, seen or visited the following people and organizations many of whom have submitted formal evidence to us.

We would like to take this opportunity to thank:

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Dr Sirri
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Benjamin Fry
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Executive Summary

London June 2006: a seventeen year old boy is admitted to a central London hostel for the homeless which also runs a methadone prescribing and needle exchange service. It is home to 90 older, predominantly male, methadone maintained but still substance abusing long term alcoholics and drug addicts - described as the hard to reach. The boy in question has been injecting heroin for four years since he was thirteen. He has been allowed to join his nineteen year brother who had also recently been admitted to the hostel for substance misuse. The substance misuse worker in charge said this was no place for these boys to be but there was no where else for them to go.

Evidence Taking Session

AN EXPLOSION IN ADDICTION

Britain is experiencing an explosion in addiction.

Alcohol consumption has doubled in fifty years and by 15% in the last five years alone. Alcohol is more than 50% cheaper than it was in 1980.[1] Young women have doubled their consumption of it in the last 10 years.

10% of the adult population smoke cannabis regularly. Unofficial records show regular cannabis users smoke between one and six 'spliffs' a day. One in ten of 16 - 24 year olds used hard drugs in the last month. Cocaine is used by one and three quarter million young adults, a number which has doubled in seven years.

In five years the price of heroin has dropped by 45% and cocaine by 22% . Cocaine and ecstacy are cheaper than 25 years ago. Drugs are cheaper and more available than ever before.[2]

The current scale of prevalence of alcohol and drugs is historically unprecedented in its combined presence in the population. Young adults are engaging in a new culture of intoxication.

Behind these drugs and alcohol headlines is the emergence and growth of a range of addictive behaviours and practices. Self harm and cutting, virtually unheard of ten years ago, are on the rise. Gambling is national addiction. Britain can also claim the dubious achievement of chalking up the fastest rise in the prescription of antidepressants and other mind-altering drugs to children in recent years: 361,832 prescriptions for Ritalin (for children diagnosed with ADHD) were written last year - licensed for children as young as six and reported to being given to some as young as three.

The "drugs and alcohol epidemic" is affecting young people

Children's alcohol consumption has doubled, not in the last 50, but in the last 15 years. 45% of 14 to 15 years olds now drink on a weekly basis; 10% Year 7 boys (11 to 12 year olds) binge drink on at least a monthly basis - 60% for boys by the time they are in Year 11. Many surveys show that girls are catching up and the consumption gap is narrowing. Today 26% of children have taken drugs compared with 5% in 1987. 4% have tried Class A drugs and 1% took heroin in the last year. In Scotland 3% of 15 year olds take drugs on a weekly basis.

Youth workers report that the majority of vulnerable children they are in touch with have a heavy dependence on cannabis while there are small but identifiable groups of 'crack addicted' children.

National statistics for both children and adults are likely to be underestimates as the prime drug-using subgroups - truants, excludees and children in care, the homeless and prisoners are not surveyed.

CONSEQUENCES OF ALCOHOL AND DRUG ADDICTIONS

Today in Britain nearly three million of the adult population[3] have some form of alcohol dependency and 8 million an alcohol use disorder. There are reckoned to be 1.72 million adult cannabis frequent users and 360,000 Class A or highly problematic drug users (more than likely underestimated). These populations overlap. Most drug users also abuse alcohol. Alcohol-related death and disease have

1 Part One: Chapters 1 and 2

2 Since the early and mid nineties the UNODC (United Nations Office of Drugs and Crime) and IDMU (Independent Drug Monitoring Unit) has noted widespread falls in the street price of drugs.

3 Adult population is defined as over 16 years old

doubled in 25 years - mostly linked to chronic liver disease, now diagnosed in ever younger people. Cirrhosis of the liver increased by 350% between 1970 - 98 alone.

Drug deaths have risen exponentially - a hundred fold since 1968 when there were just nine. Cocaine deaths have gone up 300% in five years. Today one in fifty of the estimated 123,000 plus injecting drug users are infected HIV Aids and one in two with hepatitis C - both these blood-borne infections, that the Government's harm reduction policy hoped to stem, are on the rise. Scotland is recording sharp rises in the number of 'newborn' addicts Specialist psychiatrists report that 80% of first episode psychiatric disorders, schizophrenia or schizophrenia-like illnesses, occur in either heavy cannabis users or cannabis dependents. Irreversible cannabis-induced schizophrenia is being diagnosed in adolescents and is no longer disputed. Research evidence points to a very high 'co-morbidity with mental health problems - 75% for problem drug users and 85% for those with severe alcohol disorders.

The calculable costs are massive. Twenty young people under the age of 18 are admitted to hospital each day diagnosed with conditions like alcohol poisoning. Accidents and injury cost the NHS in England £3billion a year in hospital services alone. Future health and social costs predicted on the basis of current substance misuse - including foetal alcohol and drug-related disorders - have to our knowledge not yet been computed.

'The British are delinquent drinkers' remarked Dr Gray Smith-Lang, on Newsnight recently, '20,000 funerals a year are avoidable'. He warned that "the next generation of alcoholics is coming along very nicely thank you."[4]

THE SOCIAL COST

The cost in terms of human misery is incalculable. The costs in terms of social and economic malaise may be unsustainable.

The impact on children.

Around one and half million children are growing up in substance abusing households - over a million with parents abusing alcohol and 350, 000 where there is drug-taking. Parental addiction or substance misuse leaves children neglected, un-nurtured, and exposed to abuse inside and out of the home and having to fight if they are to survive.

> I'm fed up because I've got no friends. I never go out because I have to look after my wee sister. There's no-one else there to care for her. Mum's always in the pub. I've got no life. I feel like killing myself.[5]

> When my dad left, my mum had to go out and work …. And she worked in a pub, and we were left to it really. The money went towards drink really, more than anything else. We were always scruffy, and I suppose rather than be picked on, I stood up for myself, so I soon gained a reputation as that sort of like fighting boy, and I was left alone. But it was something I had to maintain in order to get by.[6]

Child protection services, which were never set up to deal with substance abuse in families on this scale, are unable to cope with the problem. In the process children are scarred for life, families are destroyed; inter-generational harm repeated and communities corrupted

> That's how it was, everyone you know, their parents drink too much and beat their kids and all. So when people are on about people who beat their kids, you just think 'ah well, everyone gets beaten'. To me, you got beaten if your dad hospitalised you. As far as I was concerned, a kid getting beaten was actually beaten, beaten badly, because it was just the norm, from everything I saw - people committing crime and all of it, it was acceptable. And I suppose I put myself around those sort of people so I could justify my own behaviour.[7]

4 BBC 2 Newsnight 21st Nov 2006

5 Centre for Research into families and relationships Childline Scotland

6 Witness evidence from a former long term prisoner and addict

7 ibid

Impact on the cycle of deprivation

It is a key factor in a vicious spiral of emotional and economic deprivation. The reality is that children are subjected to repeating the chaotic and unpredictable behaviour of their parents. The pattern is one where one or both parents are drinking or taking drugs and are being abusive or neglectful to their children. In turn, those children are being propelled into substance abuse.[8] Substance misuse is likely to trigger truancy, truancy triggers educational failure, educational failure triggers unemployment and unemployment is a very high risk factor for increasing substance abuse. Unplanned children are often the bi product. Substance misuse appears to be as much a catalyst for family disruption and dysfunction as it is an outcome.[9]

> When I went to school I thought right I'll not get shouted at, I'll no' get hit and I'll no' get the rest of it and I'll no' see them taking drugs and I thought at school, at the same time, kinda thing, what's gonnae happen the day when I'm not in the house?[10]

The presence of a step parent is also undeniably a negative factor. 28% of 15 year olds living with a parent and a step-parent reported using drugs in the last month compared to only 18% of 15 year olds who lived with both parents. Our own polling data supports this finding.[11]

Drug misuse is perpetuating social disadvantage and is associated with definable social groups.

It is disproportionately prevalent amongst younger age groups and males. One third of those presenting for treatment for the first time are under the age of 24. Over 71% of clients presenting for treatment are male, only 28 % female.

- It has a high incidence amongst school truants and is a predictor of truancy rather than the reverse.
- Children in care are also dramatically more likely to use and abuse drugs and alcohol than the rest of their age cohort, one study showing almost three quarters, 73%, reporting smoked cannabis, 34% reporting smoking it daily, 10% admitting using cocaine and15% ecstasy within the last month. 10% had also used heroin and crack cocaine.
- Two thirds of young offenders are hard drugs users. It is of note that one third of young offenders have been in care and half have no qualifications at all.
- Over 50% of prisoners have used hard drugs and up to 70% of those going into prison have a pre existing drugs problem - 40% with severe dependence. More than half began drug using before they were 16, with 15 being the median age for starting cannabis, amphetamines following after, then heroin and cocaine with 21 being the median start age for crack cocaine.
- 88% of young homeless in London were found to take at least one drug and 35% of them to use heroin. 81% of the homeless surveyed by Crisis said that drugs and alcohol abuse had preceded their homelessness, that drug use was both a trigger of homelessness and prolonged it.

The impact of the epidemic of heavy drinking and drug-taking is particularly severe for the least well off - those who have the fewest resources to cope with addiction or to recover from it - hitting both inner-city and outlying estates the hardest. Young, predominantly single, under-educated and unemployed boys and young men are amongst the most badly affected and the most at risk.[12]

THE CAUSES OF THE EPIDEMIC

The underlying causes of this epidemic are inevitably complex, hard to measure or quantify and difficult to disentangle. The causes of the increase in heavy drinking include the deregulation of the industry and a failure of restraint on the part of the sellers or the buyers of alcohol. Sudden increases in licensed capacity, the cheapness and availability of alcohol along with a new tolerance of drunkenness, increasing social acceptability of a 'culture of intoxication' involving drugs as well and the growth of recreational club drug use, have played their part.

Witness Accounts

The reasons for the dramatic rise in drug use and abuse are even more complex and multi-dimensional. Witnesses

8 Part Two: Witness evidence
9 Ibid and Part Two: Chapter 4.7
10 Addicted Britain Chapter 5.3
11 You Gov Nov 2006 Social Justice Policy Group Polling
12 Part Two: Chapter 5.4

have cited psychological, social, economic and legal causes for the current epidemic. Abuse, poor parenting, lack of supervision and parental alcoholism - broken homes and unhappy childhoods - have been amongst the foremost. They have cited life -long institutionalisation - from being in care as children through to imprisonment as adults - with drink or drugs being a buffer against feelings. Counsellors cite pain and trauma rooted in childhood. Parts of the media, while highlighting aspects of this epidemic, have also played their part in glamorising celebrity lifestyles associated with drugs.[13] Some witnesses cited contemporary youth music and a violent and aggressive rap culture. Others argued strongly and passionately that criminalisation of drug use has driven both expansion of, and entrapment by, drugs.

Official Insouciance - Government Policy on Alcohol

Government policy though well intentioned and ambitious with regard to reducing drug harm if not that of alcohol, has failed: The government is guilty of a double inaction with regard to alcohol; There is a massive under-provision of alcohol-related funding and treatment facilities in relation to the scale of the problem. Dedicated spending by primary care trusts and local authorities to support alcohol harm treatment stood at just £217 million in 2003/4 (the last officially released figures). The Commission is in the process of taking evidence from those involved with alcohol addiction to find out what type of service provision and treatment is likely to have the best outcomes. So far both 'addicts' and counsellors report that the concept of 'harm reduction ' is misplaced and that for the 'alcoholic', abstinence, not the controlled drinking programmes often recommended by government funded services, is the route.[14]

It has also ignored the body of researched evidence that control of the population's consumption is the most effective way to reduce harmful and/or hazardous use of alcohol and alcohol dependence - a body of evidence that is backed by the majority of specialist doctors. One described the government of being guilty of 'official insouciance'.

Government Policy on Drugs; Treating Symptoms rather than the causes

The level of family breakdown and its consequent impact on children, is high both historically and in comparison to other EU countries. (This is dealt with at greater length in the reports from the Education Failure Working Group and the Family Breakdown Working Group.) The current structure of drugs policy is not targeted at those areas where drug and alcohol dependency are most concentrated and where children are most affected.

The drugs-harm reduction strategy of the last nine years, culminating in Out of Crime: Into Treatment cares only for the addict in terms of wanting to find a cost effective way of 'maintaining' him or her to reduce his re-offending rates. It has pushed treatment in the wrong direction, preferring maintenance (substitute prescription) to recovery.[15] 65,000 of those 'in treatment' in England are on prescribed methadone this year. Just under 60% of them are put on a static dose for at least six months.[16] At £4000 per client per year it offers no care for the addict as an individual trying to free himself from addiction. This method has had minimal impact on re-offending figures - the hypothetical savings claimed are questionable - and it has had a non existant impact on rehabilitation and recovery. The question is whether 'state sponsored addiction' is now replacing illicit drug addiction.

Government Targets undermine effective treatment options

The current system is unsustainable and driven by the National Treatments Agency's requirement to meet government targets. Backlogs will occur, waiting lists will expand and the current treatment system will have to place quotas on new entrants into 'treatment'.[17] While the massive expansion of administrative structures and commissioning systems has brought unprecedented numbers of problem drug users 'into treatment services' it has still left residential rehabilitation - the service proven to provide the most likely route to recovery - under-funded and running down.[18] The miniscule 2% of treatment provision currently ascribed to residential

13 Part One: Chapter 1.6

14 Part Three: Alcohol

15 Addicted Britain Part Three: Briefing Paper 2 - UK Drugs Policy A Critical Overview Part One: Treatment Policy and the Drugs Harm Index, Russell White. Our research has shown that the construction and use of the Drugs Harm Index as an overarching tool to measure policy success is flawed, based as it is on crime reduction and other health benefits. It misses the substantive 'immeasurable' social costs

16 Note that any point beyond six months is unmeasured although many clients stay on methadone indefinitely.

17 Part Three: Briefing Paper 4 - Drug Treatment Services in England (excluding prisons): An Analysis of Capacity, Provision and Efficiency, Russell White

18 Addicted Britain Part Three: Case Study 'Empty Beds' the group's research has highlighted an ongoing crisis in funding and referrals. In fact many agencies have already closed due to funding issues and current residential services have reported that they are having the worst occupancy rates in the last decade. This has culminated in a crisis for them leading to widespread closure and loss of capacity in the sector this year.

rehabilitation services is now, as result of pressures put on Drugs Action Teams, to 'up' the overall numbers going into 'treatment', likely to decline. Furthermore, misplaced policy objectives have led to a crisis where half the already very few residential rehabilitation beds - only 2,400 in the first place - are lying empty and the remaining half at risk.[19] The cost of a 12 week residential rehabilitation course at approximately £8400 is a proven investment for real returns for recovery.

Major and costly policy initiatives have not been evidence based.

The current implementation of Drugs Treatment and Testing Orders was based on an initial report that was described as 'inconclusive though promising'. The overall reconviction rate for the English study tracked two years after the initial pilot and published after the government decided to implement the strategy nationally, was 80%. So an expensive national roll out was implemented before the study and the publication of high attrition rates. While sounding good, it was inadvisable.[20] It has damaged the perception of the treatment system in the eyes of both substance abuse workers and of those trying to access treatment. [22]

Control of supply of drugs has been less than forceful and dominated by redefined targets. The numbers of Class A drug seizures show a drop of 11.8% to 2002. Total drug seizures between 1998 and 2002 similarly show a drop of nearly 10%. (14,410 seizures) This followed a six year period in which the number of drug seizures rose . The latest England and Wales statistics for 2003 shows a further significant fall in drug seizures (post a temporary rise between 2000 and 2002) The much-heralded Serious Organised Crime Agency will have little impact while the PSA (Public Service Agreement) drivers for supply-reduction management bear little relation to market penetration and little relation to street availability; and while border control remains so weak.[23]

DIRECTIONS AND SOLUTIONS?

The nature and the scale of the addiction problem, detailed in the main report, along with the failure of this Government's drugs strategy, suggests that prevention and intervention will be the underlying themes of the policy solutions proposed in the final report.. The Commission will be taking evidence on the best treatment practices for recovery outcomes for both alcohol- and drug-associated problems, with the aim of identifying those providers with the most successful track records and client endorsement.

19 Part Three: Case Study 'Empty Beds - A Crisis in Residential Referrals' Russell White

20 Addicted Britain Part Three: Briefing Paper 6 - A perspective on Drug Interventions in the Criminal Justice System, Andy Horwood

21 Part Three: Briefing Paper 6 - A perspective on Drug Interventions in the Criminal Justice System, Andy Horwood

22 Addicted Britain Part Three; Briefing Paper Number 5

23 Part Three: Briefing Paper 5 - UK Drugs Policy A Critical Overview Part Two: The Governments Supply Reduction Strategy, Russell White

Introduction

'ADDICTION'

Our remit is with addiction. It is a word that has only come into common currency in the last 50 years. We recognize it as a term relating to a series of behaviours that cause harm to the individual involved as well as to those around him or her and to society - be it gambling, alcoholism, drug abuse - prescribed or illicit - or anorexia, all of which have become a feature of modern life. Addiction is a problem that most people today have come into contact with if not directly experienced.

Addiction by definition is rarely defined by one substance though arguably the term has come to be overly identified with drugs. Alcohol and drugs are the foremost addictions affecting children today and have become part of an ever younger, and ever more destructive mass youth culture. As a result, increasing numbers of families are confronted with and devastated by a combination of addictions. For these reasons it becomes less and less credible to look at drugs and alcohol separately.

SEPARATE DRUG AND ALCOHOL POLICIES

Historically, however, governments have drawn up policies to control alcohol and drugs and their 'harms' separately. To date they have directed their main energies and resources towards specific 'wars on drugs', with alcohol 'harm reduction' strategies following on as the poor relation – to the dismay of under funded alcohol service providers. Whether the government has its priorities right is currently the subject of much dispute. The apparent failure of the government's approach to have any effect on the problem also has raised issues of debate about the priority given to crime and public health related 'harm reduction' measures rather than to the problem of addiction itself.

USE OF TERMINOLOGY IN THE REPORT

Accepted current usage (from academics through to policy makers and 'service' providers) appears to be the preferred term 'substance misuse' although this appears more to reflect political correctness than medical science or to be a product of dispassionate sociological analysis. The term presupposes that the other side of the misuse coin is a notion of acceptable or of 'alright' use. While this is broadly culturally accepted with regard to alcohol – though definitions as to where the dividing line comes will vary from person to person – this is not the case for illicit drugs.[2] The distinctions used here with respect to alcohol follow government guidelines and are to some extent arbitrary. But importantly these guidelines recognize 'dependence' as a definite condition. In the case of drug use the evidence base is much weaker and there are no parallel, medically approved standards of safe, hazardous or harmful use in relation to amounts consumed. Some drugs are deemed to be more powerfully addictive or toxic than others and this is reflected in their categorisation in a Drugs Harms Index which designates the level of criminal offence for their possession. There is no commonly held agreement about what constitutes safe and acceptable use of drugs.

Clinical psychiatrists have replaced the term addiction in relation to alcohol with the concept of 'dependence syndrome' and the major diagnostic systems in current international usage employ dependence terminology. Similar social distinctions have been employed in epidemiological analyses of alcohol 'misuse' prevalence. These are made between 'hazardous and harmful' users and 'dependent' users. However with reference to drugs 'usage' distinctions drawn are less defined (though different drugs are assigned diagnostic dependence values) and drug use or 'prevalence' is simply distinguished from what experts and commentators loosely refer to as 'problem drug use'. We have chosen to follow the terminology as used in the different sources we refer to and elsewhere follow current usage. Consistency has proved difficult.

ORGANIZATION OF THE REPORT

The first section **'The Self Harm Society'** reviews 'prevalence' - the extent and scale of alcohol and drug misuse in the population with historic and recent trends and examines the adequacy of the evidence base particularly for drug use in the population.

The second section **'Shattered Lives, Collateral Damage'** examines the costs, consequences and causes of the current levels and spread of 'substance misuse' - the impact on the individual, on children, on the family and the community. It reviews the public health and crime costs that are in the public domain and look ahead to future trends and problems. We include comments from key 'expert' witnesses, academics and practitioners who have given evidence to us to date.

The third section, **The National Drugs Strategy – A Pathway out of Addiction?** comprises a series of six briefing papers critiquing several aspects of current UK policy

and practice. The first essentially explains the National Drugs Strategy, the second sets out an analysis of the Drugs Harms Index used by the government to measure the reduction 'harms'. A third paper gives a perspective on the commissioning of drug treatment systems and the fourth analyses drugs treatment services – their capacity and provision. The final two papers examine the efficacy first of the government's 'supply reduction' strategy and secondly of its drug interventions in the Criminal Justice System in the form of the original Drugs Treatment and Testing Orders and Drugs Interventions Programmes. Each of the papers points to flaws in the policy as administered and the counter productive impact of bureaucratic requirements

INCOMPLETE

We are continuing to see expert witnesses. We have invited some 60 different 'service providers' from all sections in the field of alcohol and drugs treatment provision to tell us what is working and what is not working. We are still in the process of visiting treatment centres – from drop in centres, to structured day care to residential rehabilitation – from those services run directly by the Drugs Action Teams and Primary Care Trusts to those run by voluntary charities and providers. We have visits planned to both Holland and Sweden to see how their very different drugs policies work. We plan to start taking evidence regarding the role of 'prevention and education' as a possible policy focus.

The reason for reviewing our findings at this stage is to invite those involved in the formulation of drug and alcohol strategies, those engaged in the provision of treatment and particularly those whose views have been ignored in the past – the addicts, recovering addicts and former users themselves – to help find and effect the right policy solutions. It is also to invite them to draw to our attention other areas of concern and to assess the various approaches to treatment and prevention or suggest entirely new ones.

How to do this can be found on our website www.povertydebate.com on which our upcoming hearings and visits will be posted.

We hope our evidence when collecting and analysed will inform debate and find solutions pointing to alternative scenarios, actors and providers in the face of this unsustainable, damaging and costly cultural change.

Kathy Gyngell

Chapter summaries

Chapter One sets out evidence of UK trends in alcohol and drugs use showing a dramatic growth in consumption of both; and striking social changes in use especially for children, young people and women:

- Alcohol consumption has doubled to 8 billion litres per year in the last 50 years growing by 15% in the last five; it to be over 50% cheaper than in 1980 with wine spirits and Alco pops dominating recent market growth
- Nearly three million adults with some sort of alcohol dependency; over 9 million drinking above weekly guidelines; alcohol related death and disease doubling in 25 years and a 350% increase in liver disease between 1970 -98
- A doubling of consumption by young women in ten years, the gap between male and female drinking narrowing; massive expansion of licensed capacity; a new culture of intoxication.
- Drug use - from non existent to epidemic in 35 years with 11 million people having tried any drug, 4 million Class A drugs with 1.6 million cannabis dependents, 360,000 'problem users' but cannabis remaining the drug of choice. A 300% rise in cocaine use in the last five years; a 100 fold increase in drugs deaths since 1968 and a doubling of those on methadone substitution treatment since 1995
- A leap in cannabis use by school children between 1988 and 99 from 2% to 29% of 14 to 15 year olds. 19% of all school children using any drugs in the last year and the age band for drug use getting younger and widening.

Chapter Two sets out evidence of current prevalence and demographics of alcohol and drug use showing a) while this remains a predominantly young male problem the gender gap is less apparent amongst young people and hardly evident amongst children, and b) that drug use has a stronger correlation with low socio economic status than does alcohol use:

- Men (38%) are more than twice as likely to have any alcohol use disorder as women (16%)
- Six million under 25 year olds binge drink every week; 45% of 14/15 years drink on a weekly basis; older people drink the least; consumption has risen fasted amongst middle class women. Consumption is much higher in north England
- Drug use correlates with age, gender and class more than alcohol. The highest numbers of drug users are amongst young adults under 25. 45% have used drugs at some point. Half of all cannabis users are under 24. But the age band is widening.
- Drug use correlates with single status, lower socio economic status, being male and with unemployment. The male female ratio is roughly 45% men to 35% women. With opiates the difference disappears. It is regionally variable.
- Consumption data is poor to in existent with regard to drugs

Chapter Three sets out evidence about the prevalence of 'problem' drug use showing the demographics mirror those of drug use but that it is closely associated with being young and male, with offender, prisones, 'care leaver' and homeless population sub groups :

- Current estimates from treatment statistics are of 360,811 problem users in the UK, 287,670 in England and an overall 123,498 injecting drug users. Other surveys suggest much higher prevalence of dependency.
- Significant regional variation e.g. 30.8 injecting drug users per thousand in Glasgow compared to 2.8 in the Orkneys.
- Half of problem drug users are under 29 and nearly three quarters are male.
- Crack cocaine prevalence in London at 1.3% of population and four times higher than in general population; three times higher amongst men than women, with 60% also opiate users.
- Club goers, care leavers, young homeless, arrestees, young offenders, serious offenders have high drug use, often with alcohol. There are very high rates of dependency amongst prisoners with 39% having used both crack and heroin. (HIV is 15 times higher in the prison population than outside) Only 10,000 of the total prison population are sentenced for drug offences.

Chapter Four sets out evidence about children's alcohol and drugs consumption showing that after alcohol, cannabis is the drug of choice and initiation:

- 25% of all school children drink on a weekly basis and 45% of 14/15 year olds. Average consumption is 10.4

units a week. Children who begin to drink young cumulatively drink more as they get older. 10% of 11/12 year old boys 'binge drink' - more than 5 units in one go - on a monthly basis
- There is no gender gap; 15 years old girls are drinking more than boys.
- 12% of all school children used cannabis in the last year. By 15 it is 33% and the gender gap between boys and girls has closed.
- Cannabis use has not gone down since the introduction of the National Drugs Strategy and 'any drug use' has risen from just over 20% in 1999 to 28/9% in 2004 - with rises in cocaine, poppers and solvents. 1% of all children took heroin in the last year. Age of initiation appears to be dropping.
- Data about volumes of drugs consumed does not exist. Socio-economic data for drug and alcohol use is limited. Risk factors include truancy, family disunity and disruption and low family affluence and living in a deprived area
- Average age of initiation has dropped

Chapter Five sets out testimonies of former drug users, drugs counsellors, parents, magistrates, estate residents and children on the impact of substance misuse; the huge numbers of children affected; the multiple ways substance abuse creates cycles of emotional and social deprivation and cements or leads to economic disadvantage- through teenage pregnancy, damaged health and life chances and to crime particularly in those communities least resourced to cope:

- 920,000 children living with parental alcohol misuse at home; 350,000 with parental problem drug use - alcohol being a prime factor in domestic violence, abuse and child protection cases.
- Children who are exposed to multiple risk, neglectful, unpredictable parenting - the traumatic roots of destructive behaviour - emotional, cognitive and behavioural problems leading to their own substance abuse, poor educational attainment and offending - hidden harms that child protection services are not dealing with and the government is not responding to.
- Children who engage in early sexual encounters an experience early teenage pregnancy and sexually transmitted disease. 40% of sexually active 13 and 14 year olds are drunk or stoned at first intercourse. A 100 fold increase in new cases Chlamydia and gonorrhoea occurred since 1995 - 40% of those with gonorrhoea under 20 years old. 1,300 babies born with foetal alcohol syndrome each year.
- Profound consequences for truancy, educational failure and homelessness - 21% of homeless have been made to leave home because of their drugs or alcohol use.

Chapter Six sets out witness and research evidence as to why widespread use of cannabis by children and young people is so risky and socially damaging - for dependence and mental illness, for health - increased cancer risks, for educational performance and driving

- Growing evidence to suggests that early and regular marijuana use is associated with later increases in depression , suicidal behaviour and psychotic illness, and may bring forward the onset of schizophrenia
- Though impossible to prove causally research shows cannabis may significantly increase risks of subsequent poor school performance and, in particular, early school leaving

Chapter Seven sets out the estimated public health costs and impacts of alcohol and drugs for death, injury and disease - specific costs to the NHS and to hospitals, to employers plus recent estimates of very high crime costs

- For alcohol - £3 billion to employers and £3 billion to hospital services (not including Scotland). For drugs (GP visits, emergency care and mental health treatments) £1.3billion.
- Peak times in A&E Departments: 40% of all attendees raised blood alcohol level; 14% intoxicated; 43% problematic drinkers.
- Raised risks of brain damage, heart disease, cancer and early onset liver disease from alcohol. Raised risks of death from heroin and methadone.
- Alcohol is a factor in 47% of violent crime and more than 50% of victims of assault have been drinking and offences are concentrated around licensed premises. Drugs and alcohol contribute to the majority of homicides
- Drugs related crime costs put at more than £16 billion a year- plus the original academic computation of all costs (health, social and justice system) at £11.9 billion.

Chapter Eight sets out testimonies on the causes of the current drug misuse epidemic from academics, lobbyists, and former users and includes an interview extract with an ex offender on the role of prison.

- Psychological and social causes are cited: abandonment by fathers, abuse, poor parenting, lack of supervision and parental alcoholism - broken homes and unhappy childhoods. Life time institutionalisation -

from being in care as children through to imprisonment as adults - with drink or drugs being a buffer against feelings are commonly given reasons. Experienced counsellors cited pain and trauma rooted in childhood. The additional impact of a negative youth music culture impacting on damaged children is also cited. Others argued strongly and passionately that criminalisation of drug use has driven both expansion of use and entrapment by drugs.

Part Three sets out the double failure of the government with regard to alcohol policy and introduces our policy review of the role of the national drugs strategy - its failure offer a pathway out of addiction, concluding that an emphasis on 'harm reduction' serves to 'treat the symptoms' of drug use rather than its causes.

- Massive under-provision of alcohol-related funding and treatment facilities in relation to the scale of the problem and a deregulation policy which has ignored control of the population's consumption as the most effective way to reduce harmful and/or hazardous use of alcohol and alcohol dependence
- A progressive skewing of drugs policy since 1998 to meet criminal justice drivers, with the impact of creating a punitive, bureaucratic system which misses many of the key outcomes expected from treatment
- Hampering of aspirations for the co-ordination of treatment by changing policy priorities and a target-driven approach to implementation. Aspirations for the development of accessible services severely constrained through inequitable funding, leaving a 'one size fits all' model of treatment.
- Failure of control of supply of drugs policies and decrease in assets seized despite redefined targets
- Recent 'crime driven' developments and associated funding less evidence-based than policy-driven,

PART ONE
the self harm society

Preface

This first section sets out evidence of an alcohol misuse crisis and of a drugs epidemic both of which mirror a general spread of use through the population and particularly to younger age groups. This spread is characterised by 'poly substance abuse' and a new and 'acceptable' culture of intoxication in which alcohol and drugs co-exist.

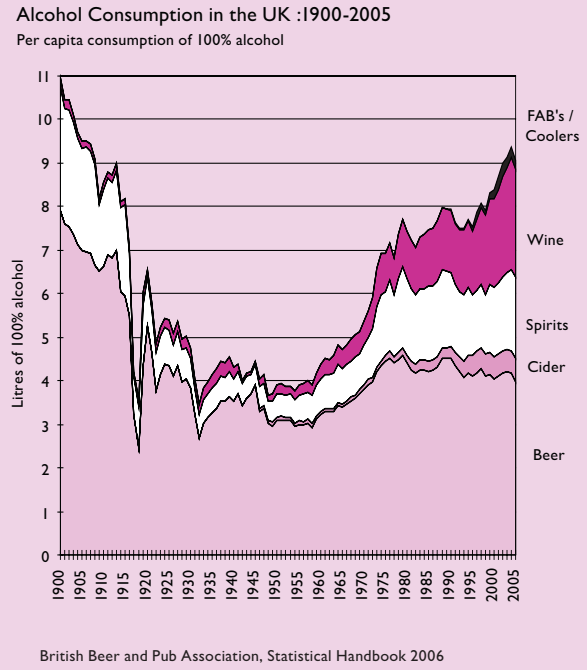
The rising use of drugs and alcohol by children, marks one of the most striking incidence of social change tohave taken place in less than two decades which as the Advisory Council on the Misuse of Drugs' recently published report 'Pathways to Problems' highlights the implications for future intergenerational harm and the increased exposure of children with addictive potential.

The appendix of European comparison tables attached at the end of this section indicates a problem in the UK that is rather worse than that experienced by most of our European neighbours. We have to ask the questions how has this come to pass and why.

Chapter One Alcohol and Drug Trends

1.1 THE UK POPULATION'S DRINKING BEHAVIOUR SINCE 1900

Overall per capita alcohol consumption in Britain has more than doubled in the period between 1957 and 2004.[1] A former prison governor has commented, "We are a country in denial about the scale of our alcohol problem"[2].



British Beer and Pub Association, Statistical Handbook 2006

The pattern of rising alcohol consumption in the second half of the twentieth century is in marked contrast to that of the first half which saw a per capita fall from around eleven litres per year in 1900 to just four litres after the Second World War. But this trend reversed in late 1950s with alcohol consumption rising sharply in the 1970's 80's and 90's. By the millennium per capita consumption had hit the 10 litre mark. Much of the increase was in the consumption of wine and spirits and more recently the consumption of Alco pops[3]. In 2001, three-fifths of the alcohol consumed was still beer but wine and fortified wine, (25% of the market), spirits (17%) and Alco pops (4%) dominated the growth in the market.

1.2 ALCOHOL CONSUMPTION IS CURRENTLY AT A HISTORIC HIGH

The last 5 years have seen a further sharp rise in alcohol consumption. The UK's alcohol market - with sales estimated at around £38bn – rose by a further 15% in this period and overall alcohol consumption broke through the 8bn litre-mark[4] fuelled by demand for wine. By 2004 some 88% of Britons drank alcohol during the year, ahead of the French at 86% and the Germans at 70%.

In 2003 the Cabinet Office Strategy Unit published Alcohol Use – How Much Does It Cost? The table below sets out the scale of the problem in exact population terms and the millions who drink above government weekly guidelines, and how many are heavy and dependent drinkers.[5]

Number of alcohol misusers in England - 2001

	Men	Women	All
Individuals drinking above government weekly guidelines	5,910,393	3,203,978	9114,371
Individuals drinking above government daily guidelines	5,201,708	3,439,693	8,641,401
Heavy drinkers	1,319,285	611,420	1,930,705
Dependent drinkers	2,242,785	591,039	2,833,824
Employed dependent drinkers	988,324	210,681	1,199,006

* Certain overlaps may exist among the different drinking catagories because these data come from different sources; as a result they cannot be added up to get a grand total

The psychiatric Morbidity Survey (ONS, 2001b) indicates that 29 in a thousand women and 119 in a thousand men aged 16 and over have some form of alcohol dependency as determined by the Severity of Alcohol Dependence Questionaire (SAD-Q) screening test. This translates into about 7.9 percent of the English population, or around 2.8 million (2,833,824) people in England aged 16 and over

1 IAS Fact sheet ibid

2 John Podmore, former Governor of Brixton Prison

3 Office for National Statistics (2005) Results from the 2004 General Household Survey (www.ons.gov.uk/ghs) and previous years

4 Mintel

5 Cabinet Offuce Strategy Unit , Alcohol Misuse: How much does it cost?

1.3 ALCOHOL IS RELATIVELY FAR CHEAPER TODAY THAN 25 YEARS AGO

Alcohol has become both more affordable and available. Although the price of alcohol increased by 24% more than prices generally between 1980 and 2003, households' disposable income had increased by 91% in real terms over the same period. Alcohol was therefore relatively 54% 'cheaper' in 2003 than it was in 1980.[6]

1.4 ALCOHOL RELATED DEATH AND DISEASE HAVE MORE THAN DOUBLED IN 25 YEARS

Alcohol-linked deaths rose in England and Wales over the same period, from 2,575 in 1980 to 6,614 in 2004.[7] Most were linked to chronic liver disease including cirrhosis. Mortality from all the commonly drink-related diseases soared during the 1980s and 1990s with rates for men doubling in Scotland and rising by two-thirds in England and Wales. Those for women went up by about half in the same period. By 2001 rates in England and Wales for liver cirrhosis deaths were 14.1 for men and 7.7 for women and in Scotland a massive 34.4 deaths per 100,000 per year among men and 16.1 for women, some of the highest rates in Western Europe. The British Society of Gastroenterology recently announced a 350% increase in cirrhosis of the liver had occurred between 1970 and 1998.[8]

1.5 PROBLEMS ARE GREATER IN THE NORTH THAN IN THE SOUTH.

Recent figures for 2004-6 published by the Centre for Public Health at Liverpool John Moores University and the North West Public Health Observatory found that across all of England, 18.2 per cent of adults drink at least double the daily recommended level in one or more sessions a week. Their analysis also showed that drinkers living in the North of England are far more likely to binge on alcohol, be admitted to hospital and die younger than their southern counterparts. Reflecting this pattern, hospital admissions for alcohol-related conditions in the North East and North West bear the biggest burden - with 1,100 men and 610 women admitted per 100,000 populations in 2004/05, compared with fewer than 700 men and 400 women per 100,000 in the South East.

1.6 WHO OR WHAT IS RESPONSIBLE FOR THE EPIDEMIC?

The social context of the consumption of alcohol has also changed dramatically since the 1950s when it was predominantly male and pub centred.

The period since has seen: successive extensions of licensing hours; liberalisation of licensing laws;[9] the widespread sale of alcohol on supermarket shelves; membership of the EEC/EU and an associated expansion of wine consumption; new producers of cheap wine from Australia to Chile; the introduction of Alco pops designed especially to appeal to younger teenagers; massive increases in licensed capacity and the emergence of a mass club culture.

Town centre licensed capacity has increased by over 240% in three years

The advent of the 'super pub' has concentrated the total licensed capacity in town centres. For example in the centre of Manchester it increased by 242% between 1996 and 1999 making for a licensed capacity of around 200,000.[10] These changes are mirrored by the growing participation of women, young women, adolescents and children in the drinking 'culture' and by the phenomenon of 'binge drinking'.

Young people are engaging in a new hedonism

Problematic alcohol consumption has increased dramatically in the recent past amongst young people generally (see fig 2 from ANARPS 2004) with 33% of young people between the age of 16 -24, the highest category of all, described as having an alcohol use disorder. Young people, on average, drink much more than older people. The average weekly consumption for young men (16-24) is twice as much as for over 65 year olds and the differences between women is even more marked.[11] A recently published international report on heavy drinking amongst students showed their inappropriate use of alcohol was of public health concern and that it was associated with those from affluent backgrounds and that young British women were amongst the heaviest drinkers.[12]

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6 ibid

7 ONS 2004

8 Care of Patients With Gastrointestinal Disorders in the United Kingdom: 'A Strategy for the Future' 2006

9 Licensing Act 2003 came into force 24th November 2004 - this the most recent of some 50 statutes since the Licensing Act 1964. Public entertainment licensing for areas outside Greater London was primarily governed by the Local Government (Miscellaneous Provisions) Act 1982, for areas within Greater London by the London Government Act 1963. The licensing of late night refreshment and night cafés was primarily governed by the London Local Authorities Act 1990, the Late Night Refreshment Houses Act 1969 and the Local Government (Miscellaneous Provisions) Act 1982.

10 IAS Fact sheet Drinking in Great Britain 2006

11 IAS Appendix A Estimating Alcohol Consumption

12 Dantzer et al, Journal of American College Health, Vo 55 September/October 2006

Binge drinking has become socially acceptable

In recent years harmful and hazardous drinking as well as being associated with these younger age groups has become characterised by 'binge drinking'. The term has gained currency referring to a high intake of alcohol in a single drinking occasion. According to the first-ever comprehensive EU-wide report on alcohol funded by the European Commission and written by the UK-based Institute of Alcohol Studies:

- The UK is one of the top bingeing nations in Western Europe, binge-drinking 28 times per year on average – about once every 13 days.
- UK adolescents are also the third-worst binge-drinkers in the EU, with more than a quarter 15-16 olds binge-drinking 3-or-more times in the last month.[13]

Teenage girls are more likely to binge drink than boys

Analysis of 2003 figures by the IAS suggests that teenage girls are now more likely than boys to binge drink – 29% of girls compared to 26% boys – and that Britain's girl binge drinkers are second only to those of Ireland.[14]

Young women have increased their consumption by 50% in ten years

Young women are fast catching up with men in each of the categories of alcohol disorder: the number of young women between the ages of 16-24 who consumed more than the recommended weekly intake has increased by over 50% in 10 years.[15]

A new culture of intoxication

The practice of binge drinking has paralleled the growth of a `culture of intoxication' involving the consumption of a range of psychoactive substances to achieve an altered state of consciousness.[16] This in turn is associated with the widespread availability of a wide range of illicit so called 'recreational drugs'. European comparisons tables for alcohol consumption are set out in Appendix Two.

The UK government's "official insouciance" about the quantities of alcohol now consumed.

Professor Robin Room of Stockholm University has pointed the finger at recent governments: "While beverage type ... and pattern of drinking might both affect the risk of developing cirrhosis, there is no doubt that the cumulative amount of alcohol consumed has a primary role. But the UK government has turned a determined blind eye to the problem and has failed to make the reduction of the population's alcohol intake a policy goal. Through the new alcohol licensing law and the official guidance on it, the national government has also done its best to tie the hands of local government on this issue."[17]

1.7 TRENDS IN DRUG USE: GROWTH AND SPREAD SINCE 1950'S

> "In 30 years the drugs problem has gone from nonexistent to an epidemic. If that can happen in a generation, what more can happen in the next 10 or 20 years?"
> *Professor Neil McKeganey, the Sunday Times, Scotland, June 11 06*

Drug taking at the start of the 1960's was a minority activity closely associated with a counter culture movement that involved experimentation with LSD and hallucinogenic drugs as well as the use of cannabis. The decade saw a spectacular and unprecedented spread of the use of cannabis in the UK and the western world generally and a spread of heroin addiction. In response the government of the day introduced the Misuse of Drugs Act in 1971 which classified drugs by their relative harms with associated penalties for possession and use.[18] By the 1980's, 'hard' drug use reached the urban poor, spreading through the housing estates and inner city areas, offering an alternative way of life that was far from benign and a far cry from the Woodstock haze of the flower power generation.

- In 1955 there were just 46 new opiate addict notifications to the Home Office Addicts Index; in 1966 there were 600; in 1996 there were more than 18,000
- 1968 to 2000 saw the number of opiate overdose deaths increase a hundred fold from just nine in 1968 to more than nine hundred in 2000. A threefold increase in incidence of opiate use prevalence between 1975-79 and a five fold increase between 1987 and 1995 (for the UK) has been calculated.[45]

13 ALCOHOL IN EUROPE IAS EU COMMISSION

14 Ibid and Dantzer et al International Study of Heavy Drinking JACH vol 55 no 2

15 ONS 2005, Results from General Household Survey 200

16 IAS Fact sheet

17 The Guardian Jan 06

18 This classification has continued to be the subject of intense debate as indeed has the "criminalisation" of drug possession and use

- By the 1980's research was charting a heroin epidemic in northern and Scottish cities as well as in London and county capitols like Norwich, largely amongst socially excluded working class males.
- 1988 to 1999 saw an exponential leap in the use of cannabis by schoolchildren from 2% to 29% of 14/15 years olds to have tried it.
- Today there are estimated to be 11 million people in the adult population who have ever tried drugs, some 1.6 million who have used drugs more recently (i.e. in the last year).[19]
- By 2002 1000 children in Glasgow were said to be living with parents who have drug problems.[20]
- By 2003 children formed 10% of new clients at drug treatment clinics in the Wirral.[22]
- By 2004 the National Drug Treatment Monitoring System identified 128,969 drug users in contact with services in England and Wales[23] of an estimated 360,811 adult problem drug users[24].
- By 2004 the number of deaths in that year relating to drugs poisoning reached 2596
- By 2005, 19% of pupils aged 11 to 15 were reported to have taken drugs in the last year.[25]
- By 2005 4 million people (1 in 8) are estimated to have 'ever' used Class A drugs; one million (1 in 31) used Class A in the last year[26]
- By 2006 one in 50 injecting drug users were infected with HIV Aids[27]

1.8 PRESCRIBED DRUG USE TRENDS

Prescribed drug use since the 60's has matched the growth of illicit drug use which, in the case of benzodiazepines had led to widespread prescribed drug dependency problems.[28]

1.9 RISES IN CANNABIS, COCAINE AND ECSTASY - BETWEEN 1998 TO 2004:55

- Cannabis rose by 2.9 per cent of the population from 26.8 to 29.7 per cent
- Cocaine rose by 3.3 per cent from 3.7 to 6.0 per cent with a significant rises in those having used cocaine in the last year and the last month
- Ecstasy rose by 2.5 per cent from 4.2 to 6.7 per cent in this period.
- By last year it was estimated that one in ten of the population had used cannabis followed by one in 50 using cocaine and one in29 using ecstasy.

1.10 AGE-RELATED DRUG USE TRENDS

- The age band for drug use is widening - drug use among 34-44 year olds has risen and remains above the national average
- Declining cannabis use amongst the 16 -24 age group by over 3% in three years – from 16.6 to 13.1 for last month usage[30] (The total number of 'lifetime' cannabis is still over two and half million of 16 - 24 year olds. The BSC does not track younger children).
- Significant recent rises in Class A drug use amongst age groups over 20 and amongst men.
- A rising number of over 45-year-olds being treated for heroin addiction in England - from 11,475 to 13,015 between April 2004 and March 06 by 13 per cent according to the NTA a period in which the total number of over 45s treated in England rose by 1,012 to 23,191.[31]

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19 De Angelis, Hickman and Shuying Yang; Estimating Long-term Trends in the Incidence of Opiate Use/Injecting Drug Use; American Journal of Epidemiology, Vol 160, No 10 (for the UK)

20 UK Focal Point 2005/ BCS Drug Misuse declared 2004/5

21 Glasgow's principle officer for addiction

22 10 Years of Drug Use Epidemiology in Merseyside and Cheshire, Centre for Public Health at Liverpool John Moores University 2003

23 The majority of whom are prescribed methadone, an opiate derivative.

24 The most authoritative country estimates are as follows: For England the total problem and drug injecting population in 2001 was 287,670 , 100,000 of whom were thought to be living in London alone. In Scotland the prevalence of problem drug use (defined as heroin and benzodiazepine use) in 2003 was estimated to be around 51,582 - a significantly higher percentage of the small Scottish population. The prevalence of problem drug use in Northern Ireland is markedly lower than the rest of the UK but that of Scotland markedly worse. The Scottish problem drug use situation is estimated to be one and a half times worse than England with some areas in Glasgow reaching 3 to 10% prevalence. The higher prevalence in Scotland is not due to better data collection according to informed sources. The degree to which false names and initials are used or the extent of accessing more than one doctor further add to the unreliability of the basic data. The larger drug problem in Scotland appears more likely to be due to the fact that it has a 'longer history' than England. Indeed it may herald what will happen in the rest of the UK.

25 Drug Use,Drinking and Smoking Amongst Young People in England, 2005 Headline Figures

26 UK Focal Point ibid

27 Shooting Up Infections amongst injecting drugs users in the UK 2005, An Update October 2006

28 Over Prescribing of Benzodiazepines:Problems and Resoultions C Heather Ashton; (3rd Annual Benzodiazepine Conference, Bangor, Maine, October 11, 2005) A campaign group called beat the Benzos was founded in 1997 - the group claim that up to 1.5 million people have been affected

29 UK Focal Point 2005

30 See Appendix for BCS charts

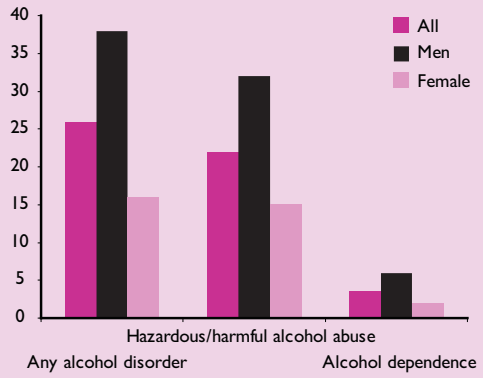
31 PA July 23rd 2006

Chapter Two Alcohol and Drugs: Prevalence and Demographics

Alcohol is the United Kingdom's drug of choice. Alcohol dependence, or what is commonly understood as alcoholism, is the tip of an iceberg of more widespread hazardous and harmful drinking in the population across age, gender and social class.[32]

2.1 ALCOHOL DISORDER, HAZARDOUS DRINKING AND DEPENDENCE BY GENDER

Percentage of people in England with an alcohol use disorder, broken down by category of problem drinking and gender[60]



The stark nature of men's relationship with alcohol and the high percentage of all men with an alcohol use disorder are identified in the table below taken from the summary findings of the 2004 National Alcohol Needs Assessment Report Project led by Professor Colin Drummond:

- 38% of men and 16% of women (age 16–64) have an alcohol use disorder (26% overall), which is equivalent to approximately 8.2 million people in England.

> I think we're something in the order of 6% for the prevalence of male alcohol dependence. But the issue for alcohol, more so than for drugs, is that there is a continuous spectrum. So, dependence isn't an all or nothing phenomenon - some of us are not dependent at all, of course, but you can be a little bit dependent, a medium bit dependent, or a lot dependent;, so it depends where you draw the line, how you define your categories. We're certainly talking in terms of hundreds of thousands of people with serious alcohol problems, and if you draw the line more broadly you're talking about millions.
>
> *Professor Chris Cook*[33]

- 21% of men and 9% of women are binge drinkers. 22% of men between the ages of 16 and 65 exceeding the daily benchmark for heavy levels of drinking.
- The prevalence of alcohol dependence overall is 3.6%. 6% of men and 2% of women meet these criteria. This equates to 1.1 million people with alcohol dependence nationally.[34]

2.2 ALCOHOL DISORDER ETC BY AGE

- Almost six million people, mainly under 25, binge drink every week according to the Government's own alcohol harm reduction strategy.[35]
- Teenagers and children are drinking to dangerous lev-

32 For a considered discussion of terminology and its meaning see Chap 2 Alcohol, Addiction and Christian Ethics, Christopher C.H.Cook, Cambridge University Press 2006

33 Formerly Professor of the Psychiatry of Alcohol Misuse at the University of Kent; interview evidence

34 ANARP DoH 2004

35 Alcohol Harm Reduction Strategy March 2004 Cabinet Office

els. Over 45% of 14/15 year olds are estimated to have drunk alcohol in the last week. One survey showed 54% of 15-16 year olds to have consumed more than 5 drinks on a single occasion in the last 30 days and that 27% of them reported doing this 3 or more times within the last 30 day period.[36]

- 3,322 children aged between 11 and 15 were admitted to hospital for alcohol-related problems in 2004 according to Department of Health figures.[37]

2.3 ALCOHOL DISORDER BY CLASS

- There are no statistically significant associations between overall alcohol consumption and occupational groupings.
- If anything alcohol consumption has risen fastest amongst middle class women and particularly young women[38].

> The enormous popularity of alcohol – our 'favourite drug' can make wise evidence based policies politically unattractive. Government and industries gain economic benefit from the production, sale and taxation of economic beverages. Alcohol is a profitable commodity. It is also a cause of social and medical harm. It is not enough that debate about matters of production, distribution and consumption are conducted simply in terms of scientific opinion, political expediency and consumer choice. Alcohol policy should also be based on soundly reasoned ethical principles.
> *Professor Chris Cook*[39]

- Hazardous alcohol use is associated with prison populations. A large proportion of both male and female respondents reported hazardous drinking in the year before coming to prison. Among the men, 58% of remand prisoners and 63% of sentenced prisoners reported hazardous drinking; including 30% in both sample groups with scores which indicate severe alcohol problems. The equivalent figures for the women in the sample were 36% of remand and 39% of sentenced prisoners reporting hazardous drinking including 14% and 11% respectively with scores suggesting severe alcohol problems in the year before coming to prison.[40]

2.4 OFFICIAL SOURCES - FINDING OUT ABOUT DRUG USE

The official annual statistical sources for population drug use prevalence for England and Wales are the Crime and Justice Survey (for England and Wales alone) the Scottish Crime Survey, the British Crime Survey for the UK, the Scottish Adolescent Lifestyles Survey and the Schools Survey for England and Wales: 'Young People Drinking and Smoking in England and Wales.' The British Crime Survey is based on a national sample of some 29,000 with a 'youth boost' for the 16 -24 age group of some 2000. It has added in its most recent report additional tables on prevalence of use amongst former truants and excludees.[41] It shows that truanting males have higher significantly higher cannabis use than 'non truants' in the 16 -24 age group (23.3% compared with 17.1% last month usage)

These surveys provide limited information about the relationship between age, gender, drug choice and frequency of use. They provide no information on volumes consumed. and tell us very little about drug consumption behaviour – the survey questions are limited to 'ever or lifetime' use, 'last year' use, and 'last month' use

2.5 AGE AND SEX ARE OF MORE SIGNIFICANCE WITH DRUGS

- Young adults under 35 are significantly more likely to use drugs than older age groups.
- Amongst those who are under 25 years old, prevalence rates are even higher.[42]
- 27% of the latter are estimated to have used one or more drug in the last year and just under 17% have done so in the last month.[43]
- Those between the age ranges of 16-34 have a higher than average drug use (both any and Class A) and of note is that this highest prevalence age band is widening.
- Over 45% of both 16 -24 year olds and 16 -34 year olds have used drugs at least once during their lifetime
- But the following table indicates frequency of use is higher in the younger part of this 16 -24 age band.

36 Hibell, 2004
37 Recently acknowledged by Patricia Hewitt, Secretary of State for Health to be of great concern. Times October 28th 2006
38 Charaterised by the lager louette culture
39 Substance Misuse amongst Prisoners in England and Wales 1997 ONS
40 Alcohol, Addiction and Christian Ethics, Christopher C.H. Cook CUP 2006
41 ibid
42 United Kingdom Focal Point Report 2005
43 ibid

- Drug use is a predominantly male activity especially amongst younger age groups
- 44.6 of young males have used cannabis compared with 35% of young women
- Across all age groups this ratio of males to females is the norm
- The male female divide is in evidence with cocaine and crack cocaine use as well as with ecstacy.
- Only with opiates and particularly methadone does the difference disappear

2.6 CANNABIS IS BY FAR THE MOST POPULAR AND FREQUENTLY USED DRUG BY 16 -24 YEAR OLDS

The next table breaks down prevalence of use of the different drugs from the four main survey sources of information and their sample size for the highest using group – the 15/16 – 24 year old age group

- It shows cannabis to be by far the most popular drug with over 40% of this age group to have ever used it and 24.5 in the last month
- Nearly half of this 'young people' population, 2.75 million (45.8 per cent), are estimated to have used 'any' drug in their lifetime and of these nearly one million (15.8 per cent) Class A drugs.
- 1.6 million (26.3 per cent) of them used drugs in the 'last year' while just under half a million (8.1 per cent) used Class A drugs.
- Nearly 1 million (16.3 per cent) of 16-24 year olds used 'any' drugs in the 'last month' and of these just over 200,000 (3.7 per cent) had used Class A.

Illicit drugBritish crime surveyNorthern ireland crime surveyScottish crime survey United Kingdom estimate

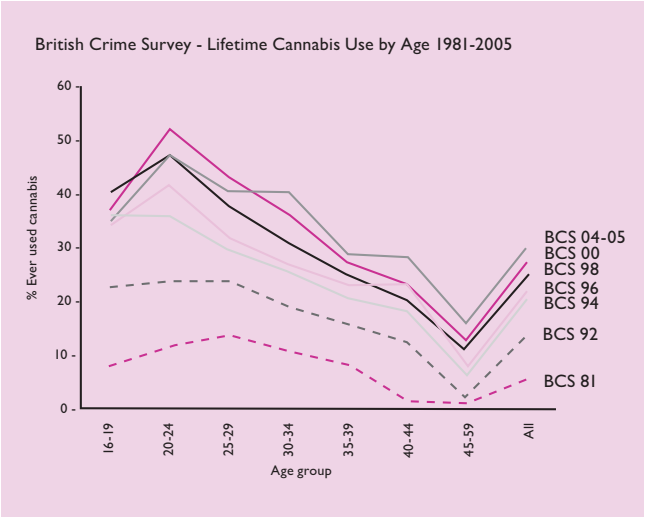
	16-24 year olds	16-24 year olds	15-24 year olds	16-24 year olds	15-24 year olds
Lifetime prevalence					
Any drug	46.6	40.1	28.5	39.8	45.4
Amphetamine	12.4	14.1	6.5	13	12.3
Cannabis	41.3	30	24	37.7	40.4
Cocaine (including crack)	9.1	5.4*	2.6	10.8	9
Ecstasy	10.7	15	10.2	1.3	11
LSD	9.2	4.9	7.8	6.1	4.5
Magic mushrooms	6.6	4.2	4.9	5.6	6.4
Last year prevalence					
Any drug	27.8	24	14.5	25.9	27.2
Amphetamine	4	1.7	2	3	3.8
Cannabis	24.8	18.6	12.1	23.1	24.3
Cocaine (including crack)	5	2.5*	1.4	5.1	4.9
Ecstasy	5.3	7.1	4.8	3.9	5.3
LSD	0.8	0	0.2	0.3	0.8
Magic mushrooms	2.7	0.7	0.7	0.3	2.4
Last month prevalence					
Any drug	17.3	16.2	14.5	25.9	27.2
Amphetamine	1.6	0.1	2	3	3.8
Cannabis	15.6	2.6	12.1	23.1	24.3
Cocaine (including crack)	2.7	0.3*	1.4	5.1	4.9
Ecstasy	2.5	1.2	4.8	3.9	5.3
LSD	0.4	0	0.2	0.3	0.8
Magic mushrooms	0.8	0.2	0.7	0.3	2.4

Data for Scotland ar efor 2003, data for England and Wales for 200/04, crime survey data for Northern Ireland are for 2002/03

* The Cocaine figures for the Northern Ireland Crime Survey do not include crack.

Source: Chivite Matthews ate al (2005); Hay (2005); McMullan and Ruddy (2005); National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit (NACD and DAIRU 2005); Northern Ireland Office (NIO 205); Scottish Executive Office (2005)

- It is estimated that one in ten use Class A drugs frequently i.e. at least once in the last month.[71]



2.7 CANNABIS IS THE MOST POPULAR DRUG FOR ALL AGE GROUPS

- 1,752,000 of the 16 - 59 age group are estimated to have used cannabis last month (just under 10%) and of that 855,000 of 16-24 year olds (2005 BSC data). It is significantly ahead of any other drug use. The overall prevalence of use has risen dramatically since BCS data was first collected in 1981.
- An Independent Drug Monitoring Unit analysis of 7 successive British Crime Surveys from 1981 produced an estimate of 15 million people in the UK as having tried cannabis and between 2 to 5 million as regular users – a statement which itself reveals the massive uncertainty about its prevalence. [45]
- The fastest rising trend is amongst older age groups as there is continuation of use as the original populations of cannabis get older, see IDMU graph below.[46] The table also shows a consistent chronological rise in total population use since 1981.
- Information collected over the years indicates that the gap between male and female us is narrowing as women users are catching up.[47]

2.8 AMOUNTS OF CANNABIS CONSUMED

The British Crime Survey, which only give us 'ever use', 'last year' and 'last month', is totally inadequate for providing data on patterns of cannabis use and the amounts consumed. The main source of information about this is unofficial, and is from the Independent Drug Monitoring Unit's self selected sample of 16,000 cannabis smokers.

- The majority of the IDMU respondents smoke between one and 6 'spliffs' (joints with tobacco) a day and report that smoking up to 20 a day is not uncommon. They reported smoking twice as many at weekends than at weekdays. A further section reports one in twenty of the users smoking one ounce of cannabis a week and one in a hundred 2 ounces.[48]
- Recent academic research indicates that men are more likely to abuse and be dependent on cannabis than women.[49]

2.9 FACTORS WHICH 'PREDICT' DRUG USE

- **Being young male and single**. Overall, males are significantly more likely to report drug use than females: the reported lifetime prevalence of any illicit drug is 39.9 per cent for males and 28.2 per cent for females (Hay 2005a) but this difference varies according to age group and is significantly less marked amongst those in their teens. The survey shows the factors strongly associated with Class A drug use are being: young, male and single (though not including being a widow/er).
- **Regional Variation**. Drug taking varies region by region and town by town. The West Midlands has the lowest use of Class A and any drug use while the North West has the highest any drug use and London has the highest Class A drug use. Areas in certain towns are known to have been blighted by drug use – for example Moss Side in Manchester and Dalmarnock in Glasgow. Epidemiologists of drug use have described a wave effect or an epidemic pattern.
- **Lower socio economic status**. Higher drug use is likely to be related to lower socio economic status as well as to youth. The UK Focal Point report points out that drugs are strongly correlated with socio-economics but that the funding is not there to do more detailed analysis[50].
- **Living in a terrace or flat/maisonette or privately renting** 23.9% compared to those who were owner occupiers 9.4%

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44 Drug misuse declared: Findings from the 2004/05 British Crime Survey (London, Home Office, 2005)

45 Cannabis Use in Britain Matthew Atha 2005 IDMU Publications The IDMU regularly surveys a self selected sample of 16,000 cannabis users. The survey is based on questionnaires distributed at venues likely to attract cannabis users. It is not representative.

46 ibid

47 ibid

48 Ibid. This sample cannot however be assumed to be representative of cannabis users generally.

49 Grant, Scherrer et al Addiction 101 1133 -1142

50 UK Focal Point 2005

- **Unemployment**. Those who are unemployed were more likely to report drug use in the last year (23.5%)[51]
- **Club-going**. There was a higher prevalence of drug use amongst those who had recently been to a club or a disco compared to those who had not defined as visiting pubs or wine bars three times or more a week or visiting a nightclub.[52]
- **Being single, divorced, cohabiting**; single respondents (24.7%) and those who are cohabiting (18.4%) were more likely to report drug use in last year than other groups or in a household with no children or as single adult with children.[53]

2.10 THE EVIDENCE BASE – ITS LIMITATIONS

By its own admission: "the BSC does not cover some small groups potentially important given that they may have relatively high rates of drug use. Nor, in practice, will any household survey necessarily reach those problematic drug users whose lives are so busy or chaotic that they are hardly ever at home….."[54] Unlike its American counterpart[55] the BSC is exclusively household based, not sampling marginal, homeless or institutionalized members of the population – particularly those in prisons; halls of residence or the armed forces.

- The British Crime Survey gives no separate breakdown for the use of opiate drugs. The assumption must be either that it is not worth asking questions about heroin, methadone or crack because of the small sample base or that their use is not likely to be reported.
- Academics have had to use opiate related mortality statistics trends making 'back calculations' in order to try to establish trends in opiate use prevalence. These are calculated with some difficulty.[56]
- The very limited information regarding frequency and volume of use provided by the BSC make it a weak tool for tracking drug use and for providing data for the government to measure its policy targets against. Problem drug users remain an elusive population. Household surveys tend to invite 'underreporting' in the case of alcohol they are likely to do so for drugs. Given the dramatic rise of drug use over the last twenty years and the problems arising from it, there is a need for a far better data base – possibly with some 'imaginative' new methods of collecting and collating information which parallel the collection of alcohol data from hospital sources for example.
- BSC provides only a limited breakdown of information on social correlates particularly occupational groupings. This is surprising since socio economic appear to be strong predictors for drug use.
- Similarly the frequency of use data – by ever or 'lifetime' use, last year use and last month use is totally inadequate for establishing any type of needs assessment or the extent of the problem of drug use with in the population. It would be regarded as totally inadequate information for alcohol use.
- This data deficit is particularly marked in relation to cannabis given its penetration of the population and that diagnostically it is recognized as a drug which can lead to dependency and other medical disorders.
- There is also a data deficit regarding cumulative consumption – we know from research that the cumulative consumption of boys from fatherless families is likely to be six times higher by the age of thirty.[57]
- There is also a national data deficit regarding the combined use of alcohol and drugs in the population, also regarding those who enter a long (above 6 months) spell of unemployment, who are likely to see an 80 to 90% rise in their cumulative cannabis consumption.[58]

All these gaps have profound implications for any 'needs assessment' regarding the extent of hazardous use and 'addiction' or dependency on any and all drugs in the population, treatment provision and to whom it should be targeted.

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51 Ibid

52 Ibid.

53 BCS(Chivite-Mathews et al.2005) UK Focal Point 200

54 ibid

55 Drug Misuse Declared: Findings from the 2004/5 British Crime Survey

56 In the USA the NSDUH is the primary source of statistical information on the use of illegal drugs by the U.S. population. Conducted by the Federal Government since 1971 it is a far more detailed survey of behaviour and correlates. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence; it collects information from residents of households, non institutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Special surveys cover persons excluded from the survey and include homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals.

57 De Angelis

58 ibid

Chapter Three Prevalence of 'problem' drug users

What constitutes 'problem' drug use and how or at what point it differs from 'recreational' or non problematic drug use appears to have no medically and socially defined threshold.[59] Rather it appears to be a product of an assumed shared cultural value that up to some unspecified level of use 'recreational' use is not a problem.[60] Thus 'estimates' of 'problem' drug use are neither based on detailed information about volume or frequency of individuals use, or on notions of 'hazardous use' or 'dependency', but on the presentation of clients who want help and treatment. But problem drug users represent an elusive population and will not necessarily present for treatment. Despite this certain extrapolated numbers have become part of an apparently firm evidence base for identifying the scale of problem drug use. Our review of the data to date is based on trawls of Home Office Research, discussion with academic experts in the field and other academic research and literature.

3.1 OFFICIAL ESTIMATES OF 'PROBLEM' DRUG USERS

The National Treatment Agency have acknowledged that the current methodology for understanding the prevalence of problematic drug users is inadequate.[61] Uncertainties relate to both the basic data source and to different ideas or approaches as to how best to make estimations or extrapolations from that limited base data.[62] The following 'official' figures must be understood in this context:

- The UK as a whole is estimated to have in the region of 360,811 adult problem drug users.[63] For England alone the figure of 287,670 is used to inform the European Monitoring Centre for Drugs and Drug Addiction.
- The number of injecting drug and opiate users is hugely variable regionally. The accepted current estimate is that there are 3.2 injecting drug users per thousand of the population giving a total estimate of 123,498. Enormous regional variation is demonstrated by prevalence research in Scotland, where figures range from 2.9 in the Orkney Isles to 30.8 per thousand in Glasgow.[64] Injecting as chief means of administration also varies between the countries of the UK; only a quarter of clients reported having ever injected in Northern Ireland, compared with the much higher level of 59 per cent in England and Wales.[65] Regional differences themselves change over time. A wave effect has been described – up in one area, down in another or the drug of choice or availability changing regionally or between urban and rural areas
- In Greater Manchester, for example, estimates of local prevalence of problem drug use are 13.9 per thousand of the population aged 16 to 54 years old totaling 19,255.[66] One local prevalence study (using the capture/recapture method deemed to be the most reliable) in Sandwell, found opiate and/or cocaine use estimated to be 21.12 per thousand of the population aged 15 to 64 or 3,773 people (with a 95% Confidence Interval of 15.93 to 28.84).[67]
- Heroin remains the number one 'problem' drug although there has been a more recent sharp rise in cocaine-based drugs. Two thirds of clients (66.2%) presenting to treatment in the UK cite opiates as their main drug. In Scotland diazepam (rarely reported elsewhere in the UK) has been the second most commonly used drug.
- In Northern Ireland, where overall drug use is much lower, nearly half clients accessing treatment reported cannabis as their primary drug problem (51.7%) with less than a quarter (20.3%) reporting the use of opiates as their primary drug. Cannabis is rarely reported elsewhere in the UK as the primary drug used by

59 Unlike the government's medically defined guidelines for safe consumption

60 Godfrey at al HORS 249 The Economic and social costs of Class A drug use ..

61 NTA Business Plan 2005/6

62 ' Obtaining information on the prevalence of a hidden and stigmatised activity is not an easy task. Whilst it is possible to obtain information on the prevalence of cannabis use through a cross sectional survey approach, such a method is inappropriate in estimating the prevalence of problematic drug misuse. Within this context there is a need to apply more sophisticated drug misuse prevalence estimation methods. Such methods (in particular, capture-recapture techniques) have been used in previous prevalence estimation work carried out within various Scottish locations.' Glasgow University Centre for Research into Drug Misuse website.

63 UK Focal Point 2005 This is on the assumption that the prevalence of problem drug use in Wales, where there is no current or recently equivalent estimate, is on a par with that in England.

64 ISD 2002)

65 UK Focal Point 2005

66 Millar et al. 2004

67 A metropolitan borough in the West Midlands in England. (Quigley 2005)

those presenting to services. This may be that treatment providers themselves do not designate long term cannabis use as either an addiction or as a problem. The existence of independent voluntary support groups such as Clearhead and Marihuana Anonymous suggests the contrary as does research regarding the 'addictive' or 'dependence' qualities of cannabis.[68]

- In Wales, amphetamines are much more commonly reported as a primary drug of use than elsewhere in the UK (14.8%); and England has the highest levels of reported use of crack cocaine as a primary drug (6.0%).
- Methadone use prevalence/dependence. According to NDTMS data 53 per cent or 85,000 of their clients in England between April 2004 and March 2005 were in substitute prescribing services and that of these some 64,518 are on subscribed methadone for treatment.[69] Following their recent audit report[70] we have been able to make the above estimate for England alone. The NTA's Communications Director has generalized that ¾ of all substitution treatment is methadone based and that 63% of all treatment is substitution treatment.[71] The level of monitoring and control of methadone prescription and use however is massively variable. Other substitute prescribing includes the prescription of heroin itself (very rare) and the prescription of another opiate derivative 'buprenorphine'
- The NTA audit shows the numbers on methadone substitution treatment to have doubled since 1995. The implications of this are discussed in the final part of this report on policy and treatment.
- Figures for methadone substitution treatment in Scotland have been guestimated about 20,000 people. This guestimate from Professor Neil McKeganey is derived by taking the total amount of methadone dispensed, a known quantity as it is paid for, and dividing it by an average dose.
- Methadone maintenance and poly-substance abuse with illicit drugs and alcohol. There is sufficient anecdotal evidence to suggest this needs tracking as it undermines the public health and crime goals of the government's harm reduction policy which underlies substitute prescribing.

> "It gets you to what is thought to be the total number getting it. Now you don't have to be a scientist to be spot straight away that that is just about the least impressive route to trying to work out how many people are getting the drug - the whole notion of an average dose is highly problematic – some people are prescribed lots and some a little. The idea of using that as your only route to find out how many people are on methadone is crazy really; and when you think that actually what we are talking about here is a drug which has a known potential for people to become dependent on it, being given to people who already demonstrated their capacity to become addicted and we don't even actually know how many of them are getting it or for how long they are getting it or indeed what benefit are they deriving from it."
> *Professor Neil McKeganey Glasgow University Centre research into Drug Misuse*

- The significant overlap between 'problem drug' using populations, clients 'in treatment' i.e. in receipts of prescriptions and polysubstance abusers, including alcohol, has been acknowledged by substance misuse workers to us and in our own interviews with those in receipt of treatment services. Of the homeless addicts looked after by one St Mungo's hostel who were all receiving prescribed methadone treatment some 90% were described by workers as polydrug users and alcohol abusers - with this pattern of behaviour continuing, though moderated, while retained on methadone substitution treatment.[73]

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68 www.clearhead.org.uk; www.marijuana-anonymous.org. Almost all addictive drugs stimulate a part of the brain, the mesolymbic dopamine system which is the central nervous system's 'reward pathway'. Cannabis receptors are found here. When stimulated, these receptors begin the cycle of reward which can lead people on to take more. This circuit is shared with animals. (Koob GF 1992). After 1986, a substantial number of studies and observations have supported these findings, i.e. that dependence develops in association with long-term use. (e.g. Miller and Gold 1989, Gable 1993 and Stephens et al 1993). It is also generally agreed that tolerance develops (Compton et al 1990, Oviedo et al 1993, De Fonseca et al 1994). This tolerance results in a rise in dosage or increased use observed in experiments and in studies of users (Swift et al 2001, Coffey et al 2000, Von Sydow et al 2001)

69 A best guess of the number of National Treatment Agency clients on methadone can be obtained from an calculations based on the NTA paper, Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2004 - 31 March 2005 and the National prescribing audit (June 2006) which was based on research carried out amongst DAT's between October and December 2004.

70 The NTA National Prescribing Audit 2006

71 Russell White Briefing Paper 2

72 Evidence session at St Mungo's

3.2 OTHER DATA SOURCES AND RESEARCH:

A new national estimate. The NTA with Home Office and Department of Health colleagues made a commitment in their 2005/6 Business Plan to ensure that a new, more robust methodology (of tracking and identifying problem drug users) developed by the University of Glasgow would be available to local partnerships in time to inform the setting of local treatment plans for 2006/07.[73]

We understand that a major national study estimating problem prevalence was finally completed earlier this year, possibly the outcome of the above commitment, and should go some way to remedying this uncertainty. Commissioned, but as yet not published, by the Home Office, it has been carried out to provide local estimates of 'problem' drug use for all 149 Drug Action Team Areas of England and thus a national estimate. It is likely that this new large scale study using a methodology based on research pioneered in Scotland will point to higher estimates for the number of problem drug users in England.[74] This analysis has also computed information from all those arrested by the police with reference to the Misuse of Drugs Act, all the people who have requested medical tests of various kinds and have indicated use of illegal drugs and from the prison population drug use data. This process will allow a statistical analysis of the various sub-populations and model of the overall population.

'Survey of Psychiatric Morbidity Amongst Adults Living in Private Households'.

Last conducted in 2001, it sampled people aged 16 to 74 in England, Wales and Scotland involving 8,800 initial and 600 second-stage interviews.. It provides more detailed information about patterns of individual drug-taking and dependency which the BCS does not address. Its key findings suggested higher levels of dependency in the general population than that derived from treatment data[75]

- 13% of men and 8% of women aged 16 to 74 reported using controlled substances in the year before interview.
- Cannabis was mentioned most frequently by both men and women (10% overall), while the use of amphetamines, cocaine and ecstasy/MDMA were also reported (2% overall for each drug).
- Prevalence was highest among 20 to 24 year olds, both for men (37%) and women (29%). The survey found that drug use decreased markedly with age – prevalence halved in each successive five-year age group. Beyond the age of 45 the proportion of adults reporting drug use remained broadly constant at between 1% and 2%.
- London was the region with the highest proportion of adults reporting use of controlled substances: the prevalence rate was 16% compared with 11% in Great Britain overall. Among women living in London the prevalence rate was double the national average (15% compared with 8%), while among London men the variation was smaller (18% compared with 13%).

Drug dependency was measured for eight drug types – cannabis, amphetamines, crack, cocaine, ecstasy, opiates (such as heroin and morphine), tranquillizers, and other 'volatile' substances (including glue). *An individual in this survey was regarded as being 'dependent' if s/he was a habitual user (daily use for a fortnight or more) or had developed a degree of tolerance for the drug.*

The prevalence of dependency on these drugs was found to be 37 per 1,000 adults in the general population compared to 9.7 per thousand from the UK Focal Point estimation from treatment monitoring data, possibly because the threshold of dependency was set much lower. The next such survey is out for tender. It could provide a more adequate benchmark against which to test the success of the government's drug policy.[76]

Imperial College London and University of Bristol crack cocaine research, Home Office Funded

An analysis of data from 12 London boroughs' reports of crack cocaine use, including numbers in specialist drug treatment, arrested, accident and emergency and community surveys, and the numbers of injecting drug users suggests that one in every hundred young adult Londoners could be a user.

It identified 4,117 crack users and using statistical modelling estimated there were a further 16,855 users who were not observed on the data sources, taking the total number to 21,000 for the 12 boroughs. The researchers

73 NTA Business Plan 2005/6 "Understanding need The current methodology for understanding the prevalence of problematic drug users is inadequate. The NTA will work with Home Office and Department of Health colleagues to ensure that the new, more robust methodology currently being developed by the University of Glasgow is available to local partnerships in time to inform the setting of local treatment plans for 2006/07.

74 The following question was tabled by David Burrowes MP on 8.11.06 1.) "To ask the Secretary of State for Health if she will state what progress has been made on a stated aim in the NTA's business plan 2005-06 to commission the University of Glasgow to develop more robust methodology for understanding the prevalence of problematic drug users and when we can expect new PDU figures and a new methodology to be published?"

75 Nicola Singleton, Robert Bumpstead, Maureen O'Brien, Alison Lee and Howard Meltzer, Psychiatric Morbidity Among Adults Living in Private Households 2000, Office for National Statistics (2001)

76 ibid

then multiplied the numbers from the 12 boroughs to take into account the whole of London, and estimated 46,000 users aged between 15 and 44, accounting for 1.3 percent of the population.

This marked a sharp rise in use and a prevalence at almost four times higher than population surveys and that crack cocaine use was more than three times higher in men, at 2.4 percent, compared with 0.7 percent in women.[77]

> "Although crack cocaine use has been a cause for concern in many countries since the 1980s, there has not been the predicted epidemic across the UK until now. We must be cautious but the analysis suggests there is a substantial problem. With almost 60 percent of crack-cocaine users also opiate users, part of the increase in use is driven by heroin users, which has implications for treatment and prevention"
> *Dr Matthew Hickman*[78]

'Club drug' use prevalence surveys.

These show drugs are used by 79% of club goers. With the expansion of the nightclub industry and the commercialization of the dance 'scene' more young people are now experimenting with illicit drugs.

- A study in which 760 club goers were interviewed in six venues across the South East of England confirmed that the prevalence of drug use is far higher among those who go clubbing than among other young people.[79]
- Among the club-goers in this study the number young people aged 16 to 29 to have used drugs at any time was 79 per cent (compared with BSC general population data of 50%).
- The highest levels found at an established dance/gay club. Levels and patterns of drug use among club-goers varied considerably across events sampled. For example, on-the-night use of any illicit drug ranged from 9% at an event at a leisure park venue to 70 % at an event at an established dance/gay club.
- Ecstasy was by far the most commonly used substance, followed by cannabis and cocaine. For all other substances a tenth or less of club-goers admitted use.
- A comparison of current club drug users with lapsed drug users (excluding those who had only used cannabis) indicated that current users were using a wider range of illicit substances, and increasingly using synthetic drugs such as ketamine and GHB.
- Over a third (35%) of current drug users said they had used ketamine at some time in their life, with just over a tenth (13%) admitting to having used GHB. The figures for lapsed drug users being seven per cent and three per cent respectively.
- A Scottish 'club drug' study found 80% use of ecstacy and amphetamine and that poly and mixing drug behaviours are more likely than mono drug use. Over 30% of the sample had also used cocaine and LSD; over 10% nitrites, psilocybin and ketamine and less than 5% had used crack or tranquillizers. Participants reported regular consumption of ecstasy and amphetamine (e.g. 35% used ecstasy and 25% amphetamine on a weekly basis) often taken in combination, with the occasional use of cocaine, LSD, ketamine and psilocybin.[80]
- Poly- and mixing-drug behaviours were significantly more likely than mono drug usage: 85% reported mixing drugs and/or alcohol; 35% driving on drugs; 36% having a bad experience on drugs;30% unprotected sex; 0.9% injecting drugs.
- Drugs were accessed through friends than from any other source. Women in the sample reported higher consumption than men.
- Data about volumes of drugs consumed remains thin.

All these studies indicate much higher levels of drug use in specific populations than indicated by the BCS and therefore a very high level of variability between sections of the populations drug use – to a greater extent than alcohol.

3.3 'Problem user' social profiles

Drug misuse is spread much more unevenly through the population than alcohol although it is often partnered by alcohol abuse. Home Office and other academic research studies and treatment data show that the most intense, problematic or high volume drug use is found amongst the young homeless, care leavers (children who have been in care), children of drug-using parents, the unemployed, prisoners and persistent offenders and arrestees.

The profiles of problem users are very similar to those of 'users' picked up in the BCS. They tend to be:

77 Society for the Study of Addiction. September 2005. Research funded by the Home Office Research and Statistics Directorate

78 ibid

79 Calculating the Risk Deehan and Saville Home Office Report 33/03 and Home Office Findings 208

80 Riley et al Addiction Vo 96, no 7 July 2001 Patterns of Recreational drug use at dance Events in Edinburgh Scotland

- Young : approximately one third of those presenting for treatment for the first time are under the age of 24 and a further quarter of these clients are between 24 and 29.[81]
- Male: 71.3 per cent of treatment clients are male and 28.5 per cent are female, proportions which have been constant over a number of years. The figure for males in Scotland is lower at 65% but research conducted in Scotland still suggests that there are significant gender differences or profiles between those entering treatment for the first time.[82]
- More likely to have considered their cannabis use to be problematic
- `More likely to have adverse early experience in the labour market; to have left full-time education early
- To be even younger if they are women (24 years old compared to 28); to have been involved with social services; to have been dependent on state benefit; sell sex; to be in arrears with rent; to live in a poorly maintained building; to have at least one child living with them; or to have been physically or sexually abused by a partner, a relative or family friend.

At an evidence taking session at a **St Mungo's hostel** in central London the substance abuse workers asserted that women are much more reluctant to present themselves for treatment.[83] They attributed this reluctance to the more chaotic lifestyles of women and to high earnings from prostitution which they were reluctant to give up. Tgis was confirmed by Bill Puddicombe, Chief Executive of Phoenix House in his witness evidence to us. They also thought that the lack of dedicated accommodation/hostels for women was a further factor but did not believe that having children was a reason as most of them would have already lost their children into care or adoption.[84] Mr Puddicombe thought that the fear of losing their children was a significant factor.

- More likely to have been physically or sexually abused; women are more likely to have been abused than men resulting in early onset drug misuse, suicide or self harm attempts, with overdose and with involvement in prostitution in the last 12 months.[85]

3.4 HIGH DRUG USING POPULATION SUBGROUPS

Care leavers

A Home Office Research Study found much higher levels of self reported drug use amongst a sample of care leavers than that found in general population surveys. Almost three quarters, 73% had smoked cannabis, with 34% reporting that they smoked it daily. One-tenth had used cocaine, Fifteen per cent ecstasy within the last month. Ten per cent of the sample had used heroin and crack cocaine.[86]

> Many young people I interviewed had lost count of the number of times they had arrived at a new foster carer or Children's Home, clutching their belongings in a plastic bin bag. As one 14-year-old girl who had been through 30 placements remarked, 'you feel like a bit of rubbish yourself who no one wants.' They had also ceased to count the turnover of social workers in their lives. Another girl explained, 'They come and go and never say goodbye - just like my mum really.'
>
> *Harriet Sergeant, Handle with Care - An Investigation into the Care System, CPS 2006*

Other witness evidence suggests drug use by children in care homes is the norm.[87] As Harriet |Sergeant recently observed, "The State make a rotten parent":

The year ending 31st March 2005 there were 60,900 children in care. This year approximately 6000 teenagers will leave care. 4,500 of them will have no educational qualification. Within two years of leaving care 3000 will be unemployed, 2,100 will be mothers or pregnant, and 1,100 will be homeless.[88]

The young homeless.

A Local Authority estimate has put young homeless at between 36,000 to 52,000. Of these they found that 86% had been forced to leave home and one third had attempted suicide and many had experienced family violence.

A dedicated study of the alcohol, tobacco and drugs use of 160 homeless young people (aged 25 and younger), conducted in Cardiff, Brighton and Hove, Canterbury and

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81 ibid

82 Neale (2004a) This research was part of DORIS, where 1,033 treatment clients were interviewed in Scotland.

83 St Mungo's is the largest provider of hostel accommodation to the homeless. Over 80?% of their client also have multiple and often long term problems with substance and alcohol abuse. They would be described as amongst the most hard to reach.

84 The St Mungo's Endell Street Hostel for example has 95 beds of which only 8 are allocated to women.

85 McKeganey et al. (2005) This research was part of DORIS, where 1,033 treatment clients were interviewed in Scotland.

86 Home Office Research Study 260 February 2003

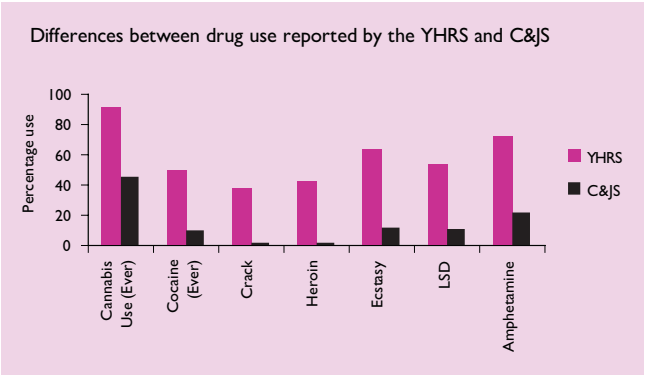
87 Sergeant, Harriet. Handle With Care, CPS 2006

88 Ibid

Birmingham over an 18 month period from January 2001, found:

- Almost all (95%) had used drugs and three-quarters continued to do so.
- Cannabis was the most frequently used drug, followed by amphetamine, ecstasy, LSD and cocaine.
- Rates for heroin (43%) and crack (38%) were still high although lower than for other drugs.
- Over half of those who used heroin and crack (55% and 58% respectively) had first done so after becoming homeless.
- Half of all the current users felt that they would like to give up and 40% thought that they would need help or treatment to do so.
- 17% of the young people were identified as 'problem' drug users and 14% as former 'problem' users.
- Problem use was defined (at a high threshold) *as using heroin, crack or cocaine on five or more days in the last week*. The problem users were predominantly white and male. Most reported family conflict and running away. Many also had mental health problems. Most wanted access to help or treatment.[89]

This particular study of the young homeless indicated a dramatically higher drug use than a parallel Crime and Justice Survey[90] and pointing to some of the limitations of the BCS and the Crime and Justice Survey in providing a full enough picture of drug use in population subgroups. The differences in drug use documented is clearly illustrated in the following table



The C&JS analysis found that some 28 % of young people account for 61% of those using Class A drugs in the last year and that 'the most vulnerable' are twice as likely to engage in frequent drug use:

- 24 per cent of those identified as 'vulnerable' used drugs frequently during the last year compared to 5 per cent of those who were not identified as vulnerable.
- Those identified as being in more than one vulnerable group had higher levels of drug use than those in just one vulnerable group. So, frequent drug use in the last year for the former was 39 per cent, compared to 18 per cent for the latter

How useful the concept of 'vulnerable' in this context is questionable as by definition drug users become vulnerable.

Arrestees.

The Arrestee Drug abuse monitoring programme, the 'NEW-ADAM' programme, which started in 1999/2000 has begun to provide a data base of drug-testing results for arrestees (although covering only 16 locations in total, and in each of these conducting a survey only once every two years).

Urinanalysis results have shown that the average rate of positive tests across all locations, excluding alcohol, was 61 per cent. The equivalent rate including alcohol varied between 72 per cent and 82 per cent of arrestees depending on location.

The most common drug identified was cannabis (46% tested positive) followed by alcohol (25%), opiates (18%), benzodiazepines (12%), amphetamines (11%), cocaine (10%), and methadone (8%). No arrestees tested positive for LSD. Unlike the general population – cannabis rather than alcohol is the drug of choice.

Young Offenders.

Anecdotal evidence confirms that problem drug use is an issue with the majority of young men entering Young Offender's Institutes (between the ages of 15 -21). Ray Lewis was the Governor of Woodhill a Young Offenders Institute near Milton Keynes housing some 700 young men:

> "From my experience eight out of ten of these boys were involved in drugs in some way or another on arrival. Cannabis was not usually on the register for me – it was usually much more. Nine out of ten would arrive, dealing, using, and pushing. Most of them had a habit. They were stealing and such like to fuel their habit. Drugs are a huge part in the lives of youngsters nowadays – it is like a rite of passage – it's just what's done, everybody does it now and some it hooks and leads to a downward spiral ….[91]

89 Youth Homelessness and Substance Abuse; Report to the Drugs and Alcohol research Unit. Home Office Research Study 258 2003

90 Drug Use Among Vulnerable Groups of Young People: findings from the 2003 Crime and Justice Survey. Home Office Findings 254 2005

91 From Latchkey to Leadership, Kathy Gyngell and Ray Lewis, CPS 2006

On 30 January 2004, there were 10,645 under 21-year-olds in prisons in England and Wales.[92] We can estimate from Mr Lewis's assessment that some 8,000 of this group of young people alone there could be problem drug users. Reoffending rates are as high as 84%[93].

Serious or Frequent Offenders and Truants.
These two groups show the highest Class A drug use in the last year, 13 per cent for serious or frequent offenders and 16 per cent for truants.[94] 8% of young people between the ages of 12 -30 are estimated to be persistent or serious offenders. This is an extraordinarily high risk group for drug use according to Godfrey et al, who have estimated the numbers amongst them using hard drugs, distinguishing between 'recreational' use and problem use.[95] Cannabis use is not considered in her calculations.

- Nearly two thirds of persistent offenders are hard drug users
- Half are under 21
- More than a third were in care as children.
- Half have no qualifications at all and nearly half have been excluded from school.
- Three quarters have no work and little or no legal income."[96]

Prisoners.
Rates of drug use amongst adult male prisoners are far in excess of that seen amongst the general public. Of a random survey of 1009 prisoners conducted in 1995 a total of 557 had previously used heroin cocaine or amphetamine.[97]

A detailed audit of substance misuse in prisons conducted by the Department of Health in 1997 found:

1 Very high rates of drug use and dependence prior to coming to prison with rates among remand prisoners being slightly higher than among sentenced prisoners.
2 Among male remand prisoners, 10% reported moderate drug dependence and a further 40% severe drug dependence (3 or more symptoms of dependence) while 11% of male sentenced prisoners reported moderate and 32% severe dependence in the year before coming to prison.
3 Among the women the equivalent figures were 7% of remand prisoners reporting moderate and 47% severe dependence with 8% reporting moderate and 34% severe dependence among sentenced prisoners.
4 Respondents reported starting to use drugs at a young age, more than half starting to use one of the six drugs considered in detail in the survey before the age of 16.
5 The median age for starting cannabis use was the lowest (about 15), followed by amphetamines, then hero-

"Of the approximately 8000 people that are in the London prisons at the moment, we would estimate that around sort of anything from 55 to 70% of those have got a pre-existing drug problem of some sort that would benefit from some sort of intervention.. We've got a concentration of people that have got drug issues, a large proportion of whom may also have mental health issues and all sorts of other things that might mean policymakers would decide that prison isn't the right place for them. As it stands at the moment, prisons – whether they're the right place or not – to someone turning up at a prison reception, we haven't got the right or the authority or the luxury to say, 'sorry,' – like a school does; for instance, school can say 'your behaviour is too challenging, you're excluded' – we don't have that ability. So, we have to deal with whoever walks through the door. Given that, and we know that prisons cost a lot of money' the actual element that is spent on care, sometimes, when you look at things like the drug interventions programme, although we've had a lot of resources from that, that have helped us greatly in doing better work, but we get only something like 5% of what the community gets. Out of a total budget of around £450 million over three years, about five million of that comes into the prison service nationally, to deal with a very concentrated group of people.
Huseyin Djemil, MCMI London Area Drugs Strategy Coordinator

92 Prison Reform Trust Briefing, 2004
93 Young Offenders Insitutions, 28 June 2005 Politics.co.uk
94 UK Focal Point on Drugs 2005 Annual report to the European Monitoring Centre for Drugs and Drugs Addiction.
95 HORS 249
96 Home Office, 2001
97 Strang et al Persistence of drug use in imprisonment. Addiction Vol 101 no 8 August 2006

in and cocaine powder, with crack use commencing later at around 21 years.[98]

6 Among male remand prisoners, 38% reported having used drugs during their current prison term as did 48% of male sentenced, 25% of female remand and 34% of female sentenced prisoners.

7 The drug most frequently used was cannabis, followed by heroin – other drugs were mentioned far less frequently.

8 There is no evidence to suggest any improvement in the problem. A more recent drugs review of prisoners conducted by a CARAT assessment showed that 62% had used heroin, 49% crack and 42% cannabis in the 30 days before custody in 2004/5 with 39% having taken both heroin and crack.[99]

9 The prison population is highly transient, with 73% sentenced for less than 12 months and 65% of first receptions into London prisons are on remand. Almost 50% of prisoners are from Black Minority Ethnic groups (a highly disproportionate number) and 34% classified as Black or Black British[100].

10 The influence of ethnicity on illicit drug use remains an under-researched topic. Ethnicity overlaps with other social variables including, for example, unemployment and single parent hood, so that it becomes very difficult to identify the specific influence of ethnicity on drug use. The National Treatment Agency has published a literature review in this field but concluded that no comprehensive needs assessment had taken place. The literature review does not point to any factual evidence base about consumption by comparison with other ethnic groups.[101]

There are a high proportion of foreign nationals in prison in London, 51% of the 10,000 in custody through out England and Wales, creating significant problems with language and management.[102]

And a recent study commissioned by the Home Office revealed heroin, cannabis, crack cocaine are all available allowing prisoners to maintain low level drug dependency. It disclosed extensive drug dealing in jails including operations where prisoners use mobile phones smuggled into the prisons to set up deals with suppliers in the community. Exchanging drugs and moving supplies was considered easy by those interviewed. Trafficking is sophisticated and big business. Prisons are targeted because they are a ready made market. More than a thousand prison officers are believed to be or have been involved in this corruption.[103]

3.5 A PROBLEM OF EVIDENCE

The recent Science and Technology Committee report on the Home Office's Advisory Council on the Misuse of Drugs (ACDM) criticised the weak evidence base for policy[104]. It is also evident that the UK survey evidence base on drugs prevalence informing government policy is also thin. We are not confident that the conventional household and schools surveys provide adequate information about prevalence and patterns of drug use or volumes of consumption.

This does not however mean to say that there is a lack of good research in the area of drugs and alcohol misuse. There is a failure to communicate it to either policy makers, opinion formers or the general public – other than sometimes in the most distorted or sensationalist way:

> I would say that at least 95% of research findings on the drugs problem are never communicated to anybody beyond the funder and one or two others. Most researchers don't communicate with the population at large, their audience are a small array of like minded other academics, or a small array of civil servants.
>
> *Professor Neil McKeganey, University of Glasgow, Centre for research into Drug Misuse* [105]

Huge effort goes into such research. Often the findings are of key relevance. Often their significance is ignored. This research needs to be systematically reviewed for its implications for policy. There is a need for dedicated funding for identifiable series of research reviews.

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98 ibid
99 ibid
100 ibid
101 ibid
102 Times report August 15th 2006
103 House of Commons: Science and Technology Committee. Drug Classification, making a hash of it? Fifth report of session 2005-2006
104 Ibid
105 Interview Feb 21 06

Chapter Four Children: Alcohol and Drugs Prevalence

> It's not just adults, young people have (also) been targeted by the drinks industry and drinks promotions, alcopops and so forth. There was a little piece of research done not so long ago that found out that school age children were actually more familiar with these Budweiser frogs than they were with the little characters on the back of the cornflakes packet, so the market penetration of young people have been very successful and that's resulted in a doubling in alcohol consumption in children of school age - both boys and girls.
> *Professor Colin Drummond*[106]

The Advisory Council on the Misuse of Drugs have recently published an in depth and comprehensive survey of the hazardous use of tobacco, alcohol and other drugs by young people in the UK and it implications for policy, 'Pathways to Problems'.[107] It is based on a comprehensive review of the various sources of information and research which with our far more limited resources we cannot possibly replicate.[108]

In this section we highlight some key points of concern that we have found to date, some of which, notably with regard to alcohol, complement the findings of the above report.

The first is the increase in alcohol consumption by children and adolescents despite the statistics indicating a small drop in the overall numbers of children using alcohol on the equivalent figures for 2004.[109]

4.1 CHILD ALCOHOL USE TRENDS: "MORE ALCOHOL IS GOING DOWN FEWER THROATS"

The percentage or total numbers of school age children drinking on at least 1 day during the previous week has declined over the last 15 years for both boys and girls in each age category:[110] But while the numbers of school children drinking alcohol appears to have dropped the overall amount of alcohol consumed by children (the mean consumption) has risen dramatically in the last 15 years – a trend that shows no signs of reversing. Dr David Regis of SHEU who has been tracking children's alcohol consumption since the 1990's argues that "more alcohol is going down fewer throats" and that this coincides with the growth of binge drinking.[111]

- the children who drink, drink twice as much as their peers did in 1990
- The average consumption among those pupils aged 11 to 15 who drank in the last seven days nearly doubled from 5.3 units of alcohol in 1990 to 10.4 units in 2000, and has fluctuated around this level since then.
- In 2005, the average weekly consumption was 10.5 units[112] This is consistent with the upward trend noted by SHEU of 14 and 15 year olds who had drunk more than 10 units in the last 7days.[113]
- In numbers terms data for 2005 shows that over a quarter of 11-15 year-olds drank alcohol in the last week and that for 14-15 years olds on their own this figure reached 45%.

4.2 CHILDREN WHO START DRINKING YOUNG HAVE A CUMULATIVELY HIGHER PATTERN OF CONSUMPTION

- The Edinburgh Longitudinal Study of Youth Transitions and Crime shows a pattern - that by the age of 14 the proportion of those who have not previously drunk drops away and both weekly and monthly alcohol consumption of those already drinking alcohol rises.[114] – that regular alcohol use rises again at age 15, with half of the cohort drinking alcohol either weekly) or at least monthly.[115]
- The study also shows that children who begin their drinking careers young continue to drink and more.

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106 Professor of Addiction Psychiatry at St George's Hospital Medical School

107 Pathways to Problems September 2006

108 See Appendix

109 SHEU (Schools health Education Unit) - embargoed till publication of their 2005 Young People and Alcohol Report

110 Interview evidence

111 ibid

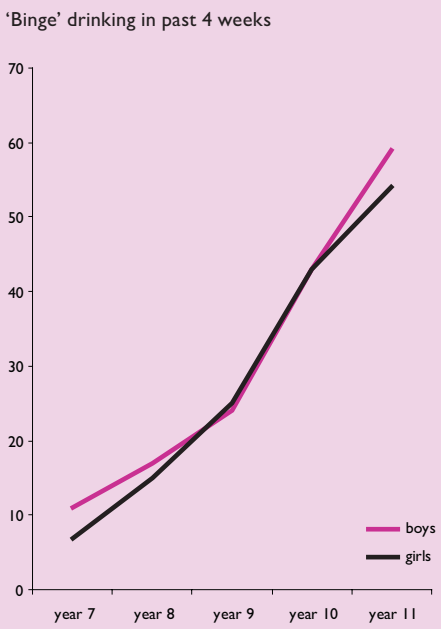
112 Young People Drinking and Smoking Headline Figures

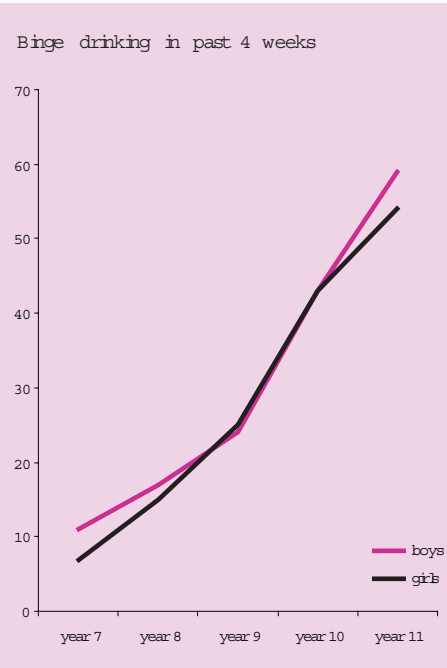
113 SHEU embargoed

114 See Appendix

115 Adolescent Smoking Drinking and Drug Use; Number 7 Edinburgh Study of Youth Transitions and Crime a longitudinal research programme exploring pathways in and out of offending for a cohort of around 4,300 young people who started secondary school in the City of Edinburgh in 1998.

- Another survey of youth found binge drinking to be common in even younger school age children.[116] In this study, binge drinking was defined as consuming five or more alcoholic drinks in a single session. The graph below refers to children between the ages of 11 and 16. Those in Year Seven where 10% of boys are reported to have 'binge drunk' in the past 4 weeks are between eleven and twelve years old.[117]





4.3 TODAY'S 'EARLY STARTERS' DRINK MORE AND GIRLS ARE CATCHING UP WITH BOYS

The Adolescent and Lifestyle Survey in Scotland details an increase in earlier consumption with the relative differences in prevalence of drinking between the age groups for all pupils narrowing since 1990. Then nearly three times as many 15 as 13 years olds drank 'in the last week'; by 2004 it was only twice as many. By this date, for the first time, prevalence of drinking amongst 15 year old girls was higher than that among boys of the same age.[118]

4.4 CANNABIS TRENDS AND SCHOOL AGE CHILDREN

The Pathways to Progress Report defines 'hazardous use' of drugs by children by last month consumption. By their definition 11% of all schoolchildren between the age of 11 and 15 are now engaged in a hazardous use of drugs.

> The most pronounced increase in use of any drugs over time is amongst school children; their use of drugs has doubled in the last decade.
> *UK Focal Point*[119]

- Children's cannabis use has risen exponentially over the last thirty years with some children exposed to their parents' use as well as to that of their peer group's.
- By 1980 one American social scientist had already observed that the spread in the use of cannabis and other illicit drugs in the population represented, at that time, one of the most striking and best documented incidences of social change in the last decade. She noted that repeated annual surveys indicated rates of marihuana use that far from stabilising as had been anticipated earlier (National Commission on Marihuana and Drug Abuse 1971) were still increasing and primarily amongst adolescents.[120] The main features of the rising trend are set out below:
- A steep rise in the use of cannabis by children in the late 1980's continued through the nineties, peaking in 1997/8.
- Consistent evidence of a younger age of initiation.
- A drop in use since 2001 may have reversed last year. Changes in measurement systems have made comparisons difficult

116 Youth at Risk: A national survey of risk factors, protective factors and problem behaviour among young people in England, Scotland and Wales produced by Communities that Care

117 IAS Fact sheet

118 SALSUS National Report 2004

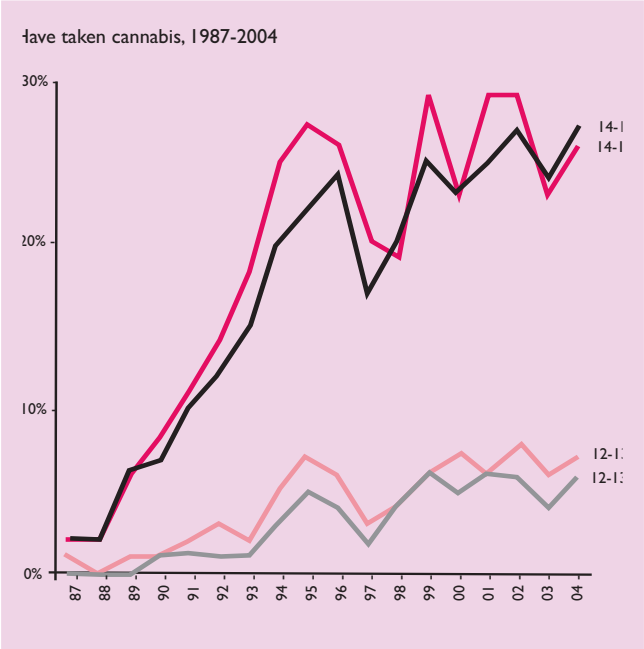
119 UK Focal Point 2005

120 Drug and Drinking Behaviour Among Youth Denise B. Kandel Annual Review of Sociology, Vol. 6, 1980 (1980) , pp. 235-285

- Possible evidence of 'plateauing' of use at the continuing high prevalence levels for 14 to 15 year olds
- The more children have been offered cannabis, the more have taken it[121]
- Evidence that experimentation with other drugs stabilised at below 20% between 1999 and 2004[122].
- Cannabis remaining overwhelmingly the drug of choice among school age children. 12 per cent of 11 - 15 year olds have used it within the last year (up 1% on previous year)

The table below, reproduced by kind permission of SHEU 'Trends Young People and Cannabis' 1987-2005 shows the consistent rise in cannabis use by boys and girls from 12 through to 15.

It is interesting to observe that there has been an increase in use since the Government's National Drug Strategy was instituted in 1998 as against a marked decrease in usage in the years preceding from 1995. How this should be interpreted is not clear.



Increase in the numbers of children requiring treatment[123]

Recent official statistics published in Scotland showed that the number of children accessing drug treatment and rehabilitation services for cannabis use has more than doubled in the last 5 years. The statistics also reported that a child as young as nine in Lothians was treated for cannabis use in the last year. A Scottish parliamentary answer revealed that the number of new clients under 16 years reporting cannabis use and who had accessed drug treatment and rehabilitation services in the last 5 years in Scotland increased from 127 to 376.[124]

Figures for the UK were set out by Health Minister Caroline Flint on October 18th: "The percentage change in the number of people entering drug treatment between 2003-4, the first year for which data is available, and 2005-6, the latest data, where cannabis has been identified as the primary substance of misuse is an increase of 117%." She insisted that this increase was due to the availability of treatment.

4.5 'ANY' DRUG TRENDS AND SCHOOL AGE CHILDREN

Children's use of all drugs rose steeply to 1996 and gradually since then. It is difficult to tell from the available data whether it has 'plateaued' since this peak or whether it could be rising again. The following table from the same source shows an overall upward trend in those taking any drug.

- 26% of 11 – 15 year olds are estimated to have taken drugs. The current estimate is that 26% of pupils

121 SHEU 2005

122 Ibid

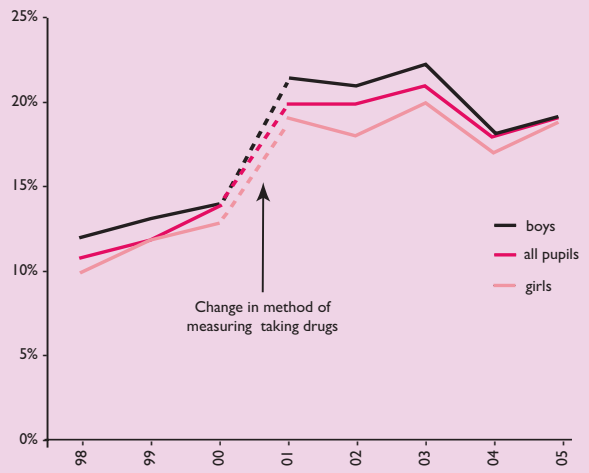
123 Research from the USA shows that cannabis is the commonest reason for 12 to 17 year olds to be placed in treatment centres, 60% of all cases, a rise of 142% in a decade. The Observer of Sunday 13th June, 2004.

124 SNP published 27.06.06

between the age of 11-15 have ever taken drugs and 19 per cent of them in the last year – this was up 1% on the previous year. Of these 4 per cent took Class A drugs. 6 per cent of pupils of this age group report to have taken drugs once a month or more. [125] (2005 Headline figures)

- 7% of all pupils used volatile substances in 2005 up 1% from 2004
- 1% of pupils had taken heroin in the last year
- While the prevalence of drug continued a gradual climb between 1998 and 2005 the prevalence of cigarette smoking appears to have plateaued[126]
- The following table shows how girls are catching up with boys in the last year
- By the age of fifteen a third of all pupils had used drugs in the previous year with 4 percent of them having used Class A drugs.

Whether taken drugs in last year, by sex: 1998-2005



- Although 2001 to 2005 saw an overall decrease in use of Cannabis from 13 to 12 per cent and Ecstasy from 2 to 1 per cent this masked a rise of 1% between 2004-5. The period also saw a rise in the use of Cocaine and Poppers from 1 to 2 per cent and 3 to 4 per cent respectively.
- Overall the most recent figures for 2005 show the numbers using drugs rising again with 11% of pupils aged 11 to 15 having taken drugs in the last month and 19% of pupils having taken drugs in the last year, up on 18% in 2004.[127]
- Gender differences diminish as children get older (as well as diminishing over time).. Between the ages of 11-15 gender appears not to be a significant determinant in the proportion using drugs. Previous years data tabulations showed higher use among boys.

4.6 CHILDREN'S FREQUENCY AND AMOUNT OF DRUG USE – A DATA DEFICIT

Cannabis use figures need to be read in the context of the threefold increase in potency of nearly two-thirds of the cannabis market in the UK (detailed in Part 2).

Age	11	12	13	14	15
Male %	7	11	15	26	34
Female %	6	8	14	27	34

Source: Table 2 Drug use, smoking and drinking among young people in England in 2005, (London, Home Office, 2006)

Lots of kids smoke here – weed and skunk. You may be getting to 25% (regularly). It's a really serious problem. Use is starting younger than it did. And it is doing much more damage to society than crack or heroin because of the sheer number doing it. It affects their health. It affects their mental health. It undermines their schooling and their life prospects. And it affects everyone else. The reality is that smoking or puffing is just not thought of as a big deal. With the kids I deal with I can see it in their behaviour. I am well enough in with them; they make absolutely no attempt to hide it from me – none whatsoever. They smoke on the way to the bus to go to school. It affects their ability to concentrate and their ability to be in class. They want to leave school to be able to smoke. It has a really bad effect on their motivation. It's a physical fact that as a teenager you need more sleep. They don't want to get up anyway, so if they've been puffing it makes it that much harder for them.

Shaun Bailey – Youth Drugs Worker, North Kensington Estates[128]

The gap between the official picture and that presented by youth drugs workers is wide: youth workers describe pat-

125 Smoking, drinking and drug use among young people in England in 2005: Table 9.11 (London, Home Office, 2004)

126 ibid

127 DRUG USE, SMOKING AND DRINKING AMONG YOUNG PEOPLE IN ENGLAND IN 2005: Headline Figures

128 No Man's Land' CPS 2005

terns of use that are not touched on by the official surveys -adolescents who smoke several 'spliffs' a day, often beginning on the journey to school.[129] Similarly Kids Company which works across 25 schools in London and has seen or worked with over 5000 vulnerable children finds that a large percentage of these children are **addicted** to cannabis and that there is a smaller but identifiable group of 'crack' addicted kids.[130]

Official data is limited to a number of questions asked in the various surveys.

- 6% of children said they usually took drugs once a month or more – this ranged from 1% of 11 to 12 year olds to 13% of 15 year olds. Weekly figures are 0% of 11 year olds to 2% of 15year olds[131]
- In Scotland the reported figures are with 3% of all 15 year olds and 1% of all 13 year olds reporting that they used drugs 'at least once a week'.[132]
- Anecdotal evidence reveals some children smoking several 'spliffs' a day. No survey data reaches into these groups.

The picture painted is incomplete. It is difficult to judge how meaningful all this information is given firstly the very small size of the English Schools sample that is surveyed (approx 9000 – SALSUS has a much bigger sample size of 23,000 in relation to a much smaller overall population). Secondly given the fact that the more frequent drug users are the least likely to be represented in any school based survey by virtue of school absence – truanting we see below is highly associated with drug use and to a lesser extent exclusion. This was acknowledged in their recent survey:

"Recorded levels of truancy and exclusions should be viewed with caution as they are based on self-reported data. In addition, regular truants and those excluded from school during the fieldwork period were almost ce tainly underrepresented in the sample, despite efforts to include them."[133] It is not known how the schools deal with poor literacy of those potentially completing long and detailed questionnaires and whether this could be a variable.

No data is collected on volumes consumed. There appears to be no alternative or additional evidence base about the numbers of children 'problem' drug users as opposed to deductions about 'hazardous' users.

> There are many factors which influence whether or not young people will use tobacco, alcohol or other drugs hazardously. The most important of these include early life experiences, family relationships and circumstances, and parental attitudes and behaviour. It is difficult to predict who will develop serious problems.
> *Pathways to Problems, Advisory Council on the Misuse of Drugs,* [206]

4.7 RISK FACTORS FOR CHILDREN - EVIDENCE OF SOCIAL CORRELATES

One conclusion in the recent report 'Pathways to Problems' published in September 2006 was that:

Research suggests that we can be quite specific about the behaviour patterns and family circumstances of children that are highly predictive of drug use:

- **Previous smoking and drinking** - cigarette and alcohol use precedes drug experimentation and cannabis is usually the first drug to be experimented with.[134]
- **Early onset of cannabis use** raises subsequent rates of consumption very substantially. In early adolescence, the effect of delaying onset by a year may be a reduction of a third or more in consumption cumulated to age 30.[135]

Research evidence reveals both environmental and family conditions as well as parenting practices are added risk factors for children's drugs use and patterns of use

- **Family disunity**. 25 % of those in single parent families and 28% of pupils living with a parent and a stepparent compared to only 18% of 15 year olds who lived with both parents reported using drugs in the last month. The proportion of pupils who reported using drugs *was lowest in families with both parents at home.*

129 'No Man's Land ' Shaun Bailey, CPS 2005

130 Witness evidence Camila Batmanghelidjh, Kids Company

131 'No Man's Land' CPS 2005

132 SALSUS 2004

133 P163 Drug use, smoking and drinking among young people in England in 2005: Full Report

134 David Regis SHEU interview evidence

135 Stephen Pudney Keeping of the Grass. An Econometric Model of Cannabis Consumption by Young People in Britain, 2002 based on an analysis of Youth Lifestyles Survey Data for Home Office Research Study 253

- **Family disruption** is associated with higher levels of substance use among young people[136]
- **Low levels of parental monitoring.** Pupils reporting drug use in the last month were more likely to perceive low levels of parental monitoring. Sixty-nine per cent of 15 year olds using drugs in the last month had a lower than median level of maternal monitoring.[137] Twenty-five per cent of 15 year olds who reported using drugs in the last month reported spending every evening with their friends.[138]
- **'Fatherlessness'** has been shown by predictive modelling to be a likely factor in heavier cannabis consumption - for example, a fatherless male cannabis user with a working mother has an expected level of cumulated consumption more than double that of an otherwise similar cannabis user from a 'normal' family background.[139]
- **Low family affluence** relates to drug use in both boys and girls: around a quarter of 15 year old boys (23%) from **low affluence families** reported using drugs in the last month compared with 16% from high affluence families.[140]

Truants have a significantly higher incidence of illegal drug use, underage drinking and smoking than non-truanting pupils and rates of substance misuse increase over time.

Long-term truants exhibit a higher incidence of all forms of substance misuse in comparison with other categories of truant.

Illegal drug use and smoking significantly predict truancy after controlling for a range of other explanatory variables, including school experience, victimisation, parenting and a range of personality characteristics such as self esteem and impulsivity.

Truancy, School Exclusion and Substance Misuse', Lesley McAra, Number 4, The Edinburgh Study of Youth Transitions and Crime. A longitudinal study

- **Social deprivation** in the geographical sense is very important. A young person living in one of the (roughly) 10% most deprived areas of Britain has an expected cumulative consumption raised by around 65%.[141]
- **Poor and crowded housing** and outdoors street social life[142] The Scottish Schools Adolescent Lifestyle and Substance Use Survey (2004) asked pupils where they used drugs. The most commonly reported location was outdoors (39% of 15 year olds boys and 49% of 13 year old boys who had ever used drugs likewise 33% of 15 year old girls and 45% of 13 year old girls). The 'outdoor' figure grew by 10% between 2002 and 2004.[143] The second most reported location of drug use was in someone else's home, particularly among older pupils and girls with, over a third of 15 year old girls and 26% of 15 year old boys who had ever used drugs reporting that they were in someone else's home the last time they used drugs. Similarly among 13 year olds 23% of girls and 16% of boys said that they were in someone else's home.
- **Truancy** is highly associated with illegal drug use (however it is illegal drug use that significantly predicts truancy). While early truanting is predominantly a male activity, by second year of secondary education girls form the majority of truants (including persistent truants). It is linked to low attainment.[144]

Exclusion is also associated but less strongly. Pupils who have been excluded from school report a significantly higher incidence of illegal drug use, underage drinking and smoking than their non-excluded counterparts. Illegal drug use is only weakly predictive of exclusion after controlling for other explanatory variables, including school experience and anti-social behaviour.[145] The findings of the Edinburgh longitudinal study confirm that substance misuse is only one element of a much larger and complex set of problematic behaviours and adverse circumstances associated with unauthorised absence and exclusion from school.

136 Sutherland and Shepherd, 2001
137 ibid
138 ibid
139 Stephen Pudney Keeping of the Grass. An Econometric Model of Cannabis Consumption by Young People in Britain, 2002 based on an analysis of Youth Lifestyles Survey Data for Home Office Research Study 253
140 SALSUS 2004
141 Stephen Pudney ibid
142 See 'No Man's Land' Shaun Bailey CPS 2005
143 SALSUS 2002, 2004
144 ibid
145 ibid

Being in Care. The high rate of drug use by care leavers is detailed in section 3.4 above. What is not known is the role the child's drug abuse may play in a child being put in or given up for care.

4.8 HOW TO MEET THE DATA DEFICIT

Knowing what percentage of the population of children is estimated to be using drugs is of course important, but it is not enough. We need to know far more about the children who are using drugs regularly, how many there are, who they are, and where they are. Apart from anything else, this is a health issue. If these children are likely to be found in areas of social deprivation there are likely to be other associated issues, of poor nutrition and general health care. We need to:

- **Identify and map the children who are at most risk** by improving and extending survey data and instituting remedial surveying of truants and excludees. We are in the process, from Michael Murphy, senior lecture in Social Work at the University of Bolton and from Joy Barlow at the University of Glasgow's centre for Research into Drug Misuse amongst others, about the best additional methods of identifying such children and those at most risk.
- **Survey and monitor drug use of children in care**. If 18% of children in care have had no dental check[146] it is not likely that other aspects of their needs and lifestyle are recorded. More than 75 per cent of young people leaving care having no formal qualifications at all; and have had high levels of non-attendance and exclusion from school, and are more likely than any other category to become homeless.
- **Study trends in children's drug use through longitudinal surveying**. We also need to look further at the 'autonomous trend towards early initiation and heavy use in successive birth cohorts.' For example, cumulative consumption by early onset users born in the mid 1980s has been predicted to be more than six times than that for similar users born in the late 1960s.[147]
- **Collect data about the 'mean consumption'** of drugs by children and the variability in relation to other factors.
- **Extend the 'Young People Drinking and Smoking Survey'** to something more comparable with SALSUS to include frequency of use and volumes consumed by the highest risk groups of children. The published survey as it stands provides no analysis of which children from which socioeconomic groups or family backgrounds - may be consuming more and which less; in what circumstances or environments their drug and alcohol taking occurs.
- **Establish 'remedial' surveying for truants and excludees**

146 ibid

147 Stephen Pudney ibid

Appendix One

FROM DRUGS MISUSE DECLARED:
FINDINGS OF THE 2005/6 BRITISH CRIME SURVEY, HOME OFFICE OCTOBER 2006

Figures for the proportion of 16-24 year olds reporting having used drugs in the last month, 1996 to 1005/06 BCS

	1996	1998	2000	2001/02	2002/03	2003/04	2004/05	2005/06	significant change 1998-2005/06	significant change 2004/05-2005/06
Class A										
Any Cocain	0.6	1	1.9	2.2	2.3	2.8	2.2	3	/\	/\
Cocaine powder	0.5	0.9	1.8	2.2	2.1	2.7	2.1	3	/\	/\
Crack cocaine	0.2	0	0.2	0.1	0.3	0.2	0.1	0.2		
Ecstacy	2.3	2.2	3.2	3.5	2.7	2.6	1.9	2		
Hallucinogens	1.4	0.5	1	0.7	0.7	1	1	0.9		
LSD	1.1	0.4	0.6	0.4	0.3	0.4	0.2	0.2		
Magic Mushrooms	0.4	0.3	0.7	0.5	0.5	0.8	0.3	0.7		
Opiates	0.1	0.7	0.3	0.2	0.2	0.3	0.1	0.1	\/	
Heroin	0.1	0.2	0.3	0.2	0.2	0.3	0.1	0.1		
Mehtadone	0.1	0.5	0	0.1	0.1	0.1		0.1		
Class A/B										
Amphetamines	5.7	5.3	2.9	1.9	1.7	1.6	1.3	1.6	\/	
Class B/C										
Tranquillisers	0.4	0.5	0.5	0.4	0.4	0.3	0.4	0.4		
Class C										
Anabolic steroids	0.1	0.3	0.1	0.1	0	0.2	0.2	0.1		
Cannabis	16.1	18	17.4	17.6	16.6	15.8	14.1	13	\/	
Not classified										
Amyl nitrate	1.6	2.4	1.8	1.4	1.7	1.6	1.2	1.6		
Glues	0.2	0.6	0.4	0.3	0.1	0.2	0.1	0.2		
Total										
Class A	4.2	3.6	5	4.9	4.2	4.5	3.8	4		
Any drugs	19.2	28.8	19	19.3	18.1	17.5	16.4	15.1		
Unweighted base	1412	1233	1455	3084	4200	5327	6182	5875	\/	

1. Source 1996, 1998, 2000, 2001/02, 2002/03, 2003/04, 2004/05 and 2005/06 BCS
2. '/\' Statistically significant increase at the 5% level. '\/' Statistically significant decrease at the 5% level
3. From 2001, the reporting year for BCS data switched from calendar to financial years
4. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the BCS assumes all reported amphetamine use to be of the Class B variety. Similarly tranquilisers can be either classified as Class B (eg barbiturates) or Class C (eg benzodiazepines). Consequently Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquiliser respondents used
5. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse.
6. The table includes revised figures for young people's drug use for the period 2001/02 to 2004/05 to reflect amendments to weighting procedures.

Appendix Two

EMCDDA GRAPHS SHOWING EUROPEAN COMPARISONS BY DRUG USE

Figures for the proportion of 16-24 and 16-59 year olds reporting having used drugs in the last month by gender, 2005/06 BCS

	16 to 24		16 t0 59	
	Male	Female	Male	Female
Class A				
Any cocaine	4.1	2.1	1.7	0.7
Cocaine Powder	4.0	2.0	1.6	0.7
Crack cocaine	-	-	0.1	0.1
Ecstasy	2.7	1.2	0.9	0.5
Hallucinogens	1.3	0.4	0.4	0.2
LSD	-	-	0.1	0.0
Magic Mushrooms	1.1.	0.4	0.3	0.1
Opiates	-	-	0.1	0.1
Heroin	-	-	0.1	0.0
Methadone	-	-	0.1	0.1
Class A/B				
Amphetamines	2.2	1.0	0.7	0.4
Class B/C				
Tranquilisers	0.6	0.1	0.3	0.1
Class C				
Anabolic Steroids	-	-	-	-
Cannabis	17.1	8.9	7.3	3.1
Not classified				
Amyl nitrate	1.9	1.4	0.8	0.4
Any drug	19.2	11.1	8.6	4.0
Unweighted base	2731	3145	13434	16170

1. Source 2005/06 BCS
2. 16 to 24 year old analysis includes the youth boost sample, the 16 to 59 year old analysis is based on the core sample

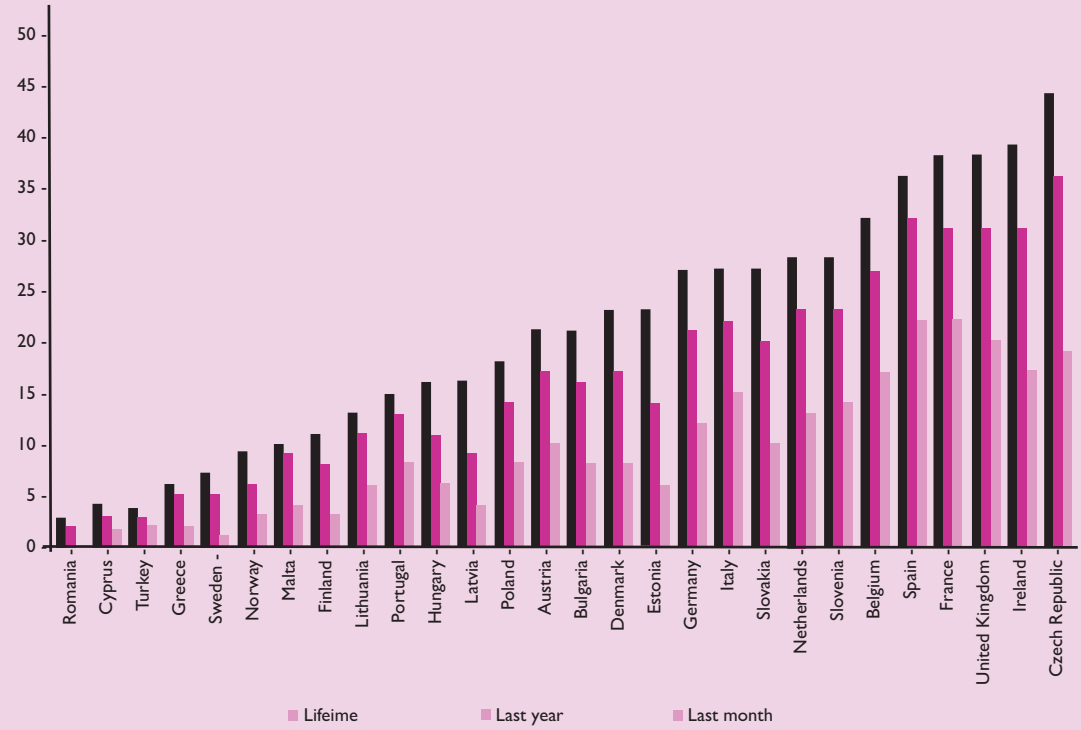
Figures for the proportion of 16-24 year olds reporting having used drugs in the last year by whether truanted or been excluded 2005/06 BCS

	Truants	Non-truants	Excludees	Non-Excludees	Total
Class A					
Any cocaine	11.2	3.0	11.5	4.5	5.9
Cocaine Powder	11.1.	3.0	11.4	4.8	5.9
Crack cocaine	1.0	0.0	1.0	0.0	0.4
Ecstasy	9.0	1.8	9.7	3.3	4.3
Hallucinogens	6.8	1.6	6.4	2.9	3.4
LSD	2.2	0.2	3.1	0.6	0.9
Magic Mushrooms	6.0	1.5	5.1	2.6	3.0
Opiates	-	-	-	-	0.2
Heroin	-	-	-	-	0.2
Methadone	-	-	-	-	0.1
Class A/B					
Amphetamines	6.9	1.3	7.5	2.4	3.3
Class B/C					
Tranquilisers	1.7	0.2	2.3	0.5	0.7
Class C					
Anabolic Steroids	0.6	0.2	0.7	0.2	0.3
Cannabis	33.9	14.3	33.8	19.2	21.4
Not classified					
Amyl nitrate	7.3	2.1	6.8	3.4	3.9
Glues	1.2	0.1	1.3	0.3	0.5
Total					
Class A	15.8	4.5	14.5	7.3	8.4
Any drug	39.8	17.6	39.1	22.9	25.2
Unweighted base	2041	3457	689	4055	5802

Source 2005/06

Appendix Two

EMCDDA GRAPHS SHOWING EUROPEAN COMPARISONS BY DRUG USE



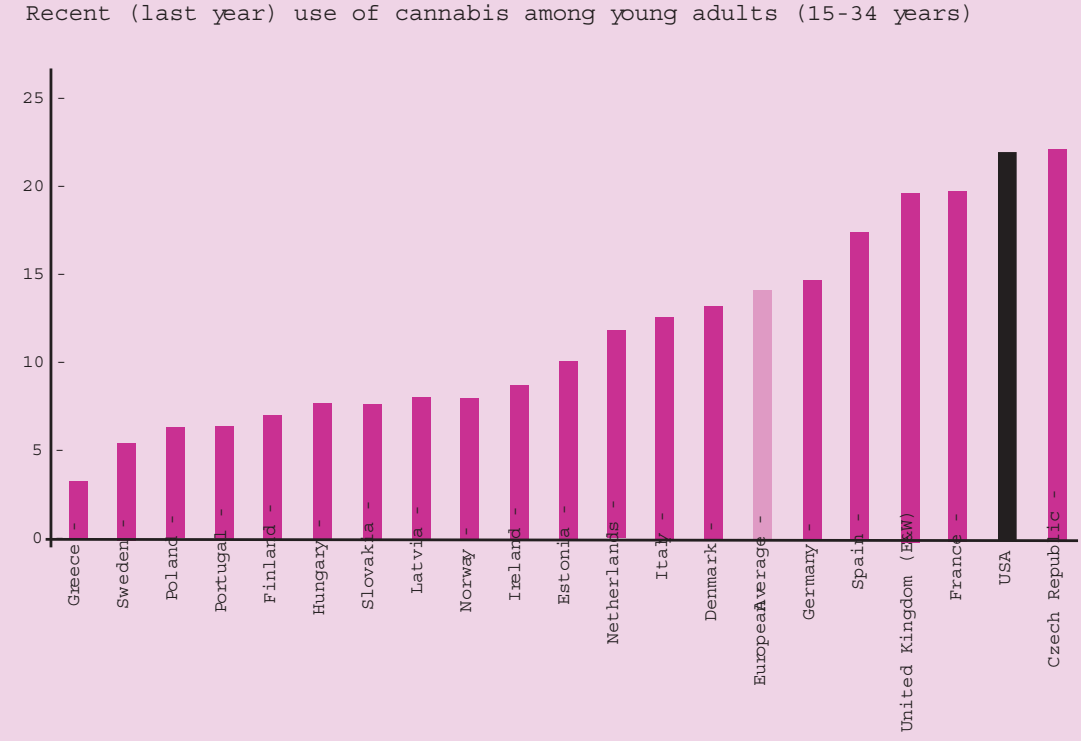
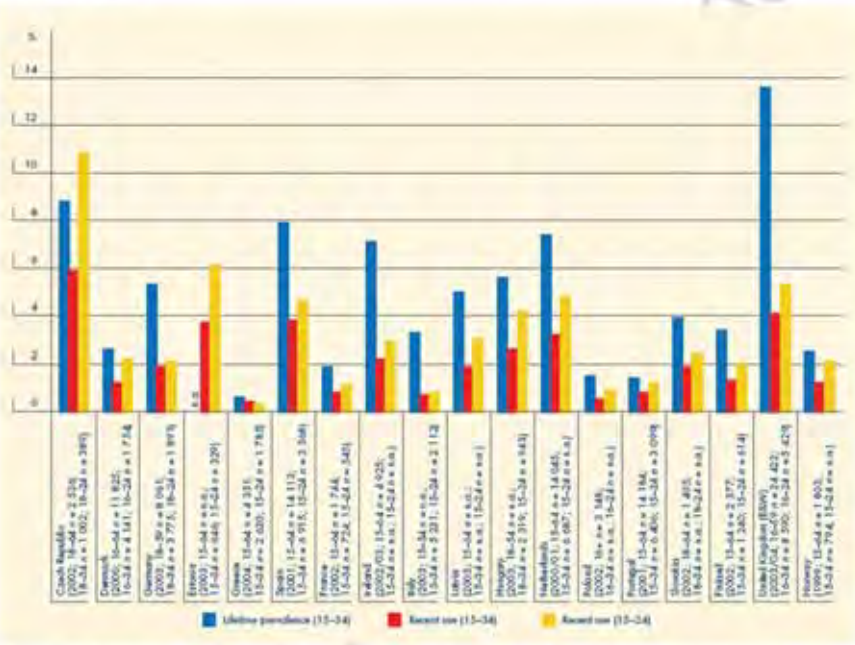
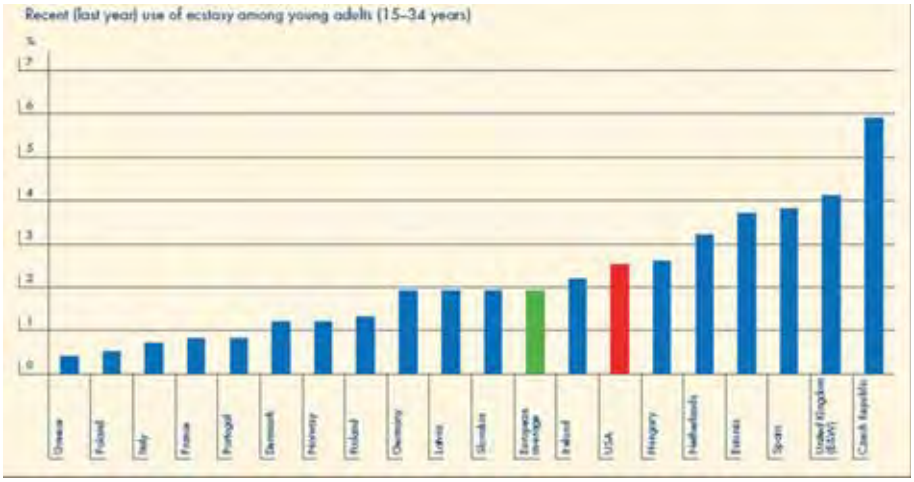


Figure 7: Lifetime prevalence and recent (last year) use of ecstasy among young adults at selected ages, 15–34 and 15–24, measured by population surveys



Recent (last year) use of ecstasy among young adults (15–34 years)



Recent (last year) use of cocaine among young adults (15–34 years)

Appendix Three

SUMMARY OF THE SURVEYS PERTAINING TO CHILDREN'S DRUG AND ALCOHLO ABUSE[176]

Study name	Study design	Study population	Sample size	Survey dates	Substances
Pre-teens					
Avon Longitudinal Study of Parents and Children (ALSPAC)[72]	Cohort study	Children living in the Avon and Bristol area born to mothers pregnant in 1991–92	14,000 at birth; 7,000 aged 8 and 10; 1,700 aged 12 (incomplete dataset)	Every 2 years: 2000, 2002, 2004	Tobacco and alcohol aged 8 and 10; cannabis, tobacco and alcohol aged 12
11–15-year-olds					
Edinburgh Study of Youth Transitions and Crime[73]	Cohort study	Children recruited aged 11–12 in Edinburgh in 1998	About 4,300	Annually, 1998 to 2004	Tobacco, alcohol and other drugs
Belfast Youth Development Study[79,80]	Cohort study	Children recruited aged 11–12 in Belfast in 2001	About 4,300	Annually, 2001 to 2005	Tobacco, alcohol and other drugs
Health Behaviour of School Children (HBSC)[13]	International cross-sectional survey	11, 13 and 15-year-olds. In 2001–02 included 35 European and North American countries	1,500 in each age group in each country	England: 1984, 1998, 2002 Scotland: Every 4 years 1990–2002 Wales: Every 4 years 1986–2002	Tobacco and alcohol aged 11; tobacco, alcohol and cannabis aged 13 and 15
European School Survey Project on Alcohol and Drugs (ESPAD)[1]	International cross-sectional survey	15–16-year-olds in 30 European countries	In 2003: about 90,000 across 35 countries	Every 4 years: 1995,1999, 2003	Tobacco, alcohol and other drugs
Smoking, Drinking and Drug Use in Young People (ONS/Nat Cen/ NFER)[2]	National cross-sectional survey	England and Wales; Scotland	England and Wales: about 9,700 in 2003 and over 9,000 in 2005 Scotland: about 4,700 in 2000	Annually from 1998	Tobacco from 1982; tobacco and alcohol from 1988; tobacco, alcohol and drugs from 1998
Scottish Schools Adolescent Lifestyle and Substance Use[16] Survey (SALSUS)	National cross-sectional survey	Scotland	In 2002: about 23,000 In 2004: about 7,000	2002 and 2004	Tobacco, alcohol and other drugs

176 Pathways to Problems. ACMD report 2006

PART TWO
Shattered lives and collateral damage

"Addiction means you lose empathy and time to think about yourself. Drugs and alcohol are used by adolescents to deal with emotions they otherwise cannot cope with."
Melanie Gill, forensic psychologist, Witness Evidence

"Children arriving at Kids Company often have deep drugs problems – the main issue for them is drugs and alcohol. We smell alcohol on them when they arrive – typically they are losing weight, they are rejected, they have poor attachment and many have gone into prostitution."
The House Manager, Kids Co, Witness Evidence

PREFACE AND TESTIMONIES

The costs of substance misuse are not measurable simply in terms of public health or crime costs. They exist in the shattered lives of the individuals and families concerned, the devastating physical and psychological inheritance handed down to children, and in the corruption and destruction of wider communities. These are what we describe as 'psycho social' costs. The real costs of child neglect and abuse - children in care, subsequent low educational attainment, unemployment, dependency, prostitution, crime and/or mental health problems and homelessness - defy quantification but none the less have a negative effect on the social, economic and political health of society – on society's general wellbeing.

In this section, we examine how substance abuse contributes to this cycle of deprivation. It is one which leaves children ever more neglected, their families overwhelmed and unsupported and their behaviour unchallenged. We consider:

- The ways substance misuse damages life chances particularly of lower socio-economic groups where there are no 'safety nets'
- The part it plays in youth and gang culture in inner city areas and housing estates blighted by substance abuse.
- The particular role and dangers of cannabis for these children's and young people's lives. It is the drug of initiation for most young people, it shares all the harms associated with cigarette smoking, many more which are uniquely damaging to adolescents.

Then we review the calculable and 'officially presented' health and crime costs of drug and alcohol misuse which have informed the government's approaches to and choices about drugs treatment policy and provision. We suggest that of itself this is an incomplete way of assessing 'harm'. And finally, in this section, we present the views of former addicts, substance abuse workers and academics on the causes of the massive spread of substance abuse through the population. We are making every effort in our enquiries to listen to those who have been affected. Some of their testimonies are presented here

Ruth

As far back as I can remember my mind was confused. I watched children with parents and thought why haven't I got a mum or a dad? What did I do wrong? Then suddenly I was taken to a home with parents but only for a short while, then I had to move on., why? I was taken to children's homes and through these years I longed for someone to cuddle me and tell me they loved me, as I just didn't belong. I cried and I cried but no one heard. My tender heart was breaking and at the age of 8 I tried to come to terms with everything. The tears stopped and gradually my heart was hardening as I realized that no one cared. I was alone and lost so I decided to fight back. Physical, mental and sexual abuse made me feel worthless and somehow I blamed myself.

Soon I was the victim of self harm and overdose. I then tried to fight back and became very violent, music built the aggression and by now I was addicted to hard drugs. Labelled uncontrollable I was locked in a secure unit; I became a dangerous person, hard, bitter and anti social. I had social workers, drugs counselors, methadone programmes, probation officers, psychiatrists, psychologists, housing officers but my barriers were so high no one could break through. Then came the prison sentences. I was in a cell with a girl and she talked to me, I planned to try to share my hurts with her, but the next morning she was hanging from a rope in my cell. Dead. I became untouchable.

Former addict and inmate of first a secure unit then prison.[1]

1 Witness evidence (Through the help, care and love she found at Victory Outreach UK this young woman's life has changed. She is doing courses in Health and Social Care, Horse Care and Animal Management

Craig

My dad left when I was about seven or eight, and then we lost the house and we moved onto the estate. But money was always tight anyway, because looking back on it now I assume the money went towards drink really - more than anything else. My mum had to go out and work and get as much money as she could; it was quite difficult getting the maintenance off my father anyway. And she worked in a pub, and we were left to it really. We were always scruffy, and I suppose rather than be picked on, I stood up for myself, so I soon gained a reputation as that sort of fighting boy, and I was left alone…..

I don't know when I first experimented with alcohol, but it was very young. We were never discouraged from drinking, particularly. I drank to get drunk from about nine or ten years old. I also smoked at about the same time, so I'd say about ten years old when I started smoking. I was hanging around with all the older children, my mum was working in a pub, so I was out roaming the streets to all hours of the night. She'd then go on to clubs, and I suppose she wanted – because she got married so young – she wanted a social life as well….

There were letters threatening to exclude me from school within weeks of me being there, and by the time I was twelve . . . my behaviour was off the wall and she put me into care when I was twelve years old. I arrived in care, within a week I was I was introduced to solvent abuse and began experimenting with cannabis. . . you know when I got there, everyone else was fifteen, sixteen years old, and I was twelve, and I was in with all of those…..I also clocked up my first criminal conviction for shoplifting.

I missed a large amount of my education. Returning to mainstream school at fourteen I was expelled six months later and got another couple of convictions for petty offences. Between the ages of fourteen and sixteen I was moved constantly and also expanded my drug scope to include speed and LSD. My criminal record also expanded. From sixteen years old I loved being on my own and was experimenting with ecstasy. At this age I also received my first custodial sentence. By the time I was nineteen I'd been back twice and had begun taking heroin. Between then and twenty-four I was constantly in and out, more in. Then it was just in. I received seven years imprisonment for drug offences.

A former addict[28]

A young girl

"I got involved in a new group of friends who used drugs and who did a lot of drinking, and it just sort of, you know, went on from there. I basically followed the pack around, I was a sheep, you know, if they drank I drank, if they took drugs, I took drugs. It got to a point where – with me only being so young – I couldn't get the money for the drugs anymore or the drink. So a friend of mine at the time turned round and said, there's this boy, he fancies you, go out with him, and I did what she said, and that's how I ended up getting my drugs…

…I had my father who drank a lot, my sister was only young and my mam wasn't around – so really I was on my own apart from these friends.

…..you just feel as though your body's been taken from you, as though you're no longer a person, you're just like a piece of meat, you don't mean anything, you have no emotions, you're at the very, very bottom you can ever be at, and it just feels like there's light, there's no going back, there's no nothing. And you feel as though that's how you were meant to be".

A teenager talking on the Today programme, 14th June 2006, in an item about the work of Barnado's in helping such young people.

2 Witness evidence Following a long sentence at Dartmoor and a final sentence Wormwood Scrubs with a period in an intensive therapeutic group under the late Dr Max Glatt (now discontinued) Craig transformed his life and completed a degree in journalism.

A Care Provider

One major factor with any addiction is the need to fund the ever-increasing habit. This often begins with deceit, cheating, anti social behaviour, lying and considerable anger. These can then easily lead into threats, fights, stealing, robbing, malicious wounding and prostitution, and can then end up with violence expressed in murder and suicide.

The addiction often leads to considerable personality change, and as the addiction builds the craving increases that then causes manipulation of both self and others. One expression is a need to gain control in what is an every increasingly chaotic life style. With the strong this can be expressed in violence and alternatively the weaker person will often move into depression and even suicide.

Dinah Sansom, Co-Founder and Director of Victory Outreach UK, a Christian organisation that provides an extended family support for an average of sixty young people

An academic 'substance misuse' researcher

I think probably the role of grandparents is one of the great unsung heroics, actually. They're not paid a thing for what they do; their role's not really recognised, and yet they are in the foster carer's situation, but without the foster carer's allowance and the foster care's support groups .. . (you see) less than fifty percent of addict parents are living with their children. I think, you couldn't ask for a clearer statement of how drugs impact on families and your ability to parent than the fact that over fifty percent of these parents are not looking after their children.

Professor Marina Barnard who has interviewed twenty grandparent 'carers' of their addict children's children as well as sixty four addict parents – drawn from those who checked in at the Drugs Crisis Centre in Glasgow

Chapter Five The Costs and Consequences of Substance Misuse

5.1 HEADLINE STATTISTICS

Alcohol Impact

- An estimated 920,000 children in the UK are currently living in a home where one or both parents misuse alcohol; 6.2% of adults grew up in a family where one or both of their parents drank excessively.
- An estimated 80,000-100,000 children are affected by parental alcohol misuse in Scotland alone.
- Marriages where one or both partners have a drink problem are twice as likely to end in divorce as those not affected by alcohol.[3]
- Between 60% and 70% of men who assault their partners are said to do so under the influence of alcohol.[4] According to a recent UNICEF report 40% of domestic violence incidents in the UK are alcohol related.[5]
- 23% of child neglect cases identified via helpline calls involve parental alcohol misuse; parental alcohol misuse was also reported in 13% of calls about emotional abuse, 10% of calls about physical abuse, and 5% of calls about sexual abuse.
- Anything between 240,000 and 963,000 children are exposed to domestic violence 40% of which is alcohol related
- One third of cases of child abuse are associated with alcohol consumption
- Heavy drinking by parents was identified as a factor in over 50% of child protection case conferences
- In 2004 9 children per day were admitted to hospital for alcohol poisoning.
- Hospital admissions for children with mental and behavioural disorders due to alcohol use have risen in England - from 2455 in 1998 to 3216 in 2004, a rise of some 30%
- Potentially, three and a half per cent of the population could be affected by pre-natal alcohol exposure, possibly as high as 2.1 million people and more than three out of every hundred babies born could have been damaged by their mother's drinking during pregnancy[6]
- Growth defects are the cardinal feature of fetal alcohol syndrome. Prenatal alcohol exposures predicts continued deficiency at 14 years[7]

Drug Impact

- There are estimated to be 350,000 children in the UK with an addict parent. (There is no estimate of the number of children in households where there is contact with illegal drug use – relatives and friends of parent and siblings. This group of children is likely to be well in excess of the numbers in the first group and they are also at increased risk).[8]
- In Scotland alone there are estimated to be 40,000-60,000 children affected by parental drug use.[9]
- Across Scotland, the rate of births involving drug abuse has risen from 4.4 per 1,000 live births in 1998/99 to 6.1 in 2003/04, the year covered by the latest figures – that is by about 30% . In some places they have more than doubled (Argyll and Clyde), almost quadrupled in others. Greater Glasgow recorded the largest number of newborn addicts, 70, followed by 58 in Grampian, 40 in Argyll and Clyde and 39 in Tayside.
- More than 300 babies are born addicted to heroin and other illegal drugs every year in Scotland.
- In parts of North England 7.5 babies per 1000 live births born to drug-misusing mothers have been documented (ten times higher than previously documented prevalence).
- 16% of pregnant women from one UK inner-city clinic tested positive for one or more illicit substances.[10]
- Opiate, cocaine and cannabis use in pregnancy increase risks of premature delivery lower birth weight, ante partum haemorrhage and intra-uterine death, postnatal breathing and metabolic problems, and neonatal withdrawal syndrome, birth defects and disabilities, including cerebral palsy, blindness and hearing problems.
- Infants born to cannabis-smoking mothers are believed to be at a much higher risk of developing leukaemia in later life.

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3 Alcohol Concern, Alcohol Problems costing Britain 3.3 billion a year 2000

4 Galvani. Alcohol Concern Acquire winter 2005

5 Behind Closed Doors: The Impact of Domestic Violence on Children, Unicef August 17th 2006

6 Dr Raja Mukherjee St George's Hospital London, BBC Today 29th October 2006

7 Alcoholism: Clinical & Experimental Research. 26(10):1584-1591, October 2002., Day, N. L.; Leech, S. L.; Richardson, G. A.; Cornelius, M. D.; Robles, N.; Larkby, C.

8 Professor Neil McKeganey, Interview May 25 06

9 ibid

10 Sherwood RA, Keating J, Kavvadia V, Greenough A, Peters TJ "Substance misuse in early pregnancy and relationship to fetal outcome" European Journal of Paediatrics; 1999; 158 (6): 488-92

- There is almost no dedicated drugs treatment provision for children
- In 1997 88% of young homeless in London, a high proportion of whom have previously been in care) were found to take at least one drug and 35% of them to use heroin.[11]

5.2 HIDDEN HARMS OF DRUG MISUSE

The Hidden Harm Report published in 2002, commissioned by the Government ACMD, for the first time focused government attention on 'hidden costs' – particularly the adverse consequences for children of parental drug misuse and on the existing research evidence for this. It has not however become the plinth from which drugs policy has developed.[12]

Harms Accruing to the Individual [13]

- Physical - including major injecting-related problems, e.g. abscesses, blood-borne virus infections; overdose; accidental and non-accidental injury.
- Psychological - including priorities dominated by drugs with drug ingestion usually a daily event and an essential requirement for everyday functioning; unpredictable and irritable behaviour during withdrawals; chronic anxiety, sleep disorders, depression, suicidal behaviour; post-traumatic stress disorder; serious memory lapses
- Social and interpersonal - including family break-up; loss of employment; unreliability; chronic or intermittent poverty. Rejection by former friends and community. Victim or perpetrator of physical, psychological or sexual abuse. Eviction and homelessness. Need to engage in property, crime, fraud, drug dealing or prostitution to pay for drugs. Association with other persistent offenders.
- Financial - including constant requirement to find large sums of money to pay for drugs. Substantial debts and inability to pay for basic necessities.
- Legal - arrest and imprisonment. Outstanding warrants and fines. Probationary orders. Drug and alcohol abuse lead to prostitution….and to jail

Harms associated with 'substitute' or 'prescribed' (usually methadone) drug use dependency, and the extent to which it results in a similar set of harms is one that now concerns politicians and academics as well as substance misuse workers have voiced concern about its use.[14]

Harms accruing to children living in Substance Misusing Environments

- The adverse consequences for children are multiple and cumulative and vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment.
- The stark impact of parental drug abuse on their children is known from interviews with 30 recovering heroin addicted parents who said their children experienced material neglect, were exposed to drug use and dealing and to the risk of violence and physical abuse.[15]
- A specially commissioned poll conducted for the Social Justice Policy Review has thrown up 'testimonial' evidence of the close interrelationship between family breakdown, parental substance abuse, early (negative) childhood experience and subsequent substance abuse.
- Substance misusing parents themselves are usually single and the mothers have high levels of vulnerability. They have often been in care themselves or known to social services as a child.[16]
- Those working with parents misusing drugs have noted the highly unpredictable patterns of behaviour that expose their children to multiple risk. Professor Marina Barnard has worked closely with a sample of Glasgow families where parental drug abuse was taking place

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11 (Flemen 1997)

12 The response of the Scottish Executive has been much stronger than that of the UK government

13 Extract from the Hidden Harm Report- responding to the needs of children of problem drug usersHome Office 2002

14 Duncan McNeil, MSP for Greenock, BBC Radio 4, Today, 12th May 2006, Professor Neil McKeganey, Witness evidence

15 McKeganey et et al Drugs;Education, Prevention and Policy, Vol 9 No 3 2002

16 Parental Substance and Child Welfare: A Study of social Work With Families in Whivh Parents Misuse Drugs or Alcohol, Judith Harwin and Donald Forrester, Brunel University

Professor Marina Barnard

With drug misuse things change so quickly – a person could be on methadone and be getting methadone every day for a week but then on Friday someone comes round to visit them with a load of drugs and they just go haywire. I've got cases - it's absolutely integral to my data – which show it's not a kind of 'add on of addiction' but that it's a central feature, this unpredictability, the way that things can change within an hour. I'll give you an example of a mother. A bloke came round to her house, he had some heroin and a lot of money and they took off. From Scotland they went to Brighton where they set up a tent and just injected drugs for three months. She rang her mum and said, 'mum, can you pick up my son?' so mum went and picked up her son. The mother was not in contact with them for three months after that. Her son didn't know where she was, he didn't know if she was alive or dead. The grandmother didn't know if she was ever coming back, nobody knew anything. The drugs were there, they were on offer and she just went. That's the compulsivity that's at the heart of it. With alcohol people binge but it's not the same. I think the key thing is the degree to which children are vulnerable. If you've got a mother who is using drugs, and she is the main parent carer, and every other bloke who comes in that she comes into contact with is using, which is largely the case, then you've got a child who is very vulnerable. Drug users are much more likely to be single parents than alcoholics. Fully three quarters of them will be single parents and where they are not they have their partner who is a drug user. I don't know any woman who had a non-drug using partner. Then the children are much more exposed to the full force of it . . the fact that the effects of the drugs wear off after a few hours, they start to withdraw and that's a physical state and a very dangerous time … because parents are highly irritable . . . so for a children it's a time when they keep out of their way basically. Then parents will go on this mad chase across the city, or whatever, to try and find drugs, with or without the child. That's a decision that has to be made every single time you use drugs, 'do I take the child or do I not take the child' . . . and either way, the child's at risk . . . left at home alone or . . .

The government's response to Hidden Harm, is that they don't want to recognise the incipience of the problem; they want to talk about it as being a sort of 'manageable risk', that they can put services round families to manage that risk. And the reality is you can't really manage that risk.[17]

Evidence presented to us included countless examples of children who have witnessed their parents' drug and alcohol use; who experience the uncertainty and chaos of family life dominated by substance misuse, strangers' drug use, their own abuse and exposure to criminal activity such as drug dealing, shoplifting and robbery:

'Letter to Julie'

I remember hearing of you as a nine-year-old in a school in south London. I was supervising your trainee therapist. She clearly cherished you, her smile always cut short halfway as some worry would interrupt the delight she felt. We knew you had secrets, but you were too well guarded. Your joy in the play room, touching every toy as if it was yours. But your desperation signaled alert. And your sadness was heartbreaking, as you left the session. A little nine-year-old with such composure, such dignity and a silence deeply burdened.

Years later, you were to tell me that this was the age at first, when your mother offered you cannabis. I will never forget the sense of betrayal. I remember my worry; I took it to bed, pondered it at night wondering what you were so unable to tell.

You and your siblings suddenly disappeared and we never saw you again, like so many other vulnerable children a shifting statistic leaving one register, to perhaps reappear on another. Faceless, mindless trafficking of children from place to place.

Two years later, when our children's centre opened at The Arches you reappeared. I had never seen you, but I had never forgotten you through the description of your therapy sessions. You seemed silent, vigilant and bewildered, still secretive. With you came your eight-and nine-year-old brothers as well as your five-year-old sister. Your feisty little family, beautiful glinting faces faded behind the dirt. You were only a 12 year old, but the responsibility was palpable in every inch of your tense muscles. You disguised your need and kept busy meeting the desires of your siblings. It was simple things they wanted: food, warmth and shoes.

Soon we discovered none of you were in school. When you had disappeared from your primary as a 10-year-old, you had not gone back to school; neither had your brothers and sister. You kept bursting into tears, but we could not identify the origins of your pain. It was sad, sad to see so many official letters had been sent home, demanding your parents to send you to school. So many letters threatening them to be taken to court. But no human being had bothered to knock on the door and find out where four children had gone. You invisible children, drifted to the streets disappearing in the mayhem of Peckham. No one really knew your secrets.[18]

17 Witness Evidence

18 An extract from Parental Addiction, Shattered Lives, Camila Batmanghelidjh, Jennifer Kingsley 2006

- The system at present renders the children invisible Professor Barnard argues. . . . " If (services) are not asking about the impact of your habit on your children, if the doctor is prescribing you 80mls of methadone, and he doesn't know if you have young children in your care, and he doesn't know what impact that methadone has on the child, that's a problem. If you have drug workers who are not thinking about how that parent's drug use impacts on their ability to care for their children, that is a problem and those are the ways in which children have been kept invisible."
- The education of such children is disrupted; they have to act as carers for their parents and younger children; they live with the fear of public censure and separation. Professor Barnard succeeded in getting the children to talk openly about their feelings. She tells of a 14-year-old girl describing her ambivalence about attending school when her parents were problem drug users:

"...When I went to school I thought right I'll not get shouted at, I'll no' get hit and I'll no' get the rest of it and I'll no' see them taking drugs and I thought at school, at the same time, kinda thing, what's gonnae happen the day when I'm not in the house? What's gonnae happen, what's ma Mum and Dad gonnae do the day kinda thing?"[19]

She found children stayed off school out of anxiety over what might happen to their parents whilst they were away.

"And just I used to stay off tae make sure my Ma didnae get drugs and all that...'Cause I hate it...I'd follow her and not let her do it...like I would make sure she stayed in the house with me." [20]

She reported their feeling a deep sense of absence and isolation which was conveyed in the often used phrase that their parents were not 'there for them'. One 12-year-old boy, for example, kept his mother's drug problem a secret out of fear of the consequences of not doing so, including being mocked by his peers.

"I just couldn't tell anybody 'cause it's like...it's hard to tell someone and if they find out, they like phone the police and you might-get took off your Mum and your Dad and the Police will get involved and that."[21]

Child protection failure and lack of appropriate intervention exacerbates the harms for children

- Parental substance misuse is not dealt with by social workers and the child protection system is inadequate.[22]
- Although substance misuse has been found to be the most common issue that social workers deal with – it is the one they appear to be least equipped to deal with. Most social workers are not substance abuse professionals nor do these families usually have other substance abuse professionals working with them.[23]
- Outcomes can be lethal: A two year old toddler died after swallowing his parents methadone, a case which highlighted the risks of unsupervised use of the drug. The responsible Director of Public Health Medicine of NHS Lothian said the majority of the 3000 addicts in his area were allowed to take methadone home on at least one day a week.[24]
- Of all the uncertainty and reliability of the information about the numbers of problem drug users the most glaring data deficit concerns their children. There is no record or proper monitoring of this population of children at risk.

The first recommendation of the Hidden Harm Report, was that problem drug using clients accessing treatment should be asked for basic information about their children. It is not clear that nationwide implementation of this has taken place.[25] This is a priority. An active reluctance on the part of professionals to ask about children is a factor.

Camila Batmanghelidjh, Founder of Kids Co.[26] reports writing to directors of social services begging for protection for children who were prostituting themselves to pay for their addiction:

".. and then the social services would write back denying the events as I described them. Imagine being told a teenager with a drug habit of £150 - £170 a day didn't have enough pocket money from social services to buy drugs and therefore she couldn't be addicted."

19 Hidden Harm Home Office 2004
20 Barnard, M and Barlow, J. Discovering parental drug dependence: Silence and disclosure. Children and Society, 2003; 17: 45-56.
21 ibid
22 Harwin and Forrester, Op Cit.
23 ibid
24 Scotsman Evening News 11.3.06
25 Government Response to the Hidden Harm Report
26 Kids Company is an inner city safe haven giving vulnerable kids a greater resilience

She has concluded that:

> *"… there are fundamental flaws in the way we treat children and in the way our services are structured. The services unwittingly discriminate against the disadvantaged, especially against the children who do not have a competent carer in their lives"*[27]

One expert witness, who wished to remain anonymous, commented to us: "Drug services in Scotland are getting better, but there was a while ago, (a situation) where you kind of think the drug service is almost complicit with the drug user in just not asking questions about children. It's a kind of 'it's not my job' scenario. 'I deal with the adult and their substance misuse problem, not anything else'."[28]

Another anxiety identified to us was concern that asking addict parents about their children would frighten them and drive them away from treatment. However Professor Barnard told us that:

> *"There's a substantial body of research evidence from the States showing that where child protection concerns have been raised directly with clients and, irrespective of anxiety of whether they would or would not leave treatment, with the vast majority of them it didn't actually affect their therapist relationship, or if it did affect it, they came round and worked through it and it was a better relationship for having done it."*

She concluded that it was:

> *" a kind of cowardice, actually to ignore it and that if the therapist or substance misuse worker wants to have a true relationship with the client he or she has to deal with the difficult issues. Irrespective of all of that you have a duty of care to know where that child is and how that child is being looked after. It's not really an either/or issue. In fact, the Children's Act clearly states that every person, every person in this room has a responsibility, has a duty of care to those children."*[29]

Recommendation

The emotional deprivation resulting from widespread parental substance misuse and the traumatic roots of destructiveness and violence in such early parenting experiences warrant greater attention than as yet given by the government. The government's reaction to the Hidden Harm report is generally accepted to have been deeply disappointing in England, by comparison with Scotland. Its recommendations need to be acted on.

> There's a real hypocrisy, isn't there, that in one sense we talk vehemently about how we are concerned for the welfare of our children, and yet we tolerate such widespread abuses of our children. When parents are clearly harming their children as a result of their drug dependency, you're going to reach a point where you have to make the choice: is it in the child's interest to remain in an addict family, or is it in the child's interest to be placed elsewhere? Invariably, somebody says to me, 'well, we know that the child will do worse if you take it away. And I always say, well what's worse than having a child care system that doesn't look after children? It's knowing you've got a childcare system that doesn't look after children, and not doing anything about it. How anybody can make that assertion with a degree of comfort - just make a bald statement that we can do no better by way of parenting these children than the neglectful lives, mired in criminality and neglect which they have in their own homes?
> *Professor Neil McKeganey*[30]

The duty of care to children should be paramount in the minds of substance abuse works and social workers in contact with substance abusing families with appropriate training initiated

Harms accruing to parents and siblings of drug abusing children

Professor Barnard also told us of other families where the parents are thrown into disarray by the discovery that one or more of their children had developed a drug problem and of the impact in terms of human misery and helplessness that drug abuse by a family member causes:

> *Me and Shona(wife) for ten year our life got kinda took away from us. I felt that we were in a big hole hanging on to the sides … and I think it was the helpless, the powerless stuff, you know. I n my whole life I was never so fucking powerless or helpless to deal with anything that came my way. One way and another, I could deal with it but I couldna deal with this. I couldn't change it. I couldn't make it better.*

27 Shattered Lives Camila Batmanghelidjh, Jennifer Kingsley 2006
28 Witness evidence
29 Professor Barmard Witness Evidence
30 Witness evidence

Families spoke of the unpredictable and uncontrollable behaviour of the drug using member caused by dependency on drugs.

She would smash up the room and all this to get out. One time we said we're going to lock the front door. We should not need to do that. No mother should need to lock the fron door on their kids but we were desperate… And the next minute a lassis is shouting up '…Sonioa, Mary has fallen out of the window.' She was in hospital three or four weeks and on crutches for another three or four. She was very lucky and I could not get how she was dying to get out. See this compulsion she had, she wanted out that door.[31]

One mother who gave evidence to us also spoke of having to cope with the fact they are living with a long term problem:

When my son was sentenced his case hit the newspapers a large number of people wrote to me saying they had had similar experiences. Many people I know said their children or their friends' children had been addicted. They had all gone through agonies trying to get help and in many cases their children had died. My son relapsed several times … methadone never worked for him…. he went into custody where they gave him this drug buphrenophine, and he detoxed by reducing the dose, which is easy to do, because it doesn't involve your . . . methadone gets right into you, and this is relatively easy to do. I mean, it's not a piece of cake, but you can do it. And he was on probation, he was in a bail hostel, he had a certain element of monitoring. He was given a voluntary job, working at a children's centre, and, you know, touch wood, he's alright now three years on. He's working in a different job, but for the moment he's recovered. But you do have to come to terms with the fact that it's like being an alcoholic, you can relapse.[32]

5.4 DAMAGED LIFE CHANCES – CYCLES OF ADDICTION, CHILD ABUSE, EDUCATIONAL FAILURE, HOMELESSNESS AND UNEMPLOYMENT

The testimonials we heard from former addicts and offenders. These indicate the extent to which parental alcohol abuse is at the heart of child abuse, neglect and family breakdown and appears to be a significant risk facts for a child's substance misuse, risky behaviour and later addiction:

Early sexual encounters.

The UK has the highest rate of teenage pregnancy in Western Europe as well as one of the highest levels of alcohol use among teenagers in Europe. Both cause concern because of the further risks associated with them, educational failure, unemployment and poverty.

A personal account

I was brought up as a kid around drugs, my mum being an addict and my father being a bad binge drinker at weekends. So I always say that it was kind of natural for me to progress from a child into drugs. In my early childhood… we were all going through this period where my father wasn't violent but he was abusive, more mentally. My mother, being an addict . . . and I would say to the social worker, 'look, this is what we have to go through, we have to go through on a weekend my father waking us up at half past three in the morning to clean the house', you know, which for any child should not happen. And because my house was clean and tidy, and my mother could speak as I am speaking to you now, and my father could during the week, nothing was ever done.

As a child I wasn't listened to.

It could have been prevented then, probably. I'm not saying that it would have been, but it probably could have been better. But because by the time I was nine years old, it was natural for me, to skin up a joint. When I was eleven, it was natural for me to turn to amphetamines and start to kind of get high every day. I was a speed freak first, then I went into amphetamines. Didn't go to school, or when I did I always sat at the back of the class, because it was thought that I had a learning disability. No one ever realised that I was actually addicted and a speed freak. Plus I was a troublemaker anyway; so combined with everything, I kind of slipped through the education net.

I ran away from home, came to London, thinking that I could change. The natural thing for me was to be found in Piccadilly Underground, and get out of my head on barbiturates. From there it was just progression after progression to harder stuff. And in fact, I got worse and became a heroin addict. By the time I was twenty-one, I was a full time addict. And for years and years . . . I came across the bridge (coming here) and I could see a couple of places where I used to sit in the mornings, you know – six o'clock in the morning, guarantee it, I would be there every morning. You know, and I'd beg for my first hit. And it sounds crazy now, but that first hit was me being normal and my second hit was me getting high. . . . My daily routine for years and years was to sit on the South Bank just across the road there and beg from six o'clock in the morning to get my first hit, just to be normal for the day. And that happened until I was 49 years old.

Jamie McCoy, ex-addict and ex-homeless[2]

31 Drugs in the Family The impact on parents and siblings Marina Barnard JRF

32 Witness evidence

- Severely intoxicated young people report rarely using contraception. The likelihood of teenage pregnancy is significantly associated with early age of first intercourse. Adolescents are less likely to use contraception the younger they are at first intercourse. Eighteen per cent of boys and 22% of girls who first had sex aged 13-14 said they had used no contraception
- Forty per cent of sexually active 13 and 14 year olds were "drunk or stoned" at first intercourse
- Only 13% of 16-20 year olds who were strongly intoxicated said they used contraception compared to 75% of those who were sober, and 59% who were moderately so.
- Among 15-16 year olds one in 14 said they had unprotected sex after drinking, and one in seven 16-24 year olds said they had done so
- Young people say alcohol is a main reason why they had sex, especially early sex or sex with someone they had not known very long.
- When asked why they had sex the first time 20% of young men and 13% of young women aged 15 to 19 said alcohol was a main reason
- Of 15 to 19 year olds who have had sex with someone they knew for less than one day, 61% of females and 48% of males gave alcohol or drugs as a reason
- Young people say they are more likely to have sex they regret when they have been drinking.
- After drinking, 10% of 15-16 year olds said they had sex they later regretted
- A third of 15-19 year old girls and over a quarter of boys regretted having sex that happened when they had been drinking.[33]

Illegal drug use, drinking and smoking predicts truancy

This is shown to be the case even after controlling for a range of other explanatory variables, including school experience, victimisation, parenting and a range of personality characteristics such as self esteem and impulsivity.[34]

Truants have a significantly higher incidence of illegal drug use, underage drinking and smoking than non-truanting pupils and rates of substance misuse increase over time.

Long-term truants exhibit a higher incidence of all forms of substance misuse in comparison with other categories of truant.

Substance misuse is less strongly associated with exclusion than it is for truancy but pupils who have been excluded from school report a significantly higher incidence of illegal drug use, underage drinking and smoking than their non-excluded counterparts.

One study revealed that 10% of the children interviewed admitted to have been, on 5 occasions or more, so drunk that they were sick, dizzy or fell over. A sizeable proportion had missed school on at least 5 occasions as a result of drinking[35]

Expressing concern about elementary school children arriving at school in the morning hung over Bill McGregor, general secretary for the Head Teachers Association of Scotland has said:."It is pretty clear that

Mark's story

When I first came down to London, I was told the streets were paved with gold, and it wasn't long before I found out that wasn't the case. But a long time before that I'd started smoking cannabis, drinking bottles of 'quite frightening' – the White Lightening on the streets, just a peer thing, everyone done it, and if you didn't do it you wasn't part of it. First of all I lived in Ilford… and I was once sort of banned from the whole town centre because I was such a prolific offender. And I was..using.. anything, everything, using drugs and alcohol from the minute I woke up, and I would just commit offences all day and all night. Shoplifting, it progressed into street robbery, you know, I was quite dangerous, just a menace you know. And it got to point where what I was doing, I didn't want to do any longer, but I just felt so powerless over stopping, and I didn't know how to ask for help, and you know, this was ten years ago, there's a lot more – thank God – help today than there was then. But you know, I was . . . and it was getting worse, I was smoking crack cocaine, injecting crack cocaine – and that is just an horrific drug, and mixed with alcohol, there's new research, this coke-ethylene now, which is the most toxic substance, alcohol mixed with cocaine in the body – lethal. So I was just under the influence of this all the time. And social skills didn't exist for me. I just forgot how to communicate with people. I was using the night shelters around Ilford and Redbridge at the time.[36]

Former addict and offender

33 Alcohol and Teenage Pregnancy Alcohol Concern 2002

34 Edinburgh Study of Youth Transitions and Crime Number 4

35 ibid

36 Witness evidence. He told us that many hostels which house recovering drug addicts are set up as 'wet' houses which was not conducive to recovery from substance misuse

more and more young pupils have access to alcohol at evenings and weekends." Tom Wood, chairman of Action on Alcohol and Drugs in Edinburgh has pointed out: "We have evidence of younger and younger children, including those of primary school age, being exposed to alcohol."[37]

Homelessness can be preceded and triggered by substance abuse

There is a strong association between homelessness and drug use. Crisis, the homeless charity, have noted a 12% increase between 1999 and 2000.

- 81% of the homeless surveyed by Crisis said that drugs and alcohol abuse had preceded their homelessness, that drug use was both a trigger of homelessness and prolonged it.[38]

A study of 1000 homeless young people in hostels and days centres in London found their homelessness to be closely correlated with drug and alcohol misuse. 88% of them were taking at least one drug and 35% were using heroin.[39] It found that on average:

- they had first become homeless at about 17 (15% of them under the age of 16); with many having remained invisible and lost to homelessness services; those who had experience of living in care were more likely to have run away from home.
- 21% of the young people mentioned drugs and alcohol use as a factor in their homelessness – having been asked to leave the family home partly on this account; that they were in danger of drifting prostitution and becoming ill.
- Those described as 'problem' users were predominantly white and male with many having had mental health problems and most wanting access to help or treatment
- 14% of the sample was identified as problem drinkers. Whilst 18 per cent of the sample did not drink at all, a considerable proportion was adopting risky drinking patterns
- Nearly half of all young people leave care at just 16 or 17 compared with children from stable background who tend to leave the family home in their mid-twenties. The break for the care leaver is dramatic. 'I was told I could not contact my foster mother,' said one, 'it was over.'[40] These young people are then forced to undergo, 'compressed and accelerated transitions to adulthood.(and) We expect the most in survival skills from those least capable.'[41]
- The Who Cares? Trust found that between 50-80 per cent of care leavers are unemployed, that many employers mistrust care leavers, that sixty per cent use drugs. It also found that 23 per cent of adult prisoners and 38 per cent of young offenders have been in care.[42]

In 2005 162,990 households were found to be homeless by local authorities. But Crisis estimates there are about 380,000 single homeless people living in Britain including those staying in squats, in hostels, on friends floors and in overcrowded accommodation.[43]

5.4 DAMAGED HEALTH

Alcohol Poisoning in Children

"Alcohol abuse amongst teenagers is storing up huge long-term health costs" [44]

"At Alder Hey Hospital in Liverpool, alcohol poisoning in the under-16s rose from 20 cases in 1985 to almost 200 in 1995, a pattern repeated across Britain. "Often the young person is found drunk in a car park, field, or street. Their friends have got frightened and left them alone. ….. Many have turned up with injuries." Kim Williams, the lead nurse in the casualty department, said staff treated about four cases a week among children under 15, most of them girls. The Telegraph 27/04/2004

- In 2004 that 3,322 children aged between 11 and 15 were admitted for alcohol-related problems; that some 2,760 were taken in for mental and behavioural disorders, and 562 suffering from alcohol's toxic effects, equalling nine children a day being admitted to hospital in England for binge drinking alone.

37 UPI
38 Crisis Homelesssness Factfile 2003
39 (Flemen 1997)
40 Harriet Sergeant Handle With Care, CPS 2006
41 Camila Batmanghelidgh, Shattered lives, Jennifer Kingsly, 206
42 Who Cares Trust
43 Crisis Factsheet
44 Paul Burstow Liberal Democrat health Spokesmen, Hansard Parliamentary written answer, 04/2004

- around 40–50% of 15 year olds are drinking alcohol at least weekly.[45]

Sexually transmitted disease risk

The rise of teenage pregnancy and sexually transmitted diseases has paralleled the steeply rising upward graph of alcohol intake by teenagers

- Forty one per cent of females with gonorrhoea are under 20 years old.
- A rise of over 100% of new cases of chlamydia and gonorrhoea between 1995 and 2000 was most significant among young people.[46]

Fetal alcohol syndrome risk

This as yet is a relatively unpublicised outcome of risky behaviour and is storing up significant problems for the future in terms of the health development, education and employability of these children.

One account

John Brooks and his wife adopted Edward when he was five. His biological mother was an alcoholic who died from liver failure. Edward shows classic signs of foetal alcohol syndrome. Not only does he have behavioural and learning difficulties, his physical development has been compromised. He is just four feet two inches tall. However, Edward has never officially been diagnosed as suffering from FAS. His adopted family has uncovered medical evidence that his mother underwent rehabilitation several times to try to bring her alcoholism under control. But she told doctors she was sober during pregnancy - and they believed her. At one stage Edward's adoptive parents were even blamed for his failure to grow. John Brooks said: "They made a big thing about his size, also that they thought he wasn't getting enough food. We were gutted. Without a diagnosis, we've never been offered any treatment for Ed because you can't give somebody something without a diagnosis." Ed still doesn't sleep at night, either I or Josephine have to be awake to keep him safe.[47]

- The National charity FAS Aware UK claims that more than 1,300 children a year are harmed in the womb due to their mother's drinking. Others put the estimated numbers higher affecting between one and three in every 1,000 live births.[48]
- The continuous upward trend in young women's alcohol intake suggests this figure will grow.
- One newspaper recently reported that a baby a day is born in the West Midlands with learning difficulties or physical deformities linked to Fetal Alcohol Syndrome.[49]
- Heavy drinking can impair the child's growth, his physical and mental development and result in behavioural problems.[50] Heavy post natal intake of alcohol by the mother severely increases the risk of 'sudden infant death' syndrome.[51]

Lord Mitchell questioning government inaction on fetal alcohol syndrome in the House of Lords observed:

> *"In most cases, FASD children look pretty normal, but some do have certain facial characteristics. They may be somewhat underweight and smaller than average children, but to the untrained eye they seem much the same physically as anyone else. Typically, they continue to pass as normal, until they reach early puberty, then they tend to be abandoned by their playmates. They adopt new and younger friends, only to be dropped again when they too reach puberty. Eventually, such children become friendless. Their peers outgrow them and leave them behind. Unable to hold down even the simplest of jobs, in adulthood they become totally dependent on families and friends. They become a massive economic burden on society and many become homeless and many end up in prison. The truth is that they are permanently damaged. The irony is that it is all totally preventable."*[52]

Substance misuse during pregnancy. The impact of opiates and methadone on pregnancy and infant growth – research findings[53]

No name yet designates drug impact syndromes on the unborn child, new born or on the developing infant but evidence of impact has been recorded.

- Neonatal abstinence syndrome or withdrawal symptoms occur in 55–94% of neonates exposed to opiates in utero (American Academy of Pediatrics Committeeon Drugs, 1998). Commonly seen symptoms include irritability, high-pitched cry, tremors, hypertonicity, vomiting, diarrhoea and tachypnoea.
- Hyperphagia also occurs, usually associated with

45 Pathways to Problems ACDM Home Office 2006
46 Public Health Laboratory Service 2001
47 Newsnight 4th Feb.2003
48 Lord Mitchell, Lords Debate, 18th October 2004 Hansard
49 Birmingham Post July 5 2005
50 The numerous and damaging medical problems related to alcohol and those passed to the foetus and to the developing child are to be found in Appendix X of this report
51 Arch Dis Child 1999;81:107-111 (August)Caffeine and alcohol as risk factors for sudden infant death syndrome
52 Lords Debate ibid
53 Substance Misuse During Pregnancy, K Johnson, C DGerada and A Grrenough. British Journal of Psychietry (2003) 183

weightloss, but occasionally with excessive weight gain (Shephard et al, 2002).
- Methadone, compared with heroin, causes more severe and more prolonged withdrawal (Chasnoff et al, 1990).
- A strong relationship has been reported between the maternal methadone dose at delivery and severity of neonatal withdrawal as assessed by the Neonatal Abstinence Score, length of stay and duration of treatment (Malpas et al, 1995).
- Infants of women taking opiates, particularly the synthetic opioid methadone, have a two to three times increased risk of unexplained sudden death in infancy (Davidson Ward et al, 1990); this may be due to abnormal respiratory control.
- Persistent weight retardation at age 12 months correlated with methadone usage during pregnancy, although this was not corrected for social status (Vance et al, 1997).
- Cocaine has been associated with placental abruption, particularly if taken around the time of delivery, and opiates increase the likelihood of antepartum haemorrhage.[54]
- The mean reductions in birthweight associated with drug misuse were 489 g for heroin, 279 g for methadone and 557 g for the combined use of heroin and methadone[55]
- Reductions in birth weight and head circumference appear most marked in infants of women taking cocaine or of those who are multiple drug misusers[56]• Developmental outcome may be impaired in infants of women who misuse drugs, as indicated by the wide variety of mild cognitive effects in pre-school children reported by researchers using the Bayley scales of mental development (Gauthier et al, 1999).

Children born to women maintained on methadone have been suggested to be more likely to show poor development, further compounded by factors associated with drug misuse such as smoking, alcohol misuse, poor nutrition, housing and education (Johnson et al, 1990).

Cirrhosis, suicide, assault and injury

Early onset liver disease is an issue of growing concern. Deaths from liver cirrhosis are rising faster in Britain than anywhere else in Europe.
- The death toll began accelerating 20 years ago, doubling in the decade to 2001 in Scotland and increasing by 2/3 in England. Researchers have blamed the culture of binge drinking.
- The rise has been especially sharp in men and women aged under 45, where death rates now exceed the European average. Between 10 and 25 per cent of alcoholics develop cirrhosis, but some do not because of genetic factors.
- Professor Moira Plant, a specialist in alcohol studies based at the University of West of England, said:

"There are now young women in their late teens and early twenties developing liver damage that in the past was not being seen until the age of 60 or 70."[57]

- Heavy drinking also been associated with heart disease, poor sexual performance, dementia and muscle degeneration.[58]
- Alcohol is associated with: 65% of suicide attempts and with 76,000 facial injuries each year. It makes the individual more accident prone, more likely to be in a car crash, and more likely to be the victim of an assault.

5.5 DAMAGED COMMUNITIES AND CRIME – PERSONAL RECORDS

Drugs and alcohol corrupt communities and permeate the lives of young people in many of Britain's inner city areas and some of its large outlying council estates creating a criminal and violent environment for those living in

54 (Hulse et al,1998)
55 ibid
56 (Gillogley et al,1990).
57 The Telegraph 7.4.06
58 Medic8r Family Health Guide

Shaun Bailey

"Where I live, the peer pressure to offend surrounds you. Crime is everywhere.1 Education on the estates is not an issue. The teenage pregnancy rate is well above the national average. There is a teenage drugs epidemic. There are significant mental health and disability issues. There is little mobility out of the area. The number of people in contact with social services is way above the national average…….

" ….Just from my immediate peer group, 12 have been in prison. ….. they had all got involved in a life of burglary, stealing, fencing and all sorts of drugs-related crime. The false financial opportunity that drug-dealing offers appeals very much when you are young and have no prospect of a job. You know people, people know you. You need the money. You've got nothing else doing…

"…these (are) young men of 19, 20, 21, and 22 who were in real need but not getting helped. It's then that their drug habits really grow because of the pain they were feeling. Their problems are greater than teenagers' because there is more expected of them .

Yet they have few extra skills to show. They are under a lot more pressure. People will say, "what are you doing? You're 20, sort your life out". But they have no more experience or education than a 16 year old. Where they've been in that time is no man's land."[260]

them. 'Drugland Manchester'[59], broadcast two years ago, showed the extent to which crack, heroin and other drug dealing had spread into the everyday life of the local community. It exposed a culture of drug loans to ever younger 'punters' who moved into heavy drug use from their early teens.

We have first hand witness accounts about the lives of young people on the housing estates in North Kensington.

Fear mirrors the violence. Karen Buck, the MP for this same area, has commented, "…fears about crime and security remain at or near the top of the list of my constituents' concerns. …. Many lives are blighted, not only by crime and the consequences of drug abuse, but by the fear of crime."[621]

An estate resident's diary, published in The Times records the intimidation which characterises these areas:

Diary extracts

April 19 At 4.15pm I saw gangs of youths aged between 13 and 18 congregating outside [named teenager's] home. They were all smoking cannabis, throwing stones and they were using bad language. This went on until 10pm. This is a terrible way to live, yobs just running riot. It makes me feel sick and I can't sleep at night.

April 23 There were gangs outside [two named properties]. They were drinking alcohol, their language was awful, couples were virtually having sex in the street. [Named young girl] was out until all hours of the night, sitting with all the drunks and druggies. Children and adults were also up and down the road all day on a quad bike.

June 1 There were 35 of them in the street, ranging in age from 14 to 23. I saw [named boy] holding a stick, running after a boy and hitting him with it.

June 2 I saw a gangs of about 20 youths, doing whatever they wanted. I left home at 6.30pm and arrived home at 9.45pm, where there was a gang of about 40, male and female, and a man on the floor. He is about 50 years old and has learning difficulties. He uses crutches to walk about. [Named girl] was using her mobile phone to take photographs of the incident. I break down in tears quite a lot now.

June 3 Gangs of youths including [six named teenagers] were all day long smoking cannabis. They also had bottles of brandy and cans of alcohol. [Named teenager] has a motorbike, they were all drunk and riding up and down on this at a very fast speed. Also [named girl] was up and down on her quad bike while her mother watched. The police arrived at 7.15pm to move the gangs on. At 9.45pm I saw [two named females] in the street. They were drunk. I cannot go outside my own home. I feel very intimidated.

June 30 There seemed to be gangs everywhere and young girls drinking all day. I saw [named female] in the street and she was drunk. She is only 13 years old. I was woken at midnight by screaming and shouting. The police had been up and down the street quite a few times that evening. At 2.15am I heard female voices shouting and screaming. I didn't look out of the window. I felt totally fed up with everything. I felt that if nothing was done I would have a nervous breakdown.

June Hopkins 2006

59 A documentary broadcast in January 2004 BBC2

60 Shaun Bailey 'No Man's Land' CPS 2005

61 Karen Buck MP for Regents Park and Kensington North, Hanard 16 Jul 1999 : Column 745

"Over the past 12 months there have been times when as many as 40 teenagers congregate in the street day and night. They have destroyed garden walls, burned wheelie bins, destroyed garden plants, throw their cans of beer on the ground, smash empty vodka bottles, shout, scream, swear, spit and play football until all hours of the night. One youth [named] walks in front of me when I have walked to or from the local shops. I don't go out now unless I am with a member of my family."[62]

62 The Times, September 30th 2006

Chapter Six - Cannabis specific risks

There is a commonly held assumption that substance misuse leads to crime. However the evidence received by the working group reveals a more complex picture. Shaun Bailey reports from his own work experience has observed that that the cycle with young people often begin with bullying and mobile phone theft at school and that this leads to gang membership for protection, which in turn promotes petty crime and into substance abuse, leading to more crime and more substance abuse.

Whatever the causal relationship survey research evidence suggests a strong association between both alcohol and drug misuse, crime, assault, and being the victim of crime and assault. (detailed later in this section)

> *I think cannabis is one of our most dangerous drugs. That's not because the medical harm is so acute - although it clearly is for some users - but because it has achieved what no other illegal drug has. It has divested itself of its association with illegality. It has become so commonplace and that has opened up a portal of willingness to consume mind-altering substances way beyond the drug itself. Ecstasy is going the same way. It is associated with lifestyle rather than pharmacology. But if you want to tackle the drugs problem, you have to tackle it at source and that source isn't heroin but cannabis. If the 40% of teenagers now using cannabis increases, that is not something we can ignore. It could be of enormous significance.*
>
> Professor Neil Mckeganey[63]

A first hand account was given to us by the chair of a Police and Community Consultative Group. She also acts as an appropriate adult, someone who is called to give support to an arrested vulnerable child through the whole process in custody. Often called out for youngsters as young as 10, her experience is that most are heavy skunk users (high THC cannabis). She found the children did not consider this to be drug abuse at all. Her explanation for this was the mixed messages given out by the government. She said told us that she is often called out for youngsters in trouble with the police, some of them as young as 10. The one thing these youngsters had in common was their abuse of skunk. [64]

Through her outreach work with the community she has been visited by Moroccan mothers in North Kensington distressed by their youngsters abuse of Skunk and how it made them anti social and aggressive – mothers who spoke about their children's 4 to 4 lifestyle, waking up at 4pm, robbing, smoking Skunk and going to bed at 4 am and about which they felt powerless to do anything..

Other evidence presented to the working party has pointed to adolescents' particular vulnerability to addiction in terms of their brain development. This has been explained to us in terms of the dopamine system developing ahead of the inhibitory area and resulting in an imbalance which can encourage impulsive and risky behaviour. Research scientists and psychiatrists have warned that teenagers are the most likely to experiment with drugs and the experience will have more profound (and sometimes permanent) effects on them than such experimentation might have on adults.[65]

Evidence from the government's own surveys showed that cannabis is usually the drug of initiation.[66] Youth workers are concerned that this still takes insufficient account of the 'volume' of cannabis abuse and dependency in the context of the earlier age of initiation. Concern has been expressed about the impact of this drug by psychiatrists, teachers, magistrates, policemen and youth workers. It is in this light that we examine evidence of its risks.

6.1 SUICIDE AND DEPRESSION.

Research suggests that cannabis users have increased risk of suicide than non-users though the link between cannabis use and suicide may well be an indirect one by way of depression and psychosis.[67]

Former UK senior coroner, Hamish Turner, has claimed that as many as one in 10 of the 100 deaths he has dealt with have had some link to this drug.[68] He is also of the opinion that many deaths recorded as suicides or accidents have some connection with cannabis use.

Biologist and researcher, Mary Brett who submitted her research review to us told us that:

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63 Glasgow University Centre for Research into Drug Misuse interviewed in the Sunday Times Scotland June 11th 2006

64 Karen Clark Chair K&C Police and Community Consultative Group, Witness evidence

65 Chambers and others) in 2003

66 Shaun Bailey Op Cit

67 "Cannabis Harms" evidence submission from Mary Brett see www.povertydebate.com

68 Daily Mail November 2003

"There has been a 22% increase in the number of hospital admissions of cannabis users with mental illness since down-classification in the UK. In the year April 2003-04, the number of admissions was 710, up from 580 in each of the two previous years. In the same period, admissions caused by the abuse of other drugs including heroin and alcohol fell. The exception was cocaine which rose by 16%."[251]

She also pointed out that the most psychoactive of the chemicals in cannabis and the cause of most damage to the body is tetrahydrocannabinol (THC) and that THC content is commonly now over 20% in 'skunk' and 'netherweed' (some 3 times higher than in the past) which are grown and increasingly used in the UK where they account for more than 50% of the market. The drug's toxity has increased dramatically since the 1970's when it was widely introduced into the population as has the number of young users.[70]

The studies reviewed in her submission investigating links between cannabis and depression suggest that the likely increased risk of developing depression varies between 3 and 6.4 times. Academic reviews carried out in 2003 and 2004 concluded that, "There is growing evidence that early and regular marijuana use is associated with later increases in depression , suicidal behaviour and psychotic illness, and may bring forward the onset of schizophrenia. Most of the recent data reject the view that marijuana is used to self-medicate psychotic or depressive symptoms"[1]

Professor Heather Ashton has argued that cannabis in most recreational settings decreases aggressive feelings in humans and increases sociability but that occasional, predisposed individuals, especially if under stress, become aggressive after taking cannabis. Violent behaviour may also be associated with acute paranoid or manic psychosis induced by cannabis intoxication.[72]

6.2 PSYCHIATRIC DISORDERS, SCHIZOPHRENIA OR SCHIZOPHRENIA-LIKE ILLNESSES

Professor Robin Murray of The Institute of Psychiatry in London said, "The public health message is clear. Some cases of psychotic disorder could be prevented by discouraging cannabis use, particularly among psychologically vulnerable youths, with the youngest cannabis users most at risk. ….action is needed to avoid a further burden on our already-overstretched mental health services".

Professor Peter Jones of Cambridge University, a leading psychiatrist and expert in schizophrenia said that 80% of first episode psychiatric disorders, schizophrenia or schizophrenia-like illnesses, occurred in either heavy users or cannabis dependents. His unit, he said, might as well be called a "Cannabis Dependency Unit". [73]

A youth worker's account

Lots of kids smoke here – weed and skunk. You may be getting to25%. It's a really serious problem. Use is starting younger than it did. And it is doing much more damage to society than crack or heroin because of the sheer number doing it. It affects their health. It affects their mental health…..They smoke on the way to the bus to go to school. It affects their ability to concentrate and their ability to be in class. They want to leave school to be able to smoke. It has a really bad effect on their motivation. It's a physical fact that as a teenager you need more sleep. They don't want to get up anyway, so if they've been puffing it makes it that much harder for them."

Shaun Bailey[74]

6.3 COGNITIVE FUNCTIONING AND THE EDUCATIONAL PERFORMANCE OF ADOLESCENTS.

The impact of cannabis on children's functioning was also brought to our attention by Shaun Bailey. Evidence appears to be growing that cannabis intoxication affects mental functions in the same way whether a person is a regular user or just starting. Clear associations between cannabis dose and reaction times have been found - the greater the dose, the slower the reactions.

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69 Mary Brett ibid

70 Mary Brett ibid

71 Ibid

72 Ashton 1999 Review

73 At least two studies have shown that cannabis users can become aggressive during the withdrawal period especially in the first week. Fergusson and others in their "Christchurch Cohort Study" suggested that deviant peer associations were not responsible, and several papers show evidence for violence being due to a pre-existing personality disorder. One study of identical and non-identical twins found the presence/absence of a conduct disorder in a twin pair is a good predictor of cannabis use suggesting that cannabis use and violence to some extent co-occur due to personality tendencies.

74 BRITISH JOURNAL OF PSYCHIATRY(2006),188,148^153, 1 , 1 53BRIT RNAL (2

A personal account

Like a lot of people I began to smoke cannabis around the age of 16 – that was back in the early seventies. A lot of people of my generation stopped but I was one who carried on and smoked for the next thirty years and only stopped when I was 45. The worst aspect was that it bought into my own lack of confidence and allowed me to believe that I wasn't intelligent enough to progress. All the time it was eating at my confidence and stopping me finding my identity as an adolescent. You could say it made you happy and made it easier to see the light side of things, that it heightened your senses making everything seem more colourful. But actually it was filtering out all the things that might make you unhappy, the negative emotions – it would lower your inhibitions and make you less fearful around other people and helped control your anger and eliminate any sadness you had around you- but it meant you were going through adolescence on a crutch and it stopped you working through these emotions in a natural way.

The people I see now to help who've been on cannabis form some time typically suffer panic attacks and paranoia. In some cases this presents as agrophobia where they cannot leave home and just sit at home smoking dope all day. Many are suffering from depression.

James Langton[77]

- A recent study of Dutch school children showed that the association between cannabis use and attention problems was significant and that it was therefore not unlikely that cannabis use is associated with poor school performance.[75]
- Additional analyses showed that those using cannabis reported lower-than-average school performance significantly more often than those who did not use cannabis (13% and 4% respectively)[76]
- Lynskey & Hall (2000) concluded in their review that early cannabis use might significantly increase risks of subsequent poor school performance and, in particular, early school leaving but that a number of 'confounding factors' made it impossible to prove a causal effect.

6.4 CANCER AND CANNABIS

Cancer has been observed at a much younger age in cannabis smokers than in tobacco smokers. As with tobacco, cancers caused by cannabis will not quickly become apparent and there is a latency period of 20 to 30 years. Unlike tobacco, cannabis use in the West has only been widespread since the seventies. There is much documentation of the occurrence of cancers particularly of the head and neck in smokers of cannabis. The average age for cancers of these types in tobacco smokers is around 60.

- Marijuana users with cancer tended to be younger, one study averaged 26 years and in another none of the subjects were over 41.
- One piece of research put the odds of developing head or neck cancer in cannabis smokers at 2.1 compared with non-smokers at a consumption of one a day, 4.9 for use more than once and 36 for a combination with tobacco.[78] Recently cannabis smoking has been linked with bladder cancer.

6.5 CANNABIS AND DRIVING.

Experiments from the seventies to the present day show cannabis to have a detrimental effect on driving ability, whether the experiments were conducted on tracks free from other vehicles, simulators, or in real-life driving conditions. A low 20mg dose of THC (a single cigarette today can contain up to 200mg) has been shown to produce deterioration in driving ability similar to that displayed by a driver just over the legal alcohol limit. However it has also been found that, barring distractions or unexpected complications, strongly motivated drivers can compensate for some of the impairments. But tests on airline pilots using flight simulators showed them to be unable to land their planes properly even up to 24 hours after consumption and were completely unaware of a problem.[79]

- In 2001 27% of young men, aged 17 to 24, admitted in a magazine survey to driving at least once a week under the influence of drugs, mainly cannabis. By 2006 the same magazine found the number had risen to almost 50%, 20% said it was a daily occurrence. Generally they thought that drug testing would act as an efficient deterrent.[80]

A combination of alcohol and THC has been shown to

75 No Man's Land' CPS 2005

76 Cannabis use and mental health in secondary school children; Findings from a Dutch survey

77 James Langton now runs Clearhead a cannabis dependency helpline and website.

78 Cannabis Harms Op Cit

79 ibid

80 ibid

greatly increase the likelihood of making an error while driving, one researcher put this increased risk at 16 times compared with the use of cannabis or alcohol alone[81]. Scientists warn that, since alcohol quickly affects psychomotor function and cannabis affects cognitive processes, the combination would undoubtedly be extremely dangerous, especially in a complex traffic situation.

6.6 CANNABIS DEPENDENCE

It is not generally recognised that cannabis use can involve a compulsive need for the drug, i.e. lead to dependence. But the scientific (as well as anecdotal) evidence presented to us suggests physical and psychological addictions occur with cannabis[82]. Physical addiction involves tolerance and withdrawal symptoms, while psychological addiction involves a strong craving for the drug). Like other addictive drugs, cannabis stimulates the dopamine-producing system in the brain. This is the 'reward pathway' of the central nervous system, where cannabis receptors are present, and where the cycle of reward begins leading users to use more.[83]

6.7 FERTILITY, PREGNANCY AND NEO NATAL PROBLEMS

Like alcohol, cannabis use impacts on fertility in men and on the unborn baby. Recent research by Burkman in 2003 has shown a reduced sperm count in heavy users. THC also passes through the placenta and also appears in breast milk in cannabis smoking women. There is now consistent and clear evidence that babies born to cannabis-using mothers are smaller.

Research evidence shows categorically that use of illicit substances during pregnancy has unfavourable outcomes for both birth and infant development.[84]

- The majority of women misusing drugs during pregnancy use cannabis only[85]
- This also has been associated with a significantly lower gestational age at birth and a reduction in birthweight [86]

81 ibid

82 Eliot L Gardner in 2003 looked at 224 studies from the seventies onwards and concluded, "cannabinoids act on the brain reward processes and reward-related behaviours in strikingly similar fashion to other addictive drugs".

83 Cannabis dependence was included as a diagnostic unit in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders 1994) and ICD-10, WHO 1992 .

84 Substance Misuse During Pregancy, K Johnson et al, British Journal of Psychiatry 2003, 183 P187

85 Sherwood et al, Op Cit

86 ibid

Chapter Seven - Public Health and Crime Costs

7.1 ALCOHOL

- 33 thousand people a year die from alcohol related causes
- 25% of hospital admissions are related to alcohol
- 11 people are killed each week in drink related road traffic accidents[87]

A detailed analysis of the costs of alcohol misuse was researched by the Cabinet Strategy Unit in 2003.[88] Reviewing a number of individual UK studies which had produced estimates in key areas such as health and employment they found:

- Alcohol misuse costs in the NHS have been reported to total between 2% and 12% of total NHS expenditure on hospitals. This amounts to up to £3 billion a year on hospital services (Royal College of Physicians, 2001).
- Alcohol misuse is also estimated to cost employers approximately £3 billion a year in sickness and absenteeism at work, premature deaths, accidents and alcohol related crime (Alcohol Concern, 2002a).
- The corresponding costs for NHS Scotland and the workplace are estimated to be £95.6 and £404.5 million respectively, while the total cost of alcohol misuse for Scotland in 2001 is £1.07 billion.

The impact of chronic and acute alcohol disorders on the NHS

Alcohol-related diseases account for 1 in 8 NHS bed days (around 2 million) and 1 in 8 NHS day cases (around 40,000).

- Up to 35% of all accident and emergency attendances and ambulance costs are alcohol-related.
- Between 12 midnight and 5am, 70% of attendances are alcohol-related.
- At peak times in A&E Departments:40% of all attendees have a raised blood alcohol level; 14% are intoxicated; 43% are problematic drinkers
- Common reasons for alcohol-related attendance at A&E Departments include violent assault, road traffic accidents, psychiatric emergencies and deliberate self harm.
- In addition 1 in 5 patients admitted to hospital for other reasons are drinking at hazardous levels.
- Another cost is the stress on NHS staff – medical, administrative and support – the effect on their sickness and/or absenteeism and attitudes towards care.
- Problem drinkers consult their GPs twice as often as the average patient
- In addition 1 in 5 patients presenting to primary health care are likely to be excessive drinkers, and based on the average list size, each GP will see 364 excessive drinkers in a 12 month period.[89]

The impact of alcohol on other diseases – brain damage and cancer, including mouth and breast cancer

- Chronic alcohol dependence is associated with extensive brain damage and consumption of more than 5 standard UK drinks a day is associated with measurable declines in brain functioning and cognitive efficiency.90
- It is also associated with heart disease and cancer. Risks begin increasing significantly at an intake of around 3 drinks per day for cancers of the oral cavity and pharynx, oesophagus, larynx, breast, liver, colon and rectum.
- The rise in alcohol intake in Britain is the main reason behind the recent steep rise in cases of mouth cancer, which kills 1,600 people in the UK every year - more than cervical and testicular cancer put together.[91]
- The risk of breast cancer by age 80 years increases from 88 per 1000 non-drinking women to 133 per 1000 at 6 drinks (a bottle of wine) a day.[92]

Alcohol and violent crime

In England and Wales approximately 70% of crime audits published between 1998 and 1999 identified alcohol as an issue particularly in relation to public disorder.

- Data from more recent British Crime Surveys show that, for Britain as a whole, alcohol is a factor in

87 ANARPS

88 Cabinet Office Strategy Unit, Alcohol Misuse: How Much does it Cost? 2003

89 IAS Factsheet ibid

90 ibid

91 Alcohol Anonymous Review Jan 06

92 The numerous and damaging medical problems related to alcohol and those passed to the foetus, the child and the family are to be found in the IAS factsheet, 'Alcohol and Health'. www.ias.org.uk

47% of violent crime. This varies by the type of crime: domestic violence 45%, mugging 19%, stranger violence 58%, and acquaintance violence 51%.

- In London alone The City of London and the Metropolitan Police in 2001/2002 recorded a total of 161,359 crimes of violence against the person of which more than 75,000 were alcohol-related violent offences.[93]
- 50% of the victims of the assault were also drinking prior to crime.[94]
- Another recent review suggests that between 50% and 80% of assault victims attending Accident and Emergency (A&E) Departments have been drinking prior to the assault.[95]

Licensed premises and 'hot spots' of late night crime

Offences in all major cities are concentrated around licensed premises. A study in Camden and Islington of drunkenness, disorder and crime incidents in public places, set out the offences that were clearly concentrated around licensed premises in the area. It also looked at those attending A&E after being assaulted in a public place (as opposed to at home, at work, etc).

- the vast majority of these victims were male and under 35;
- 50% attended A&E between the hours of 10pm and 4am, with a peak at midnight; 54% occurred on Fridays and at the weekend.[96]

Alcohol and drugs and homicides

A comprehensive national clinical survey of three years of homicide cases - 1594 between 1996- 9 reveals how difficult it is to look at drugs and alcohol in isolation. It found that substance misuse (drugs and /or alcohol) contributed to the majority of homicides and recommended that a public health approach to homicide would highlight alcohol and drugs before severe mental illness.[97] It referred to other studies which have stressed that intoxicants in violence prone individuals were the most important factor in homicide.

The knife culture: drugs, alcohol and children?

- Of 820 homicides in 2004/05, 236 (29%) were killed with sharp instrument and according to Home Office sources knives were used in 6% of all violent crime in the same period.[98]
- Just over a fifth (21 per cent) of children in school said they have carried a weapon but never used it (31 per cent of boys and 11 per cent of girls)
- 47 per cent of excluded children said they had carried a weapon but never used it (52 per cent of boys and 31 per cent of girls).[99]
- 3 per cent of children in school and 14 per cent of excluded children said they had used a weapon against another person.
- 3 per cent of children in school and 21 per cent of excluded children said they had threatened another person with a weapon.
- Drug and alcohol use is much higher in truanting and excluded children

Recommendation

The relationship between knife crime and substance abuse amongst adults and children is an area that requires urgent investigation and monitoring.

7.2 DRUGS

A Cabinet Strategy Unit Report separated out the significant harms associated with drug use in terms of health, social functioning and crime.[100] Based on extrapolations from the 'New Adam' Surveys they concluded that:

- heroin and crack are the most addictive drugs and cause the most damage to health and social functioning at a cost of £5 billion a year
- injecting heroin leads to public health harms notably HIV Aids and hepatitis C
- drugs users committed 56% of total crime
- drug motivated crime is skewed towards property crime rather than 'high victim trauma' crimes
- £16 billion of drug related crime is caused by heroin and crack users to £3 billion by other drug users
- Drug use is 'responsible for' 85% of shoplifting
- Drug use is 'still' linked to 130 homicides a year and to 238,000 muggings

93 Alcohol Use and Alcohol related Harm, GLADA 2003

94 ibid

95 George 2003

96 Sheers 2001

97 Shaw et al Addiction 101 1117-1124

98 Figures relate to England & Wales

99 Source: MORI, Youth Survey (London, Youth Justice Board for England and Wales, 2004) p32

100 SU Drugs Project Phase One Report; Understanding the Issues 2003. A key source for this report is'The Economic and Social Costs of Crime, New Adam Survey of Arresttees 1999-2002

- 1 million and six thousand cannabis users are 'dependent' ahead of 256 000 dependent heroin users and that mental health admissions were significantly higher for heroin

Computation of health and crime costs

An analysis compiled for the Government by Professor Godfrey of York University in 2004 concluded that every 'problem' drug addict costs the taxpayer £35,455 a year.[101] Her figure was arrived at by a breakdown of the total cost inflicted on the country - through the justice system, health and social costs – in all totalling £11.9billion a year. Of this, the annual bill for policing, courts and prison terms was estimated at £10.6billion. The report says the overall figure is an underestimate.

Professor Godfrey has calculated that 88% of the total economic costs of Class A drug use are the costs of crime committed.[102] The evidence base for her calculations is limited.

This research paper and the New Adam Surveys constitute one of the main sources of evidence on estimated costs of drug use to societ and explain the primary focus of government policy on opiate users and its increasing focus on preferential treatment status for offenders and arrestees. This and other aspects of policy are critically assessed in the briefing papers in part 3 of this report.

Arrestees Research: drugs and crime levels

- 72% to 82% of arrestees test positive for drugs and alcohol – most commonly cannabis, followed by alcohol and opiates.[285] And a high proportion of arrestees see their drug use being the driver of their crime.

1,184,702 violent crimes were recorded by the police in 2004/05 an increase of seven per cent since 2003/04. Part of this increase is likely to be due to the continuing impact of changes in recording and more proactive policing to counter violence problems.

- Police recorded robbery fell by 12 per cent between 2003/04 and 2004/05.
- The number of homicides and recorded firearm offences increased in 2004/05, by one and six per cent respectively.[105]

> Having sat in court, day in day out, looking at drug addicts appearing before me I have these reflections on the prevalence of drug-related crime in the Magistrates' Court.
>
> Over ninety per cent of the theft that one sees is drug-related. An even higher percentage of the shoplifting element of offences is drug-related. And if you took drug-related crime out of the equation, the work of the Magistrates' Courts would be reduced hugely. I don't know what the statistics would be, but you would – certainly in Gloucestershire – be down to car offences, you know, road traffic offences but far fewer, since so many of these are drug / alcohol related too and you would be left with domestic violence (again fewer) and some Council Tax and, in London, fare evasion. It really would make a huge impact. Criminal records produced in court inevitably reveal drug offences coupled with theft and / or handling stolen goods.
>
> It is also very rare indeed to see a criminal conviction for a Class A drug offence without finding, earlier in the criminal record, a cannabis offence.
>
> *Victoria Elvidge, Solicitor, CAB advisor and Magistrate on Gloucestershire bench* [104]

Drug possession and trafficking

The recorded crime figures for drug possession and trafficking are thought to seriously understate the true extent of offending in those areas. The statistics are heavily influenced by local policing priorities in response to local drug problems, and may reflect changes in the policing of drug crime rather than real changes in its incidence.[106] The poor evidence base for drugs seizures is discussed in Part 3 of this Paper

Drugs deaths

The costs of drug abuse have traditionally been computed in terms of drugs deaths and the public health costs of blood born infections.

- The number of deaths relating to drug poisoning in England and Wales rose to 2,598 in 2004. This is an increase of 6 per cent compared with 2003. This figure is still lower than in 2000 – the year with the high-

101 The Economic and Social Costs of Class A Drug Use in England and Wales - Godfrey et al
102 HORS 249 The Economic and Social Costs of Class A drug use
103 New Adam research op cit
104 Witness evidence
105 Home Office Statistical Bulletin Crime in England and Wales 2004/5
106 Mwenda & Kumari, 2005

est recorded number of deaths at 2,967. Deaths related to drug misuse made up 55 per cent of all deaths related to drug poisoning in 2004.
- The number of deaths involving heroin or morphine rose in 2004, to 744 deaths, breaking the decline seen in the previous three years from the highest recorded number of 926 deaths in 2000.
- The number of deaths involving methadone and cocaine also increased to 200 deaths and 147 deaths respectively. This was the highest number of deaths where cocaine was mentioned since 1993.
- After heroin methadone is the next most likely cause of drug death
- The total number of deaths related to drug misuse rose for the first time since 2000, to 1,427.
- Between 1995-7 a prevalence study of current substance misuse amongst acute general medical admissions in a London hospital identified 20 per cent of admissions as substance misusers; the majority (72 per cent) of the identified patients as having an alcohol problem and 19 per cent as currently using illegal drugs and 9 per cent poly drug users.[107]

Blood Borne Infections
- The prevalence of HIV infection among injecting drug users (IDUs), in England & Wales, has increased in recent years. Overall around one in 50 IDUs are now infected, which is still low compared to many other countries. The prevalence remains elevated among IDUs in London with around one in 25 HIV infected. The recent increase in HIV prevalence has been greatest elsewhere in England and Wales: where the prevalence has risen from around one in 400 in 2003 to about one in 65 in 2005.
- Hepatitis C: Overall, approaching one in two current IDUs in the UK have been infected with hepatitis C, which is also low compared to many other countries. However, there are marked regional variations in hepatitis C prevalence within the UK, with the low prevalences found in some areas suggesting that hepatitis C infection is not an inevitable consequence of injecting drug use. Surveillance and research data also indicate that the overall prevalence of hepatitis C infection among IDUs has probably increased in recent years and that levels of hepatitis C transmission remain elevated.
- Voluntary confidential diagnostic testing: Uptake of testing for hepatitis C among IDUs in contact with drug services has increased in recent years. It is estimated, however, that almost half of those IDUs with hepatitis C in contact with these services still remain unaware of their infection. There will also be substantial numbers of current and former IDUs who are not in contact with services whowill be unaware they have hepatitis C.[108]
- Less than half of those with HIV are aware of their infection. There is thus a need to improve the provision

Elsewhere health costs of drug misuse in terms of the cost of GP visits, emergency care and mental health treatments, have been put at £1.3billion.

Government spending on alcohol and drugs policies
The direct funding provided for the delivery of the aims of the Government's Drug Strategy in 2005/06 totalled £ 1. 483 billion and breaks down as follows:

- Preventing young people from becoming drug misusers: £163m
- Reducing the supply of illegal drugs: £380m
- Reducing drug-related crime: £367m
- Improving access to effective drug treatment: £573m[109]

For alcohol £217 million was spent in 2003-04 by primary care trusts and local authorities to support alcohol treatment.[110]

107 Marshall et al. QJ Med 1999, 92, pp 319-326

108 Shooting Up Infections amongst injecting drugs users in the UK 2005, An Update October 2006

109 http://www.drugs.gov.uk/drug-strategy/funding/ This is excluding all the indirect costs to health, welfare and security budgets identified above

110 Written answer from Caroline Flint Hansrd 20 November 2006

Chapter Eight: Causes of the 'Epidemic'

The 'causes' of the current epidemic of drug and alcohol abuse are complex and multidimensional. It is difficult to say what extent government's failure to control the supply of drugs into the country, or to police their use is 'to blame'. Our analysis of seizure levels, presented in the following section of the report, suggests they have been completely insufficient to stem a widespread fall in the price of street drugs since the mid nineties. This has occurred against a pattern of rising consumption and high levels of purity. As with alcohol, increasing availability and decreasing costs have fuelled use.

In Part One, we detailed other social factors also involved in the dramatically increased use of alcohol by the turn of this century, including the emergence of a culture of intoxication. Our witnesses have spoken of the spread of availability and ease of access whether the substance be alcohol or heroin, along with relatively low prices as a significant factor. They have also spoken of the counter productive nature of media-driven moral panics, overdramatic education warnings and the continued glamorizing of celebrities known to use drugs by the media. Other have spoken of the breakdown of family structures and responsible parenting roles, absent fathers and replacement parents and the deep unhappiness at home that this often engenders for the child – the deep psychological reasons for addiction. Two of the witnesses we saw identified the prohibition of drugs as causing the problem. One former offender spoke of his introduction to drugs in prison. These views are illustrated and expressed in the following extracts from witness evidence:

8.1 WITNESS VIEWS

Former Addict and Ex-Offender

Personally I don't believe free love and drug use was as wide spread in the 1960's as it has been suggested but over time it did lead to more of an acceptance of drugs such as cannabis in society.

Whilst there has, over the decades, been an increase in drug addiction, the widespread epidemic of crack and heroin the country is currently experiencing only began in the early nineties. A reasonable conclusion to be drawn from this is that the parents of this generation were the villains. They ignored the 'media invoked moral panics' regarding youth culture. They'd grown up okay and were more likely to turn a blind eye when their children were experimenting. In fact it led to a more complacent generation. Drugs, had become 'acceptable', they'd also become more widely available than in the sixties and seventies due to organised crime's involvement.

For one reason or another heroin crept into the scene. Many people began using it to come down from other drugs such as ecstasy or cocaine or had come across it while in places like Thailand or India and developed a taste for it, eventually becoming addicted. It went from being known as skag or smack, to brown or gear. Acceptable monikers. Heroin too became more widely available. At this point though, I should point out, that as a percentage, very few of the rave generation turned into problematic drug users, ie, heroin/crack addicts causing a disturbing level of crime. It would be similar to comparing those who drank when at the same age and became alcoholics.

The media's pursuit of celebrities regarding drugs didn't (and doesn't) help, more often than not belittling the problem, again in a twisted way making it seem more acceptable. Very few of the targets are visibly physically or mentally ruined enough to deter people from using drugs. They often lead glamorous looking lives.

As already mentioned, another contribution to the problem has been drug education and government initiatives. I grew up in the eighties with the 'Just Say No' campaign and the 'Heroin Screws You Up' pictures, depicting a ruined young man all huddled up, a complete mess. The message was, if you take drugs, this will be you, and fast.

But it's not like that. So when the odd kid experiments and doesn't end up like that the message is lost. It can take years to become that ruined, and that isn't the company the youngsters are keeping until they get there, which is too late. As a result a generation brought up on the 'Heroin Screws You Up' campaign didn't see it working like that.

When, like I did, you see people who you know have been using heroin, for instance, and they seem okay, when you see them remaining sane after taking LSD or taken ecstasy and they hadn't dropped dead etc it gives a greater belief to the miss-education element.

People who take highly addictive drugs like heroin and crack cocaine don't believe they will become addicted. There are very few people who deliberately become addicts.

In the drug world heroin and crack are the last taboo but the government's guidelines on what it say's on the tin makes it as ineffective as telling people that everyone who speeds in their car is going to die or kill someone - some people are going to do it, some aren't.

Craig Morrison ex addict and offender

Residential Rehabilitation Unit Director

I think people get into difficulties, really serious difficulties with drugs, either through the pain principle or through the pleasure principle. And we deal with people who get addicted through the pain principle. The former are people who become addicts because they ….party, and it's kind of like the highlife, the cocaine scene in London, blah, blah, it's a lifestyle that goes with certain professions, and they get addicted, they get physically addicted, and they can get into serious trouble with it. They're not the people who are here. The people who are here are people who seem to have got into difficulties through trying to cut out pain, and it comes in various forms, and what transpires is that what people have in common is very low self-esteem, and it usually goes back to early childhood trauma, so it won't surprise you, a very high number of our residents here have been abused as children, come from dysfunctional families, have had a bereavement, have had major trauma in childhood. And they found an escape from those feelings in drugs, and it changes the way they feel, and they then feel they can relate to people, through the kind of drug syndrome. The average age of people here is 27, 28 which is quite old, and by the time they get here they've done a lot of using, and ….have done prison, not everybody has, but most have. And nearly all the women who are here have been prostitutes, who have been out on the street, been abused by their pimps, very low self-worth, but the only way they know to good feelings is selling their bodies

Magistrate

A reflection that I don't often see in the press or when I read about drugs is on the question of cannabis and Class A drugs, and whether one has any impact on the other. And I don't know if you've ever looked though people's criminal records, but inevitably if you see somebody with five pages of convictions, and on the last page there are Class A drugs, you will find on the first page possession of cannabis. So to say there is no correlation between the two is, in my experience, nonsense. And I think you can obviously take cannabis without graduating, but if you are on Class A drugs, you will have started somewhere. Moving on to pre-sentence reports, and what you learn about drug addicts from the pre-sentence reports – and again this maybe is an obvious statement – but you will never read a pre-sentence report which starts with the words 'the defendant comes from a happy home'. They do not come . . . the people who are appearing before you in court, have always got major factors in their background, which have perhaps made them susceptible to the drugs or to crime-related drug taking, or whatever, but you will not come across a really happy home resulting in a drug addict who is before the courts. And when a drug addict says they've got family support in the courts, it's never two parents, it may be a relation who's come along or a grandparent.

Victoria Elvidge, Magistrate and Solicitor who has spent 10 years dealing with drugs related offences Witness Evidence

One addict still on maintained methadone treatment some years after leaving prison explained in an interview how prison itself introduced him to drugs.

INTERVIEWER: Have you been using drugs since you were a kid?

CHRIS: No, since I went to jail. I went to jail . . . I got a twelve year sentence when I was 21, and I never even smoked until I went to jail. It just started from there.

INTERVIEWER: And how long were you there for? Did you do the whole twelve years?

CHRIS: I did about eight years of it. You do two thirds, and then you get your remission back.

INTERVIEWER: And what happened in jail, you were introduced immediately to drugs?

CHRIS: Oh, yeah, yeah.

INTERVIEWER: How does it work, what happens?

CHRIS: Everybody does it.

INTERVIEWER: Everyone's doing it. So it simply gets passed into your hand or .?

CHRIS: They say, 'Owt you need mate? Have a smoke?' And all that lot, you know what I mean?

INTERVIEWER: In the cells?

CHRIS: In the cells, yeah. Or (words unclear) wherever.

INTERVIEWER: Wherever. And there's no attempt to control people? The guards will see everybody smoking or . . . ?

CHRIS: It depends what jail you're in. It all depends, all jails are different. They're all run differently. Some, the screws run the jail, and some the convicts run the jail.

INTERVIEWER: And when you go in, presumably you're very depressed anyway?

CHRIS: Well, yes, yes. I've got depression, that's what started it all off, I think. I started smoking cannabis, and I got depression from it. I got a really bad case of depression, anxiety, paranoia.

INTERVIEWER: Once you were in jail?

CHRIS: Yes. This was after a while, like. I was alright at first on cannabis.

INTERVIEWER: How much were you smoking?

CHRIS: I was only smoking little bits at first. Because I didn't smoke, I didn't smoke tobacco. I would go dizzy and everything if I had a cigarette. As soon as I got my twelve year sentence, I started smoking – it was that day, actually. It must have been to calm my nerves. Anyway, a few months later, one of the other lads who was on a Category A – like high security – he passed us a joint, a spliff, a joint. And we just sat and talked all night and had a laugh.

INTERVIEWER: Made you feel better.

CHRIS: Well yeah, yeah, yeah. I didn't really realise what I was getting into.

INTERVIEWER: How do you pay for it when you're in there? Or don't you pay for it? Because somebody has got to buy it.

CHRIS: Yeah, well I had quite a lot of money, so I just got money sent in, or sent to people, or I got friends to fetch it in to me. Or I used to sell it in there, things like that.

INTERVIEWER: And over that eight year span how did your drug . . . I mean, did you get alcohol in there as well?

CHRIS: We used to make our own. It's easy, a matchbox of yeast, a matchbox full of yeast, boiling water, chuck it in, chuck two pounds of sugar in, and it all (makes whooshing sound) all froths up.

INTERVIEWER: Like hooch?

CHRIS: Hooch, yeah. That's what it is hooch. And you keep it warm, and every day, once or twice a day, put a bit more sugar in.

INTERVIEWER: So were you just letting it rise, the yeast.

CHRIS: You've got to keep it warm.

INTERVIEWER: Where do you keep it warm? On the radiator, on the pipes?

CHRIS: On the pipes, yes. Or we'd have it all wrapped up and things like that.

INTERVIEWER: So you did that. So you had your cannabis, you had your hooch, and then how did it progress to harder drugs?

CHRIS: A lad a couple of cells down from us was on amphetamines, taking amphetamines all the time, and he gave me some, and that made us feel great that, so I just started taking that most of the time, like. And then when I got out, I had only touched heroin a couple of times when I was in there, that was in like 19 . .

INTERVIEWER: And that would have been injecting?

CHRIS: No, no, just smoking it.

INTERVIEWER: Just smoking heroin.

CHRIS: Yeah, yeah. I didn't even know how to do it, I used to waste more than what I did. But that was very rare then in them days. This was say about '86. It was quite rare, only like the Pakistanis and Turks, people like that got it in, and there wasn't many of the Cockneys things like that, the main gangsters type thing, they were the main people who got it in. And they were the ones who were using it. And my preferred drug was amphetamine, but in the end I went psychotic on it, I started to go psychotic on it, see things and all sorts.

INTERVIEWER: And were there prison doctors or psychiatrists you saw in there?

CHRIS: Yes, I saw a psychiatrist.

INTERVIEWER: And were they aware of what was happening?

CHRIS: Yeah, yeah.

INTERVIEWER: You told them why you were being like that and what you were taking?

CHRIS: Well, I told them I was taking things like that, yeah. But they were doing the depression side more.

INTERVIEWER: So they were giving you tranquilisers or . ?

CHRIS: Yeah, I had about seventeen different tranquilisers in the eight years. But like six months at a time I wouldn't have them, they would prescribe them . . . there would be a big queue – have you seen One Flew Over the Cuckoo's Nest? The music goes and they all go, like robots – that's what it's like.

INTERVIEWER: Everyone going to get their prescriptions . . . and yet they would know that you were doing the amphetamines at the same time? . . . So that went on for the whole of the eight years?

CHRIS: Yeah, more or less, yeah.

INTERVIEWER: And when you were due to come out . . .

CHRIS: I went straight on to amphetamines. I couldn't like cope with going out of the house and things like that.

Residential Rehabilitation Unit Founder

From our experience of twenty-two years with Victory Outreach UK and eighteen years prior to that working with young people on the streets and in custody we have discovered that one main cause of substance abuse is the breakdown of the family and family values. This presents itself in the confusion caused by lack of parental control and the lack of a mother figure or no correction and guidance of a father. Many have said 'I didn't know who to listen to'. When parents have separated we are often told how young people have found it so hard to accept a replacement for either of their real natural parents. …. This can then lead to a feeling they do not belong anywhere with no roots and deep insecurity, and these hurts of rejection are then buried beneath anger, jealousy and violence that produces uncontrollable and anti social behaviour. Others respond by go down the route of withdrawing alone and they torture themselves, including inflicting self-harm and sadly even suicide. There are some who come from good backgrounds but have been affected by peer pressure or some kind of abuse from others including bullying, and sadly many have had worse experiences of physical, mental and sexual abuse.

Against this chaotic and sometimes perverse background we are often amazed how often we have to teach them right from wrong. However this is not surprising when in sharing their past we realise they have only known perversion and crime, and, for example, that they have been expected to steal to get acceptance. One young lady shared that she was given heroin at the age of six and then thought there was no hope. Another young man was given alcohol as a very young child drinking every day, and that becomes the norm. This lack of love and stability is every present and for example one line we hear constantly is 'no one ever cuddled me or told me they loved me' or I was always told 'I'm worthless and no good'. One young man said that he was jealous of our dogs because they belonged to us, and that he never felt that he belonged to anyone. So often they have not experienced being given gifts for, as all money was spent on alcohol and drugs, there was none left for them.

Dinah Sansom, Co-Founder and Director of Victory Outreach UK[111]

Campaigner

The issue is the way that prohibition exacerbates and actually creates both disadvantage and marginalisation. The evidence that we have is very much that prohibition is overwhelmingly counterproductive'. We have a real problem with the prison population at the moment, we lock up more people than anyone else in Europe, mainly because we have the toughest drug laws in Europe. We also have the highest levels of use and misuse. The price of a daily heroin habit is a minimum of forty or fifty quid a day. The price of a crack habit can be anything up to five hundred or a thousand pounds a day, depending on how much people are using. So when you look at it like that, you can see why people can be such prolific offenders as a result of their dependence on crack or heroin. It is also true that prices are coming down. But they haven't come down low enough to stop people offending as a result of their habit, or low enough to stop organised crime being very interested in making an enormous amount of money.

The highest proportion of people locked up are poor, and significantly and overwhelmingly and disproportionately black – both amongst men and women, significantly women who are drug mules. And it (prohibition) continues to support, either by default, or actively, a policy that has turned Afghanistan, Colombia and the Caribbean into narco-states. …I spent six months as a locum prison worker in Shepton Mallet Prison as a drug counsellor, and working in prison when you're actually carrying keys around, and you're seeing the same people and they all have the same issues. They had all suffered abuse, mental, emotional, sexual, physical abuse. Many of them had been in care, most of them had a drug dependent parent, either of illicit drugs or alcohol. Many of them had unresolved bereavements, they were all poor. So it was the same people. Totally vulnerable people, and a lot of them had mental health problems as well, mostly depression. And the last thing they needed was to be involved in the criminal justice system.

Danny Kushlick, Transform[112]

111 'Transform Drug Policy Foundation exists to minimise drug-related harm to individuals and communities by bringing about a just, humane and effective system to regulate and control drugs at national and international levels.' www.tdpf.org.uk

112 Witness evidence

We will be addressing in the course of our inquiries the debates about the legalisation of drugs and this will be presented in our final report.

8.2 FORESIGHT?

"The older age group is getting bigger. We generally see people who have started using drugs in their 20s and 30s and grown up with it…..Heroin doesn't have a high death rate so users grow older. They are less chaotic than young people but the baby boom generation who have gone through and survived heroin haven't looked after themselves….Their physical health can be more of a problem than the actual heroin. The increase is a consequence of a more successful system in England and is mostly indicative of the success of the government's drug strategy."
Dr Emily Finch, Clinical Team Psychiatrist for the NTA

One of the top drugs advisors for the Dutch Government said to me, "you know we now have old people's homes for methadone addicts" and I said "what an extraordinary notion". But I realised that here were people who came to services without a methadone problem – they came because they had a heroin problem – they were helped by being given methadone, and now they have actually been long term methadone addicts and are becoming methadone geri-addicts. So now you are providing the homes for individuals who have been artificially created - their addiction has been created by a treatment that was ostensibly meant to help them. And in a way you can see that that is a real prospect for us too."
Professor Neil McKeganey[113]

The Office of Science and Technology commissioned a group of experts to consider possible developments regarding problem drug use over the next twenty years.[114] Amongst them was Professor Neil McKeganey the founder of Glasgow University's Centre for Research into Drug Misuse:

June 2006: a seventeen year old boy was admitted to a hostel for the homeless in central London which also runs a methadone prescribing and needle exchange service. It is home to 90 older, predominantly male, methadone maintained but still substance abusing long term alcoholics and drug addicts - described as the hard to reach. The boy in question had been injecting heroin for four years since he was thirteen. He had been allowed to join his nineteen year brother who had also recently been admitted to the hostel. The substance use worker in charge said this was no place for these boys to be but there was no where else for them to go.
Evidence Taking Session

'We were asked to look at what might be the UK drugs problem in 20 years time. We looked at where the drugs problem had come from in the last 20 years, what was the growth since the late 70s and early 80s and the number of addicts in the UK and we projected that as a result of a number of developments, such as the lowering of the age that children are starting to use drugs, the growth of drug use in rural areas and the increasing proportion of women using drugs that it was conceivable in the next twenty years that the number addicts would increase from what is thought now to be around about 350,000 Class A heroin basically to around about a million.

The scale of the problem (now) is small relative to its impact. You are talking about only 2% of the population creating an enormous problem. But what if it were 3% or 4%? That is still a tiny number of people, but the problems they would generate could overwhelm our existing systems. In 30 years the drugs problem has gone from nonexistent to an epidemic. If that can happen in a generation, what more can happen in the next 10 or 20 years? If we are at the margins of what our society can cope with now, what would our society look like if instead of 50,000 addicts we had 100,000?" There is no reason to assume drug addiction in Scotland has reached a plateau. Just look at the figures for young people who feel disenfranchised. I think it is eminently feasible that it will creep up to 3% or 4%, and many of the things we take for granted now will have to change. The country must be prepared to contemplate radical solutions. "We might have to create drug free communities using drug testing or restrict addicts from retail areas between certain hours. It would effectively create ghettos. But if we can't control the addiction, all we can do is control the movement of people. We have to consider how sustainable family life would be in our communities if the level of addiction goes much beyond 2%. Already you can go to parts of Scotland where the drug problem is so prevalent it is shaping communities. This gives you a glimpse of what other communities might look like in the future and it is a shocking prospect. I think every aspect of our drugs policy should be aimed at stopping this.[115]

113 Witness Evidence
114 Foresight Brain Science Addiction and Drugs Project - Professors Neil McKeganey, Joanna Neale; Charlie Lloyd and Dr Gordon Hay.
115 Inter view with Professor McKeganey in The Sunday Times Scotland June 11th 2006

PART THREE

The National Drugs Treatment Strategy – a pathway out of addiction?

A BRIEF HISTORY[1]

This final section of the report deals with issues surrounding the national drugs policy and treatment strategy developed by the Labour Government (operating under the auspices of a National Treatment Agency since 2001). The origins of the policy lie in the Conservative Government's 1995 White Paper 'Tackling Drugs Together' which set out three goals of increased community safety, reduced acceptability and availability of drugs to young people and reduced health risks through the establishment of Drugs Action Teams across the country. Abstinence alongside reduced health harms and reduction in criminal activity were stated as the key effectiveness measures.

The Labour Government's 10 year national drug strategy 'Tackling Drugs to build a Better Britain' led to the setting up the NTA and to an increased focus on protection from crime as a key measure. The NTA's key document 'Models of Care' devised a tiered framework which has led to an emphasis on 'specialist treatment' and an expansion of the substitute prescribing of methadone. The publication of an 'Updated Drug Strategy' in 2002 put further emphasis on targeting resources towards drug misusing offenders. The latest 'treatment effectiveness strategy', re focusing on the adult service user's experience of treatment, was launched in June 2005 and emphasised rehabilitation, 'routes out of treatment' and aftercare.

INTRODUCTION TO CASE STUDY AND POLICY BRIEFING PAPERS

Our evidence collection is ongoing with regard to the operation of the government's strategy and its success or failure in meeting the problems outlined in sections one and two of this report. Our case study investigation of the 1000 residential rehabilitation beds lying empty at present time (presented below) suggests a policy in crisis. The six briefing papers which between them set out the recent history of drugs policy, its separate harm reduction objectives, its measurement systems, administrative structures and treatment 'modalities' provide damning critiques of policy imploding under the pressure to deliver impossible public service agreement targets.

These briefing papers need to be read against the background of the latest treatment outcome research which raises profound questions about the evidence base for current policy. Findings from the largest survey of 'the effectiveness of drug misuse treatment' ever conducted in the UK, led by Professor Neil McKeganey and Professor Michael Bloor, have begun to be published.[2] These findings call into question the mass prescribing of methadone – a synthetic opiate – which has been used since the 1980's as a controlled and supposedly safe heroin substitute and is the cornerstone of the treatment services built up by the government over the last eight years. The findings challenge the prevailing orthodoxies and set out the wider social benefits of coming off drugs as opposed to being maintained on methadone. The research shows that three years after receiving methadone only 3% of addicts remained totally drug-free. It found by contrast, that there was a 29% success rate among addicts who went 'cold turkey' in a rehabilitation centre. It found those free of addiction were seven times less likely to commit crime than addicts and were far more likely to be in work or education.

The recent National Treatment Agency Audit shows there are over 50% of clients (some 69,000) receiving prescribed methadone maintenance and substitution treatment in England at the moment. The briefing papers prepared for the Addictions Working Group indicate that the current treatment policy is not achieving the desired outcome of crime reduction, controlling health harms or reducing the supply of drugs. It is certainly not leading to abstinence. These findings, in conjunction with the growing crisis in referrals to residential rehabilitation, expose the topsy turvey world of drugs policy treatment priorities. The NTA has acknowledged that residential rehabilitation is proven to be the most effective of the treatments available to patients with substance misuse problems for abstinence based recovery. Yet the current crisis residential rehab referrals shows that some 50% of

1 A detailed history of policy is set out in Briefing Paper No 6 A Perspective on Drug Interventions in the Criminal Justice System by Andy Horwood

2 Drug Outcome Research in Scotland(Doris) Study, Scotland on Sunday 29th Oct 2006

the beds available nationally are left unoccupied and units closing down as the 'case study' researched by Russell White, reveals below. below. His investigation reveals how the complex and inflexible funding streams and commissioning systems that determine the type of treatment a client gets have resulted in the bizarre situation of beds lying empty while clients cry out for this service. The crisis is one example of an over bureaucratised national drugs strategy.

The six briefing papers presented sequentially in the rest of this section analyse the different elements of the National Drugs Strategy and add up to a major critique of its workings and of its inherent limitations

- The first, **A Perspective on the National Drugs Strategy** by Andy Horwood details the progressive skewing of policy since 1998 to meet criminal justice outcomes.
- The second, **UK Drugs Policy A Critical Review - Part One: Treatment and the Drugs Harm Index** by Russell White identifies fundamental flaws in the construction and working of the Drugs Harm Index as the overarching tool by policy outcomes have been and are measured.
- The bureaucratic structures and requirements implicit in the 'commissioning of drugs treatment systems' are subjected to further scrutiny in **A Perspective on the Commissioning of Drugs Treatment Systems** by Andy Horwood. He shows that a lack of clarity as to where responsibility sits risks losing small effective projects like the Drug Recovery Project in Oxford which could fall between the stools of commissioning responsibility.
- **Drug Treatment Services in England (excluding prisons): An Analysis of Capacity, Provision and Efficiency** by Russell White sets out an analysis of the capacity, provision and efficiency of drugs treatment services in England. He concludes that to maintain the system in its current structural form would become impossible in the long term without continued reinvestment in drugs services to expand capacity.
- **UK Drugs Policy A Critical Review - Part Two: A Review of the Governments Supply Reduction Strategy** identifies major problems with the Government's supply reduction strategy including: a continuing inability to analyse impacts; failure to meet seizure targets despite 'refinitions'; decreases in both the 'number' of seizures of drugs and in total 'quantities'; Structural defects in Customs and Excise mobile deployment
- Finally in **'A Perspective on Drug Interventions in the Criminal Justice System'** Andy Horwood scrutinises their efficacy revealing the high attrition rates evident in the government's original pilot projects. From 2005 figures, when 'successful' outcomes were attributed to almost 40% of DTTOs, he finds that the evidence actually suggests a sustained reduction in offending may only be being achieved by 1 in 5 of those sentenced to a DTTO, and that only 1 in 9 of those sentenced to a DTTO will have ceased using opiates.

DIRECTIONS OF ENQUIRY

In coming months, we will review evidence of the value added benefits of the expansion of treatment capacity which are touched on in several of the briefing papers and the inherent benefits of engaging higher proportions of problem drug users in services, regardless of the services they are in receipt of. However the briefing papers together are a summation of policy failure raising the fundamental philosophical question of whether policy should continue to focus on the reduction of drug related harm as it has done since the nineteen eighties or whether it ought, as Professor Neil Mckeganey recently suggested, make drug prevention rather than harm reduction, the key aim of policy and practice?[3] In his view:

> *'The paradigm of harm reduction which has shaped drug treatment services grew out of the fear that HIV may spread rapidly and widely amongst injecting drug users.'*

The questions that he puts are fundamental to the inherent logic of the policy: which, of drug use or HIV, has had the greater impact on individual and public health within the U.K. and to what the extent has it been possible to reduce drug related harm in the face of continuing drug use? He concludes that in the face of the growth in the prevalence of problem drug use over the last ten years and the persistence of an array of drug related harms including: the extent of Hepatitis C amongst injecting drug users, the extent of drug related crime and the impact of drugs on communities and families that 'it may be appropriate now to make drug prevention, rather than harm reduction, the key aim of drug policy and practice.'

Over the remaining six months of this policy review we will be taking evidence regarding drug prevention policy

3 The Lure and Loss of Harm Reduction in UK Drug Policy and Practice, Neil McKeganey, Addiction Research and Theory, Autumn 2006

proposals, of what they might consist, their evidence base, whether they are mutually exclusive with harm reduction measures, what the role of substitute prescribing in treatment provision be and what alternative treatment strategies could viably be put in place.

ALCOHOL POLICY

This concentration on drugs policy in this section reflects government emphasis and expenditure. It is not because we think alcohol problems are less important but because historically in policy terms they have been relatively neglected both with respect to 'population' policies and treatment provsion.

The very low place the treatment of alcohol has on the government's health agenda is underlined in the series of questions put by David Burrowes MP to the Minister of State for Public Health, Caroline Flint , in November 2006. Quoting ANARP she confirmed that 1.1 million people in the country are alcohol dedendent.[4] Of them, the Minister said, only 5.6% of the dependent population are accessing treatment in any year. In reply to his question of how many beds, places and treatments are available within the NHS in England for the treatment of alcohol addiction the following statement was given:

The alcohol needs assessment research (ANARP) report identified that about 167,000 people were referred to alcohol treatment in 2003-04 and that 63,000 people received treatment for their alcohol problems, this was a combination of in-patient services, residential rehabilitation and community treatments such as home detoxification, day treatment places and counselling services.

696 treatment agencies were identified. The average waiting time from referral to assessment at these agencies was 4.6 weeks and the average number of patients on waiting lists (monthly) was 15.2. ANARP indicted that 5.6 per cent. of the dependent population were accessing treatment in any year.

On funding allocations for the treatment of alcohol addiction the pitifully low figure of £217 million spent in 2003/4 was revealed in the Minister's answer:

The information is not held centrally. We do not allocate specific funding to primary care trusts (PCTs) to support alcohol treatment. PCTs fund alcohol treatment out of their mainstream allocations. PCTs are responsible for assessing the needs of their local populations and commissioning services to address those needs within the limits of the funding available to them.

The Alcohol Needs Assessment Research report identified that £217 million was spent in 2003-04 by PCTs and local authorities to support alcohol treatment (this figure also included a limited amount of support from charitable sources).

The Governments Alcohol Harm Reduction strategy has been heavily criticised by service providers within the voluntary sector (the main providers of alcohol services) for its lack of funding. The ANARP study highlighted the need for treatment against the stark lack of funding. The recent published of Models of Care for Alcohol Misuse (MoCAM), does not promise to rectify this. Our consultations show a clear consensus amongst voluntary agencies that Alcohol funding is severely under resourced. Aquarius said:

"There is very limited funding streams for alcohol specific work. There needs to be significant monies attached to the Alcohol Strategy and MoCAM."

ADAPT said

"We would also draw attention to the fact that funding for people with serious alcohol problems has largely disappeared, with the result that many individuals are in a severe physical and mental state before they will even be considered for funding by local bodies."

The underdevelopment of funding for referrals and the largely ring fenced nature of the drugs treatment budget does not allow for the flexibility that they desire. They regard it as particularly unhelpful for clients who have been dual-diagnosed.

The lack of focus on treatment needs is mirrored by a lack of focus on broad policy measures. The evidence base for these has been well documented in a series of authoritative WHO reports with the associated policy options which relate to 'population' level policies of control of supply and availability. This, however, is an evidence base that governments have ignored.[5] The most recent of these reports, Alcohol: No ordinary commodity,[6] we believe, should be taken as the starting point in discussion around future alcohol policy for the UK. The central principle that policy in this field should be evidence based should be established as a high priority.

- Taxation on alcohol is known to be a highly effective alcohol policy option. A policy for alcohol taxation is required which prioritises health.

4 Hansard November 8th 2006

5 Alcohol Control Policies in Public Health Persepective, Bruun et al 1975; Alcohol Policy and the Public Good, Edwards et al 1994 Oxford

6 Alcohol;No Ordinary Commodity, Babor et al 2003, Oxford

- A reduction in the legal blood alcohol limit for driving should be considered as a high priority.
- An independent review of recently introduced licensing legislation should be undertaken.
- Similarly, other policy options that have been shown by research to be effective (as outlined in Alcohol: No ordinary commodity) should be prioritised for review.

In our enquiries to date we found that the beverage alcohol industry is widely perceived as exerting a deleterious influence upon alcohol research and policy at the present time as well as on young people and children through promotions and advertising. The industry is perceived to economically powerful and therefore able to exert considerable influence.[7] There is evidence to support the contention that it pursues policy options which are in its own best interests, and those of its shareholders, rather than those which are likely to be to the common good of society as a whole. We have found that the reliance upon voluntary co-operation of the industry is widely perceived within the clinical/academic field as being a major weakness of the Government's Alcohol Harm Reduction Strategy for England.[8] Conflicts of interest that exist for the industry need to be taken very seriously indeed, as a matter of high ethical priority.

We are continuing to collect evidence about the lack of provision for and of alcohol treatment services and the problem of their variability throughout England. We have not yet progressed sufficiently far in our enquiries to report on possible policy directions necessary to meet the 'needs' set out by Professor Drummond in the Alcohol Needs Research Project commissioned by the Department of Health.[9]

It would be premature for us to suggest that all that is required is the application of a National Alcohol Strategy with appropriate funding mirroring the National Drugs Strategy (as has been suggested by some members of local Drugs and Alcohol Action Teams in their evidence to us). We need to take further evidence as to whether a structure of provision built into the existing drugs administration and treatment services is the answer. In view of some of the inbuilt flaws of current drugs treatment provision this is open to question. Our initial site visits have revealed that.

- Drugs Action Teams can become highly bureaucratized with energy and resources directed into multiple layers of commissioning, planning, information and liason between agencies at the expense of getting clients better.

> *"Because many people can drink quite safely there is a lot of ignorance around alcoholism - surprisingly from many GPs. I think it essential to get GP's on board as they are often in the best position to identify a problem and direct people into treatment. There are huge anomilies in the attitudes of GPs, some are very good and others have no understanding whatsoever. Alcoholism needs to be recognised as an illness and treated as such. I feel that the most important element is a belief in the abstinence model of treatment as the only way to treat addicts. We are very fortunate in having a commissioner who has a real understanding of the needs of alcoholics and is truly enlightened! She is the first commissioner we have had that has really supported the work we do."*
> Clinical Director, No. 1 Beulah Road Alcohol Rehabilitation Centre

- DAT treatment philosophy is often not based on understanding addiction as an illness but one in which "clients help identify the service they want".[10]
- Evidence from recovering alcoholics (those with life damaging dependency diagnosed) in a small day care rehabilitation unit revealed their strong

7 Addiction Vol 101. No 10 October 2006 Editorial
8 Cabinet Office March 2004
9 ANARP DoH 2004
10 Direct, Darlington Drug and Alcohol Action Team.

preference for abstinence based group support. Under DAT structures, abstinence based services are rarely high priority although there are exceptions to the rule.[10]

- We have as yet to examine the role of the GP and the GP practice (and possibly developed role) as the front line service for 'alcohol interventions' especially where harmful or hazardous use rather than 'dependence' is diagnosed.
- The voluntary sector to date has been the main treatment provider of 'alcohol services' and we will be taking evidence regarding their experience of the problem and the needs of this sector were they to expand their provision

11 How WACS Works, J. Blackledge, Winter 1999 edition of The Alcohol Concern Magazine Vol. 14 No. 4

Case Study: Empty Beds - The Crisis in Residential Referrals

ABSTRACT

There are up to 1,200 beds lying empty at the moment across the main residential rehab centres like Clouds, Adapt, Phoenix House and Yeldall Manor. Staff are being laid off and made redundant. In some cases whole units are having to close down – specialist staff and difficult to replace provision.

For many newly released prisoners, just some of the a hidden waiting list of those needing treatment, desperate for 'second stage residential rehabilitation', the chance of becoming part of this privileged minority has plummeted to near zero because drugs treatment 'commissioners' are no longer making the referrals. As a result centres are losing the funding they rely on, one of them, ADAPT, which provides a scarce and specialist service, is losing up to £50,000 of critical funding a month.

Yet residential rehabilitation is proven to be the most effective of the treatments available to patients with substance misuse problems for abstinence based recovery. This has been acknowledged by the National Treatment Agency although only a minority – 2% - of 'treatment interventions' involve referrals to residential rehabilitation compared with 52% which involve specialist prescribing. Whether provided by a GP or by local harm minimisation services, this is the prescribing of a 'substitute' drug like methadone or buprenorphine on presciption.

There is no question about real demand for residential rehabilitation – the number of problem drug users who would benefit from this treatment continues to rise. So how can this be happening? The answer lies in the failure of the administrative structure for the commissioning of drugs services to ringfence the money to maintain (let alone expand) residential treatment.

It is the result of a target-driven bureaucracy where the means have become the end and in which treatment provision is now totally unrelated to real demand or need.

INTRODUCTION

Over the last few years there has been worsening level of referrals within residential services. This year however is by a substantial stretch the worst year for many providers within the last decade. Following the increase of the PTB (Pooled Treatment Budget) it was expected that the increase would filter through to an increased usage of residential services. However this has not been the case. Occupancy rates (which traditionally drop half way through the financial year and tend to decline in numbers post Christmas) have declined abruptly.

WARNINGS OF A CRISIS

Back in early June this year Nick Barton chief executive of Clouds wrote referring to the referral crisis in residential crisis in DDN (Drink and Drug news). The response he received later that month was overwhelming, representatives of Providence Projects, Vanehill specialist care homes, Dominic Castle, the Ravenscourt Trust, Yeldall Manor, Wellington Lodge, Middlegate Lodge, Cranston Drugs services, Nightingale Addictions Unit and Thurston House all wrote in sympathising with the problems in referrals he described and complementing his view that referrals had dropped significantly.

Despite years of underfunding and underprovision of residential services the NTA (National Treatment Agency) has failed to act to correct structural defects in residential funding. The NTA 2005-06 business plan highlighted the fear of disinvestment.

> *"The scale of the increase over the next three years may attract predatory interest from local partners seeking to disinvest their own mainstream contribution to drug treatment or to divert central resources allocated for funding treatment to another purpose*[12]*"*

EVIDENCE OF DROPS IN REFERRALS

The National Treatment Agency has largely failed to act, Paul Hayes (NTA Chief Executive) said:

> *"It is difficult for us to act until we know whether we are dealing with a new crisis or a recurrence of the problems we have been living with for years*[13]*"*

He reported occupancy figures provided by rehab and detox centres showed bed occupancy, monitored weekly, was at 80% this year compared with 85% last year. These official statistics are on top of a drop of 7 per cent the previous year[14]. This figure was derived from BEDVACS (bed vacancies), which in itself is not considered accurate. Its data frequently seems at odds with anecdotal reports from individual providers regarding their occupancy rates, this was highlighted in the national needs assessment of Tier 4 services, which reported:

12 NTA Business Plan 2005-06 (NTA, NHS) p 31

13 DDN p8 9th October 2006

14 DDN 23rd October 2006

"an occupancy rate of 74 per cent –lower than the 84 per cent occupancy rate reported in BEDVACS (an online list of bed vacancies operated on behalf of the NTA).[15]"

Furthermore EATA (European Association for the Treatment of Addiction) has identified drops in referrals to service providers. Asking providers to supply specific and tangible information on where reductions in revenue funding had occurred they sent out a questionnaire to contacts. Returns were received from 17 units, 14 of responded yes to the question: Have you seen a drop in referrals to your service within this financial year?

The average occupancy rate for 06-07 so far was reported for 13 of the 17 units ranging from 100 to 33 percent with a mean of 61 per cent. When those who had not reported a reduction in occupancy rates were excluded, the mean was 54 per cent[16]. Reductions in occupancy were reported as being between 8 and 61 per cent with an average of 22 per cent. Occupancy status was researched at the beginning of October by Brian Arbery (Chief Executive) of ADAPT. He found occupancy levels at dangerously low levels at:

ADAPT: (Barley Wood)
27th September 28.6 % (16 beds occupied out of 56)
3rd October 39.3 % (22 beds occupied, one patient unfunded)

Clouds
"Below 50 per cent. Some redundancies already"

Phoenix House
"Family service units virtually empty. Some longer term bed spaces are filling up towards breaking even"

Yeldall Manor
"Below 50 per cent – closed two follow- on houses in London"
Broadway Lodge
"About 50% in primary"

Cranstoun
Oak Lodge (Putney) "Prospective closure this November of 14-bed unit, currently at well below 50 %,
Trelawn (Surrey) "around 50 per cent" under review as regards its future. Possible closure before Christmas.

RAPt The Bridges (Hull)
"below 50 %"

Western Counselling
"at 55% and declining"

Hope House (London female unit)
"55 % occupancy"

Unregistered residential
Cranstoun report severe restrictions being applied to 'Supporting People funding' in Cranstoun House at Esher, which de-registered a year or so back. It is understood that continuation of this funding is questionable, since it is being used to support non local people.

Beyond the residentials
Structured day programmes, with spot purchasing, are also being affected. The Blenheim Project in London is closing their structured day programme and SHARP London reports usage of under 50%.

CAUSES
It is clear from research that there has been a gradual long term decline in the availability of funds for residential services. The causes of this lie in the purchasing and commissioning framework. Commissioners are given large incentives to behave as they do, the current target driven purchasing model produces incentives that make it in the best interests of the provider to minimise referrals and make placements as short as possible. This lies at the heart of the underprovision of Tier 4 services which have not grown in line with the expansion of treatment provision[17].

It is believed that an underlying reason for the current climax of the crisis lies in the withdrawal of community care funds committed by social service departments which have traditionally been used to fund residential placements. The failure of the government to ring fence community care funding has caused disinvestment along the risk lines they highlighted in the 2005-06 business plan. Alongside this PCT (Primary Care Trust) funding allocations have been cut. The failure of local DAT (Drug Action Teams) partnerships to make up this shortfall using PTB (Pooled Treatment Budget) funds probably lies largely in the lack of incentives to do so and the possibility of detrimental results on the DAT's other targets.

Short term risk of imminent closure

15 National Needs assessment of tier 4 services (NTA, NHS, June 2005)
16 Paper relating to the exercise to identify reductions in commissioning of tier 4 treatment services in England (EATA)
17 National Needs assessment of tier 4 services (NTA, NHS, June 2005)

ADAPT residential centres are currently losing around 50,000 pounds per month[18]..Short term risk is currently very high with those, such as ADAPT facing unsustainable levels of referrals and imminent closure. Residential treatment is expensive to run and most costs are fixed. Services are unable to reduce staffing levels to cater for lower admissions, a residential service for example that has budgeted to break even at 85 per cent occupancy but that only fills 80 per cent occupancy will run a deficit that could be in excess of 35k a year[19]. This is a cash haemorrage which can be enough to force the service to close. Going beyond the average occupancy drop of 5 per cent reported by BEDVACS, EATA's average of a 22 per cent reduction in referrals will cause these services massive deficits and inevitable closure.

LONG TERM RISK –CONTRACTION AND LOSS RATHER THAN EXPANSION OF CAPACITY

The NTA has a clear and recognized commitment to increase Tier 4 provision:

> *"Access to detoxification and residential rehabilitation will become one of the most important routes out of treatment, not only as an alternative to long term maintenance prescribing of substitute medication but also as a planned progression from a prescribing regime. This will demand a significant expansion to the provision of residential treatment services which is contingent on additional resources being available."*

The capital development programme has allocated 54.9 million to expand treatment provision of Tier 4 services across 07/08 and 08/09. A recognized difficulty in the residential sector is that of recruiting experienced staff. The current crisis has already caused redundancies and closures and by Christmas the loss of entire services and the expertise that goes with them will provide a major barrier to future capacity building. In this respect it is recommended that the capital development programme is placed on hold until this crisis is resolved and current services experience adequate levels of funding and referrals. In the interim between the resolution of the crisis it is vital that the government ensures no further redundancies and guarantees that significant expertise within the sector are not lost.

POLICY SOLUTION

It is recommended that:

1. For residential rehab not to collapse (let alone expand) we call for **IMMEDIATE ring fencing of funds for residential placements at a level which enables ' full cost recovery'** - whether this is to come from a regional allocation of the Pooled Treatment B udget or another source.

2. These funds MUST NOT depend on the different demands made on the Community Care Budget (the source of funding that has now dried up).

3. A future expansion of residential rehabilitation services; not least for second stage residential rehabilitation which is essentisal to ensure smoother transistion from prison to external treatment - so relapse can be prevented and that progress made inside is not lost.

4. A much greater link up between treatment services in prison and those outside.

5 That it must be made a requirement that Residential Referrals are only placed in registered properties i.e. those inspected by CSCI (Commission for Social Care Inspection) or the healthcare commission.

6. That this is essential to improve social care and stamp out bad practice.

7. Ignoring this problem is shortsighted. Investment now will save long term direct and indirect costs.

Glossary

BEDVACS-	Bed Vacancies System (NTA run)
DAT-	Drug Action Team (commissioning structure for services)
DDN-	Drink and Drug News (The sector's magazine)
EATA-	European Association for the Treatment of Addiction (umbrella body)
NTA-	National Treatment Agency (English Treatment agency)
PTB-	Ring Fenced Pooled Treatment Budget for drugs.
SHARP-	Self Help Addiction Recovery Programme (programme run at Blenheim)

18 Reported by Brian Arbery

19 DDN 23rd October

Briefing Paper 1: A perspective on the National Drugs Strategy

ANDY HORWOOD

EXECUTIVE SUMMARY

- Over the lifetime of the Government's ten-year drugs strategy, the intention has been to increase dedicated funding for treatment services by a factor of ten. Such levels of investment are expected to result in a doubling of the numbers of Problematic Drug Users (PDUs) in treatment.
- Given the on-going availability and financial accessibility of illegal drugs, it is questionable that improvements in treatment are able to keep pace with the growing numbers of drug users.
- Since the publication of 'Tackling Drugs to Build a Better Britain' in 1998, the national strategy has been 'updated' twice, in 2002 and 2004. Each update has seen a greater emphasis upon community protection and the need to focus resources on those drug users in the criminal justice system.
- A number of bureaucratic developments have taken place in an effort to demonstrate the success of the strategy, with little focus on the outcomes for individuals.
- Delivery of the treatment element of the strategy has been the responsibility of the National Treatment Agency (NTA) since 2001. As a Special Health Authority, the NTA's terms of reference are evidence-based, with an emphasis on waiting times and clinical inputs, which do not reflect local needs and the range of treatments shown to have an impact on substance misuse. A belated acknowledgement of the wider range of needs with which individuals present to services has been driven by the Home Office since 2003.
- At a treatment level, the 'twin masters' approach of crime and health has been viewed as punitive, bureaucratic, and divorced from the outcomes which individuals should be able to expect.
- This paper concludes that a more inclusive approach to the planning and commissioning of treatment interventions is required, which make a difference to individuals and local communities which absorb the impact of drug use.

BACKGROUND

Between 1999 and 2007, the dedicated funding available for drug services will have increased ten-fold[20]. The percentage of Problematic Drug Users engaged in treatment has increased from a baseline of 50% in 1999 to 53.5% in 2004[21,22].

Such statements are given at the outset to provide some context to the scale of the drug problem and the impact of the existing treatment hegemony.

Further analysis of the sources for these statements indicates that, proportionately, the number of Problematic Drug Users engaged in structured treatment options has decreased between 1999 and 2004. In 1999 the baseline was established as 100,000 individuals in treatment from a projected population of 200,000, representing 50%. In 2004, the National Drug Treatment Monitoring Service reported 126,000 individuals engaged in structured (Tier 3 and 4) treatment from an estimated PDU population of 287,676, representing less than 44%.

Whilst the perceived increase in PDU numbers may be attributed to improved population prevalence techniques[23], if a similar increase in the estimated PDU population is projected forward to 2009 we would expect to see 413,787 PDUs in our communities. If the National Treatment Agency's (NTA) target of engaging 200,000 in structured treatment is met by 2008, we would still be engaging less than half the target group, despite the ten-fold increase in available resources.

INTRODUCTION

Across the substance misuse field there is a widespread acceptance that 'treatment works' and that the levels of dedicated investment are overdue but welcome. However, there is also a widespread acceptance that the current emphasis of the performance management framework which has accompanied the increased investment is

- Bureaucratic
- Divorced from outcomes, and
- Driven by the criminal justice agenda

20 http://www.dh.gov.uk/assetRoot/04/01/19/50/04011950.pdf; http://www.dh.gov.uk/assetRoot/04/10/89/05/04108905.pdf

21 Tackling Drugs to Build a Better Britain (1998)

22 Home Office Drugs Strategy Directorate (2004) Tackling Drugs. Changing Lives, Drug Strategy Progress Report, p.14

23 Frischer, M., Heatlie, H. and Hickman, M. (2004) Estimating the prevalence of problematic and injecting drug use for Drug Action Team areas in England: a feasibility study using the Multiple Indicator Method, Home Office Online Report 34/04, available at http://www.drugs.gov.uk

THE CRIMINAL JUSTICE AGENDA

The National Drugs Strategy has transmogrified from its initial emphasis on the four key areas of 'Young People, Communities, Treatment and Availability[24], to 'Reducing availability, Preventing people from using drugs, Reducing and rehabilitating existing users, and Out of crime, into treatment'[25].

This subtle change towards a coercive, punitive style of language is epitomised in authorship of key documentation moving from inter-departmental, cross-Government ownership to that of a Home Office specialised Directorate, with an accentuated undertone of threat to the public and a necessary response of protection. In this context, treatment and rehabilitation options have become a sub-set to the imperative to 'break the cycle of addiction' with the focus on the treatment of offenders, to the exclusion and detriment of the wider population who may wish to seek holistic care responses to the life-controlling condition of addiction.

To be fair, the language of the Drug Strategy has consistently talked about the need to 'protect' communities, but therein lies the paradox and the fundamental weakness of the strategy. The issue of 'protection' naturally leads people to question 'who is being protected from whom?' when the majority of those presenting to services would also be assessed as vulnerable.

Vulnerable in terms of risks to physical and psychological health, vulnerable in terms of job security and employability, vulnerable economically, vulnerable to criminality, and vulnerable in terms of family relationships and housing.

The language of 'community protection' serves only to further demonise drug users as the 'other' – they become no longer sons and mothers, fathers and daughters, members of our community deserving and demanding compassion – they become those to be 'treated', processed and done to.

The current targets of the Public Service Agreement (PSA) for the Government's Drug Strategy[26] now comprise:

- Reducing the harm caused by illegal drugs (as measured by the Drug Harm Index encompassing measures of the availability of Class A drugs and drug related crime)
- Increasing the participation in, successful sustainment or completion of treatment programmes, and
- Reducing the use of Class A drugs among all young people under the age of 25, especially by the most vulnerable young people

So that, whilst the 'helping hand' is offered to the 'vulnerable' and those able to engage, the beating stick is held behind the back in the use of the Drug Harm Index as the overarching measure for the PSA. The proposed Index[27] being a complicated formula requiring 'experts' to encode and decipher, encouraging obfuscation, denying public scrutiny and subjective experience, and unlikely to produce any verifiable results for some years to come.

TREATMENT SYSTEM HEGEMONY

The establishment of the NTA as a Special Health Authority in April 2001, and the subsequent publication of Models of Care[28], has been seen as a radical shift in the commissioning and delivery of services, providing a framework to achieve equity, parity and consistency in provision across the country.

The Models of Care approach takes account of Best Value principles and aims to be consistent with the wider developments for improving health and social services in general. As such, the terms of reference for the NTA and Models of Care are firmly within the statutory arena of health and social care in reflecting "professional consensus of 'what works best' for drug misusers"[29], and this is reflected in the dominant medico-clinical composition of the Models of Care Project Team.

Whilst there can be little argument with a robust approach to the examination of evidence, in line with the Department of Health work on Clinical Outcomes[30], it will be obvious to external observers that research and evaluation can only be undertaken with existing models of operation. This situation can therefore lead to a self-reinforcing cycle of dismissing innovative interventions for which there is either a lack of 'weight' (in terms of numbers) or a lack of 'robust methodology' (in terms of clinical expertise and/or organisational capacity).

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24 Tackling Drugs to Build a Better Britain (1998) p.3

25 Home Office Drugs Strategy Directorate (2004) Tackling Drugs. Changing Lives, Drug Strategy Progress Report

26 Home Office Public Service Agreement Targets, available at http://www.drugs.gov.uk/drug-strategy/psa-targets

27 Available at http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf

28 National Treatment Agency for Substance Misuse (2002) Models of Care, Department of Health, London, available at www.nta.nhs.uk

29 NTA (2002) ibid., p.3

30 Department of Health (1996) Promoting Clinical Effectiveness: A Framework for Action in and through the NHS, NHS Executive

The hegemony that has therefore developed has lead to a focus on the proxy measure of waiting times for access to six key structured treatment modalities: in-patient detoxification, structured counselling, specialist prescribing, GP prescribing, day care and residential rehabilitation.

This standardised approach has been regardless of Audit Commission recommendations[31] regarding the identification of the needs and profile of substance misusers within the local DAT areas, and the need to include service user satisfaction with the content and impact of services provided. It has only been within the last year that any systematic assessment of service user satisfaction has been attempted, and even this has been within the parameters of existing services. Similarly, work towards a standardised method of needs assessment is only now being developed, but is being driven and designed within the existing terms of reference and mode of operation of the NTA.

Whilst the core (Tier 3) treatment modalities may be considered as primarily orthodox, the adoption of the tiered approach to treatment does serve to emphasise the importance of the wider range of (Tiers 1, 2 and 4) psychosocial and rehabilitative interventions which contribute to the assessment, care management and referral processes of the whole treatment system. However, the overarching limitation lies within the idea that the whole treatment system can be commissioned.

The aspiration of Models of Care is for 'joint commissioning' through the local DAT. In reality there are very few examples of commissioners of Tier 1 services (i.e. general medical services, housing) working collaboratively through DAT mechanisms. Whilst the NTA explicitly acknowledges that "drug treatment services cannot be commissioned in isolation"[32], the language of the National Strategy has already served to set the target population apart, as not part of the 'generic' community.

The following quotes summarise the dilemmas raised by the use of Drug Strategy rhetoric and the concept that solutions can be found from the existing treatment hegemony:

> *"Drug misuse is a problem with linked personal and social origins….there is a societal responsibility to construct and keep in repair a social, psychological and physical environmental surround which supports the individual's capacity to stay away from drug misuse and the harms of drug misuse and helps them pull out of damaging drug misuse.[33]"*

> *"Studies of self-recovery by drug users have shown that access to formal welfare supports,* ***together with encouragement from friends, partners, children, parents and other significant individuals****, is commonly involved in the pathway out of addiction.[34]" (author's emphasis)*

It has only been belatedly, and in the context of the Drug Interventions Programme (DIP), that there has been a reluctant but increasing acknowledgement of the importance of an holistic support package which will include not only treatment in specialist and primary care settings but support for issues which may include social care and support, housing, finance management and benefits, mental health, family issues, self help, education and employment[35]. This acknowledgement is the justification for the NTA's Effectiveness Strategy expectation that "treatment systems need to be better configured to create better exits from treatment (including housing, education and employment opportunities)".[36] Again, treatment is referred to as something separate from the drug users' experience of life.

To the list of needs may be added the 'uncommissionable' holy grail of informal support, including validation, non-judgemental challenge, mentoring, listening, reflection and respect – all qualities and attributes which can only be provided within a community.

Examples of communities of interest where such support can be delivered include self-help groups (such as AA/NA, peer support groups) and in faith-based communities (churches, mosques, temples, etc.). It illustrates the disregard of the actual and potential impact of such communities that, whilst reference is made to peer support and the range of treatment philosophies which may be useful to individuals, they are expunged from the prescribed treatment system model when they are not delivered by 'professionals'. The approach employed by the Drug Strategy culminates in a 'we know best', paternalistic attitude which serves to disempower local commissioners, service providers, communities and drug users themselves.

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31 Audit Commission (2002) Changing Habits: The commissioning and management of community drug treatment services for adults. An executive briefing is available at http://www.audit-commission.gov.uk/publications/pdf/brchanginghabits.pdf

32 NTA (2002) ibid., p.23

33 Advisory Council on the Misuse of Drugs (1998) Drug Misuse and the Environment, Home Office, London, Preface, p.xxxvi

34 Rockville Department of Health and Human Services (1996) Treatment works, cited in Department of Health (1999) Drug Misuse and Dependence - Guidelines on Clinical Management, p.6

35 Centre for Public Innovation, Making Sense of Throughcare and Aftercare, available at http://www.publicinnovation.org.uk/?page=how/publications.html

36 Dale-Perera, A and Murray, T. (2005) Models of Care: Update 2005 - consultation report, NTA, p.9, section 3.6.3, available at http://www.nta.nhs.uk/programme/national/docs/MoCDM_update_2005.pdf

On the ground, where workers and service users interface, this translates in to an experience of services as punitive, with treatment and retention targets employed as both the carrot and the beating stick. Service users perceive themselves not as engaged in seamless, co-ordinated care but as part of a production line, wherein they are 'done to, not done with'.

BUREAUCRACY

The sense of disempowerment felt by the workforce is exacerbated by the increased bureaucratic and administrative demands of the performance management framework. Demands for transparency and accountability for the spending of public money are used as the justification for such measures, which only serve to undermine the very professionalism and modes of treatment delivery which are extolled.

As an example, the implementation of the DIP has been accompanied by the Drugs Intervention Record (DIR), an onerous seventeen page paper record which is required for each new client. By 2008 the Government's intention is that one thousand DIRs will be completed each week[37]. These administrative demands are in addition to any routine assessment procedures used locally, which may include the Care Programme Approach and any local arrangements to feed DAT needs assessment mechanisms and/or outcome monitoring. It is anticipated that the DIR scheme will need to have been running for 12 months before viable feedback can be given. Models of Care notes that "care planning and care co-ordination should not represent a bureaucratic burden on providers and increase unnecessary paper work."[38]

Performance management is used as the justification across the chain of delivery, with little clear analysis available of the added value provided. As an illustration, the dedicated drug treatment funding available across all London DAT areas in 1998/99 was £8,360,000[39]; the operating costs of the National Treatment Agency in 2003/04 were £8,936,000[40]. In 1998/99, 105 DATs were typically operating on a DAT Development budget of ~£37,000 per Health Authority area; as at 2005, 149 DATs were typically employing a minimum of 3 FTE personnel. Reporting requirements of providers to DATs to NTA Regional management structures now include monthly reports on numbers accessing services and waiting times for the six core treatment modalities, quarterly review meetings, and annual planning cycles.

OUTCOMES

Despite the assertion that "outcome measures are the critical indicator of whether and to what extent the programme is meeting its desired goals and what impact this has"[41], and referral to the Effectiveness Review's[42] outcome domains "as 'true' outcomes and the treatment goals to be agreed with the service user at the onset of care"[43], there still exists no systematic analysis of the impact of treatment for service users.

Instead, quantitative measures of entry and retention in treatment services are used to assess progress, with little indication of the content, efficacy or outcomes from the range of treatment modalities which this may encompass. The strapline of 'Treatment Works' is used to underwrite the quality of provision, when the National Treatment Outcome Research Study (NTORS)[44] (probably the most respected longitudinal study undertaken in the UK) notes that some individual drug treatment services achieved markedly better client outcomes than others, and that four to five years after treatment over half of the respondents were still using illicit opiates. A more accurate summary of these findings would appear to be 'Treatment works, or it doesn't'.

The other routine method for assessing progress is by waiting times for each of the six key treatment modalities. As befitting the NTA's status as a Special Health Authority, this is a concept familiar to health service management and should allow a focus for investment and remedial action to be identified. Whilst this then allows for the headline statements that "waiting times (are) down by 72% compared to 2001"[45], it has no bearing on the service user's experience of care, nor can it accurately predict a tangible outcome. It is not possible to compare drug misuse treatment options with operations and consultant diagnostic sessions.

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37 Home Office Drugs Strategy Directorate (2004) Tackling Drugs. Changing Lives, Drug Strategy Progress Report, p.7

38 NTA (2002) ibid., p.40

39 Drug Misuse Allocations, available at http://www.dh.gov.uk/assetRoot/04/01/19/50/04011950.pdf

40 http://www.nta.nhs.uk/docs/NTA_accounts2003_04.pdf

41 NTA (2002) ibid., p.196

42 Department of Health (1996) The Task Force to Review Services for Drug Misusers, London, p.4

43 NTA (2002) ibid., p.197

44 Gossop M., Marsden J. and Stewart D. (2001) NTORS after five years: changes in substance use, health and criminal behaviour during the five years after intake, London: Department of Health cited in NTA (2002) ibid., p.12

45 Home Office Drugs Strategy Directorate (2004) Tackling Drugs. Changing Lives, Drug Strategy Progress Report, p.14

CONCLUSIONS

> *"The problems of drug misuse and the solutions do not sit neatly in a single cubbyhole; they are inter-sectoral by which we mean that there are health, education, social service, employment, housing and criminal justice dimensions and it is important to remain mindful of the links and overlaps between them.*[46]"

We need to celebrate and support recovery, acknowledge the achievements of individual workers and service users, and work towards an inclusive society which values the potential of all individuals.

The greatest barriers to engagement with the current range of commissioned services are in the prevailing culture of engagement, whereby potential service users are expected to adopt 'the sick role'[47], and in the availability of affordable, adequate accommodation. The biggest omission from the strategy is the recognition that change in behaviour needs to be supported and sustained in 'real' life, encompassing the communities that people live in.

We need a greater focus on both outcomes and process indicators, which need to be tangible at both an individual and community level.

Whilst the 'community' strand of the National Strategy has been usurped by the implementation of DIP, in practice the most effective community leadership and prevention work draws upon a wide range of interdisciplinary skills and experiences to meet local community agendas, translating priorities into tangible local actions that the community feel ownership of. One study for the Greater London Alcohol and Drug Alliance[48] found that common interest comes together more effectively around locally defined 'neighbourhoods', which may not always fit easily with local authority (and DAT) boundaries. [49]

Community development takes time, time and more time, but does produce real paybacks and increased community ownership of their living spaces.

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46 Advisory Council on the Misuse of Drugs (1998) Drug Misuse and the Environment, Home Office, London, Preface, p.ix

47 After Talcott Parsons (1951), The Social System. This encompasses four institutionalised expectations: the exemption from normal social role responsibilities; the expectation that recovery cannot occur without external intervention; that 'being ill' is an undesirable state; and there is the obligation to seek technically competent help.

48 Greater London Alcohol and Drug Alliance (2004) Community-led innovation in addressing the problems caused by crack cocaine in London, GLA, London, p.vii, available at http://www.london.gov.uk/mayor/health/drugs_and_alcohol/docs/coc_community_innovation.pdf

49 ibid

Briefing Paper 2: The UK Drugs Policy A Critical Review: Part One - Treatment and the DHI

RUSSELL WHITE

1.) INTRODUCTION

This paper reviews a number of defects in the Government's strategy for tackling drugs with respect to two of its original principle aims – safeguarding communities and providing treatment. These now translate into the PSA 1 and 2 of the Action Against Illegal Drugs targets. The first and fourth objectives – the reduction of availability and reducing use amongst young people are examined in separate papers.[50]

It analyses performance assessment and shows how:

- Evidence for the reduction in drug harms is conceptually unsound, relies on a poor methodology and is based on generalized, un-contextualized and partial evidence.
- Treatment targets have distorted the modalities structure. They have placed demands for expansion broadly in line with the view that 'treatment works.' Numerical driven growth and not the evidence based provision of services have resulted in the under-provision of certain services. Even with the new 'treatment effectiveness strategy' target driven pressure for expansion in provision has continued to undermine and divert resources from a concentration on outcomes.

The broader issue of the real achievability of the policy objectives with the current legislative framework, the usefulness of the hierarchy of harm of different drugs as encoded in the law, and the issues of approaching drug abuse as a separate problem from other addictions are all beyond the remit of this paper.

2.) EXECUTIVE SUMMARY

The Government's system for measuring the success of its drugs strategy is based on an abstract construction of reducing harm. Changes in overall harms and progress in treatment provision are measured by specific 'targets' which show progress against policy objectives.

The development of treatment is measured by NTDMS statistics in regard to numbers, retention and completion. Overall changes in drug harms which form the overarching policy objective are measured by the Drug Harm Index (a basket of harm statistics) and the numbers entering treatment through the Criminal Justice System.

The thinking behind the DHI is that policy can be measured in regard to a quantification of drug harms. It supposedly encompasses all changes in drug harms in an economic style index. The head of the Drug Strategy Directorate Vic Hogg presented it as the 'FTSE 100 of drug harm[52]'

From a conceptual point of view the qualitative nature is not encompassed in the DHI's economic costings. The actual effects incurred across cases, to a user's family, children, friends, his or her job and the quality of these effects, are ignored. Impossible to quantify in general terms not least because they are subject to enormous differences in circumstance.

Within practical implementation however a thoroughly flawed methodology forms the basis for the DHI. Crime forms the main driver of change with the last update dominated by calculated proportional drops in drug related crime. Crime proportions are extrapolated to a national scale from NEW-ADAM proportions in a process which ignores the methodological limitations of the survey's regional focus. Furthermore no time based scale exists, there is inadequate research and no adequate statistical systems on which to base shifts in the baseline to encounter for drug crime persistency. HIV treatment calculations ignore anything but treatment costs and inadequate Value of Statistical Life (VOSL) estimates are in no way related to the specific life of a drug user.

These conceptual and practical problems do not give a reliable basis upon which to measure changes in drug harms. The DHI's inadequacies render it not just useless, but expose it to the criticism that it may be not simply failing to report but actually distorting any real change in drug harm.

The failings of the performance framework in regard to assessment present misleading information for policy decisions. Nevertheless the second PSA on treatment does go further to actually drive implementation. Numbers,

50 Case Study, Tier 4 referrals

51 Today Alcohol and Drugs Conference 2006

retention and completion form the basis for a type of assessment which lacks a proper analysis of quality or assessment of provision.

The thinking behind treatment cost benefit associations were arrived at by one British and three American 'drug outcome studies'[53]. The British study, the National Treatment Outcome Research Study (NTORS)[54] has been particularly influential. It outlined the concept of treatment efficiency in relation to harm reduction outcomes, specifically reductions in crime and health costs.

This measure of drug treatment efficiency, based on a combination of ideas – one that 'any' treatment is good and two that expansion of provision and retention of clients in treatment is the main policy goal, has defined a 'modality' of treatment provision in which other goals such as short or long term abstinence or recovery did not originally feature.

Subsequently the National Treatment Agency (NTA) has refocused a 'new effectiveness strategy' towards providing a greater range of abstinence and rehab services[551]. (aware that the user's best outcome was being ignored). This has not, however, harmonised this cost calculation with the most effective treatment. NTDMS and NTORS both show better rates of success in residential rehabilitation and inpatient detoxification services[56]. However according to the National Drug Treatment Monitoring System's (NDTMS) method of data collection, higher retention results, in statistical terms (perhaps not surprisingly), in more patients in treatment while abstinence approaches do not[57]. Targets regarding retention will continue to drive forward provisioning if higher outtakes continue to be demanded. The refocused strategy has not gone so far as to investigate the complicated balance between retention and quality or other outcomes. The commitment to a performance based approach remains. Further targets for increased provision for 2008 continue to severely dilute attention from what is supposed to be the commonsense purpose of treatment - best outcome for the drug user.

In both cases the performance assessment system targets for the DHI and treatment provision have produced results which attempt to make outcomes tangible. A drop in the DHI gives an easy basis upon which to measure policy success. Higher numbers in treatment and the expansion of provision drive forward change that exemplifies progress, expansion and outcomes. Yet the need for tangible results has left a poor basis for policy and actively discouraged the development of harder, less measurable yet more effective provision. There is a great need for a refocus of Public Service Agreements, the key drivers for the future treatment system need to focus on providing better outcomes. At the same time the provision of evidence based, not target driven treatment must remain at the fore.

3.) BACKGROUND TO POLICY

The U.K Drug Strategy since 1998:

Tackling Drugs to Build a Better Britain: The Government's Ten-Year Strategy for Tackling Drugs Misuse was launched in 1998 with four principal aims:

1 Preventing drug use amongst young people

- **Reduce proportion of people under 25 reporting use of illegal drugs in the last month and previous year – Key Objective**
- Increase levels of knowledge of 5-16 year olds about risks and consequences of drug misuse
- Delay age of first use of illegal drugs
- Reduce exclusions from schools arising from drug-related incidents
- Reduce the number of people under 25 using heroin
- Increase access to information and services for vulnerable groups – including school excludes, truants, looked after children, young offenders, young homeless and children of drug-misusing parents.

2.) Safeguarding communities

- **Reduce levels of repeat offending amongst drug misusing offenders - Key Objective**
- Increase the number of offenders referred to and entering treatment programmes as a result of arrest referral schemes, the court process and post-sentencing provision
- Reduce levels of crime committed to pay for drug misuse
- Reduce drugs market places that are of particular concern to local communities
- Reduce levels of drug-related absenteeism/dismissals from work
- Reduce numbers of road deaths and injuries where drugs are a contributory factor

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53 Today Alcohol and Drugs Conference 2006

54 ibid

55 Press statement 30 June 2005, New drug treatment effectiveness strategy launched: focus on the service user's journey

56 NTORS and NTDMS statistics

57 Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2003 - 31 March 2004 (London, National Treatment Agency, 2005)

3.) Providing treatment

- **Increase participation of problem drug misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime - Key Objective**
- Increase the proportion of problem drug misusers in contact with drugs services
- Reduce the proportion of drug misusers who inject, and the proportion of those sharing injecting equipment over previous three months
- Reduce numbers of drug-related deaths
- Reduce numbers of drug misusers being denied immediate access to appropriate treatment

4.) Reducing availability

- Reduce access to drugs amongst 5-16 year olds - Key Objective
- Increase the effectiveness of the overseas diplomatic and operational effort
- Increase the value of illegal drugs seized and/or prevented from entering or distributed within the UK
- Increase the number of trafficking groups disrupted or dismantled
- Increase the numbers of offenders dealt with for supply offences
- Increase the amount of assets identified, and the proportion confiscated and recovered from drug trafficking and money laundering
- Reduce prisoner access to drugs
- These were to be achieved by education, prevention programmes, expanded treatment, legal sanctions and the expansion of legal opportunities.

The Strategy was updated in 2002, with an increased emphasis on reducing the use of Class A drugs, an increased budget entailing further expansion of treatment services, expansion of services within the Criminal Justice System and doubling drug testing and treatment orders DTTO's (Drug Testing and Treatment Orders.)

The strategy was underpinned by three PSA's (public service agreements) in 2004 covering the strands listed above and outlining the new focus.

1 Reduce the harm caused by illegal drugs (as measured by the Drug Harm Index) as well as substantially increasing the number of drug-misusing offenders entering treatment through the Criminal Justice System.
2 Increase the number of problematic drug users in treatment by 100% by 2008. As well as increasing year upon year the proportion of users successfully sustaining or completing treatment.
3 Reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.

The three PSA targets are constantly analysed by dedicated measurement systems year on year. This essentially refocuses government direction and commits government departments to specific aims and targets. Explicitly missing in the 3 PSA targets is anything to do with reducing availability, this is repackaged under HMCE PSA's under the broader aims of reducing drug harm and will be the focus of a future paper.

The funding provided for the delivery of the aims of the Drug Strategy in 2005/06 is as follows:

- Preventing young people from becoming drug misusers: £163m
- Reducing the supply of illegal drugs: £380m
- Reducing drug-related crime: £367m
- Improving access to effective drug treatment: £573m
- Total: £1. 483 billion[58]

4.) PUBLIC SERVICE AGREEMENT TARGETS

"The Government's Drug Strategy, established in 1998 and updated in 2002, sets out the range of policies and interventions to reduce the harm caused by illegal drugs"

The policy goals of the four strands of the government's drugs policy are (as across the board of this Government's public policies) encapsulated in Public Service Agreements which define the targets to be met.[59]

In this section of the Paper each system and PSA (for PSA 1 and 2) is analysed, both to establish what the supporting evidence for that policy objective is, to identify flaws in government data, and to report deficits and problems in existing techniques of data collection reported.

There is a particular focus on treatment and the evidence that underlies the concept that 'treatment is good.' As well as this the basis for which this phraseology has underplayed the treatment system is analysed.

58 http://www.drugs.gov.uk/drug-strategy/funding/

59 The PSA targets to do with reducing availability comes under HMCE PSA's and dealt with in a separate paper and those to do with reducing use are also dealt with in a different paper

4.1) PSA Target 2: Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

I*ncreasing Numbers in treatment.*

National Drug Treatment Monitoring System (NDTMS) statistical report: Numbers

The national treatment agency recently announced this year finalised NDTMS figures that placed its treatment provision at 181,390 people in contact with specialist, structured drug treatment in England during 2005/6, an increase of 13 per cent on 2004/5 (160,450) and 113 per cent on the 1998/9 target baseline of 85,000[60]. This has exceeded the expansion target of a 100 per cent increase by two years.

Current targets for this year continue to push for the expansion of numbers in treatment[61].

Sustaining and Completing Treatment

Increasing year on year the proportion of user's successfully sustaining or completing treatment is defined as those "for whom the reason for leaving treatment was that treatment had been completed (whether drug free or not).[628]"

Measurements were defined on two basis, 'those sustaining' treatment itself in the tier three stage which essentially is all services other than residential, provided solely for drug and alcohol misuses in structured programmes of care. While completion is measured only by Tier four services, which are Residential drug treatment specific services[63].

The broader implied target of increasing those completing treatment only refers to those in the Tier four services while ignoring the Tier three services listed below from treatment completion rates:

Traditionally completion itself is higher in residential tier four programmes while retention is higher in tier three maintenance programmes. So there is a degree to which the PSA conveys a false impression of its actual targets.

The statistics this year showed improvements for the target with over 30,000 more people had either successfully completed or continued treatment at the end of March 2005 compared to March 2004[360]. The objectives of providing proportions as well as numbers have not been published. The numbers cited are likely to lie largely in the expansion across previous years, with the treatment system expanding significantly each year, it is no surprise that numerical outputs are higher.

4.11) Harm reduction – The Treatment message

The push for increased treatment provision has taken place to meet potential demand which under current methodological estimates places a PDU population at approximately 360,000[64].

Stretch targets have thus taken place against a backdrop that treatment is 'good,' and that it saves money. Ubiquitous in its application little distinction or discussion has surrounded the exact structure of services. Nor in their application do targets actually serve to drive forward quality as well as they should. The fact that the retention is linked to tier 3 services and completion is linked to tier 4 services (area's in which progress is easier to achieve) highlights the desire not to address the real issues with both services and allows growth in numbers to continue to be the primary target. The lack of any aftercare targets, any proper indicators beyond proxy measures or properly broken down point of exit indicators only serves to reinforce this criticism.

The history surrounding the notion that 'treatment is good' lies in the government's treatment benefit calculations, based on the NTORS outcome research:

So treatment is seen to be cost effective because:

> *"a small number of people are responsible for huge numbers of crimes - 664 addicts surveyed committed 70,000 offences over a three month period*[65]"

Treatment outcomes for NTORS lay across three tenets:

- Reduction in problematic drug (and alcohol) use
- Improvements in personal and social functioning
- Reduction in public health and public safety threats

The third received massive public attention and led to the message 'treatment works;' however the context in which this is used is in commonly cited evidence:

> "*We know that effective treatment works and is highly cost-effective. For every £1 spent on treatment at least £9.50 is saved in crime and health costs.*[67]"

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60 Target to treat more drug users achieved two years early 29th September 2006 (NTA, NHS, 2006)

61 NTA, Business Plan 2006/07

62 SR 2004 PSA Targets, Action against illegal drugs technical notes, (29th July 2004) Target 2

63 Ibid, Target 2

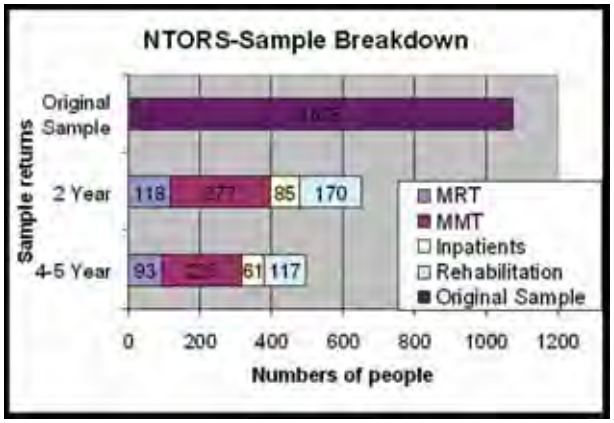
64 Department of Health: Departmental Public Service Agreements 2004, Objective 3 Access to Services

65 EMCDDA, UK Focal Report 2005

66 Government Drugs Strategy 1998 Aim 2

67 Tackling Drugs. Changing lives: Turning Strategy into reality (December 2005)

While this remains a focus analysis of NTORS results by modality with a breakdown of what happened to a sample of addicts in treatment over a 4/5 year period is shown below:



(Source: National Treatment outcome research study, (Michael Gossop, et al)

It shows that from an original 1075 registering for some sort of treatment the sample was broken down to 496 4-5 years later. Most were on Methadone maintenance as a form of treatment.

Final 'abstinence'[68] figures reported by NTORS showed that 35% of methadone clients were abstinent from the illicit opiates (after 5 years)[69]. While the residential program saw 47% abstinence. The study noted that: "The clients in rehabilitation units included the more chronic, long-term users with the most severe problems.[70]" The un-stated implication is that these different 'types' of addicts are not therefore really comparable.

The widespread focus on treatment savings and not users individual outcomes was reiterated by Christine Godfrey (the author of the prominent York paper upon which the costings of government drug policy relies) who confronted the question of 'How can Policy Makers use available evidence on the cost benefits of drug treatment'. Referring to the NTORS and American Studies she says:

> *"The most striking feature of these studies is that no account at all is taken of the individual benefits of treatment in terms of quantity and quality of life. This has a hidden implication that society puts no value at all on the participants in these treatments. This is in contrast to all other health care areas where the individual outcomes are the primary focus.[71]"*

The cost benefit calculations from crime reductions that have come to underpin progress reports in the form of the updated drugs strategy, tackling drugs changing lives and delivering a difference, they continually refer to the 1 pound spent saves 3 pounds, a figure that has now inflated to 1 pound spent saves £9.50. Over the last decade the criminal justice element along with savings to health and social expenditure has continued to reinforce the 'treatment for savings' orientated message. The evidence base for the structure of interventions and for treatment towards rigorous abstinent outcomes have been lost in this message.

4.12) The Poor evidence base for structural decisions

On the back of NTORS research current NDTMS statistics do not accurately convey proper outcomes, the information obtained on the success of treatment lies very largely in surface deep figures that demonstrate process. To underpin the utility of the treatment system NTORS acts as the evidence base. Yet further research is needed on the inter-relationships between interventions required and clients' response (in terms of their recovery) to services that are actually provided, (the user satisfaction survey is not adequate for this purpose.) Currently NTORS is very much out of date, investigations to assess the relative success of services across England is needed. At the same time it is not known with any surety why the latest 2nd year DORIS figures on abstinence in relation to methadone maintenance treatment are so different to NTORS. It is vital that the continued investment of funds in drugs treatment is accompanied by a fuller understanding of treatment interventions. At present it is arguable that the evidence base for prescribing methadone in the United Kingdom in terms of outcomes for the user is lacking. Certainly the fact that a similar study in Scotland has produced much lower abstinent outcomes than NTORS suggested is a great worry. It is hoped that the DORIS and ROSIE programme in Scotland and Wales

364 Abstinence in this case does not mean total abstinence. It is qualified in reference to the use of illicit as opposed to prescribed drugs

365 National Treatment Outcomes Research Study after five years, (London, National Addiction Centre, 2001) p10

366 Ibid

367 How can Policy Makers use available evidence on the cost benefits of drug treatment The Journal of Mental Health Policy and Economics (J. Mental Health Policy Econ. 3, 55, 2000) Abstract

will provide a further evidence base for treatment structure.

Currently however there are a number of key problems in the evidence base:

a; The most serious is that treatment itself by modality may not produce comparative outcomes. DORIS calculations are very different in regards to the success of residential rehabilitation and more seriously they highlight a vastly lower abstinent outcome with methadone prescribing than NTORS:

> *"The closest equivalent study to the Drug Outcomes Research in Scotland study is the National Treatment Outcomes Research Study in England, which like the Scottish study involved repeated interviews of a cohort of drug abusers initiating a new episode of drug abuse treatment. In this study the proportion of drug users achieving abstinence at the two year follow up point (the closest point to the Scottish 2 years 8 months follow up) was 35.9% in the case of the residential drug treatment clients and 24.3% in the case of those clients on methadone programmes (Gossop et al 2003). Within the Scottish study by comparison 29.4% of clients of residential rehabilitation services were drug free (with or without concurrent cannabis use) for a period of at least sixty days prior to their DORIS 4 interview, as were 9.0% of the residential detox clients, 7.8% of those clients receiving substitute prescribing other than methadone and 4.1% of the clients on methadone maintenance programmes. On the basis of this comparison drug treatment services in Scotland appear to be associated with substantially lower abstinence rates than similar services in England.[72]"*

The cost calculations themselves that have underpinned treatment policy are based on NTORS, some criticisms regarding cost calculations as well as treatment analysis are outlined below:

- NTORS which has been so influential in forming these policy calculations did not have a control group.
- The actual practice of 'Methadone Reduction' treatment in reality has proved to difficult to distinguish from 'Methadone Maintenance' treatment in the original NTORS Survey (Only one third of MRT clients received this treatment as planned with 2/3 of cases being delivered MMT) "Clients receiving both MMT and MRT showed improvements in a range of problem behaviours after treatment. However, more detailed analyses identified problems regarding MRT, particularly treatment integrity…the majority of MMT clients were found to receive maintenance, whereas only about one third of MRT clients actually received methadone reduction as planned. Instead they received a form of methadone maintenance (stable doses over a long period). Where it was intended for clients to receive MRT, the treatment was frequently not delivered in this form.[73]" (Written by Michael Gossop who produced the original NTORS report)
- ¼ of methadone patients showed no improvement whatsoever. "in a detailed analysis of methadone clients, we found that almost a quarter of the sample showed a poor response to treatment….the failure of these patients to improve on a range of different outcome measures despite their access to, and often extensive input from drug misuse treatment services, is a matter of concern.[74]"
- Health problems of methadone treatment are not accounted for. Maintenance produces a worry over dependence "far less is known about the comparative worth of different treatment approaches...Novel approaches that reduced the potential development of dependence could also be worthwhile.[75]" (Godfrey)
- Social problems of methadone treatment are not accounted for. This would include risks to children and the other hidden social harms

4.13) Substitution Treatment Expansion – The 'numbers game'

The 'treatment for savings' (see 4.11) message widely drawn from NTORS led to PSA's centered around growth driven targets. This approach have seen a massive expansion in substitute prescribing since 1998 to meet demands placed on departments by PSA's and to a greater extent with the development of the treatment approach as of 2003 shown below:

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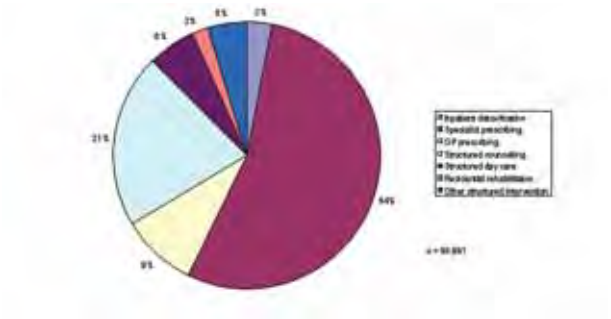
72 McKeganey, Who becomes Abstinent on the Basis of Drug Abuse Treatment In Scotland: Results from the Drug Outcome Research Study In Scotland. (unpublished, with kind permission of Neil McKeganey)

73 Treatment outcomes: what we know and what we need to know (January 2005) p9

74 How can Policy Makers use available evidence on the cost benefits of drug treatment The Journal of Mental Health Policy and Economics (J. Mental Health Policy Econ. 3, 55, 2000) Abstract p20

75 Economics of Addiction and Drugs, Cave, John and Godfrey, Christine (University of Warwick and York) p26; The economic and social cost of Class A drug use in England and Wales

Figure 1: Treatment modalities for episodes reported to NDTMS 2003/04



Source: (Figure 6: NDTMS Statistics 1 April 2003 - 31 March 2004)

The common message 'treatment works' had produced little in the way of a treatment system structured by any recognisable evidence base. PSA's have in fact formed the key drivers behind the application of increased stretch targets for local initiatives to expand numbers in treatment. Unfortunately these key drivers have distorted focus producing a predominance of 'Substitution Treatment' which totalled 63 percent of all treatment between 2003-2004 with methadone reported to be the drug of choice. The National Audit prescribing report detailed 80 per cent of substitute prescriptions as methadone based[76].

At the same time although the NTORS survey found much higher rates of unqualified abstinence associated with residential programmes their services still represent only 2 per cent of the NTA's provision.

The NTA's own statistics in the table below show Inpatient detoxification and residential rehabilitation have demonstrated these types of treatment give significantly improved success rates with abstinence (completed drug free) at point of treatment completion[77].

	tot % successful	% completed	% completed drug free	% referred on
Inpatient detoxification	40	22	16	2
Specialist prescribing	29	11	7	11
GP prescribing	38	10	8	20
Structured counselling	30	17	5	8
Structured day care	25	14	5	6
Residential rehabilitation	44	23	16	5
Other structured intervention	35	19	4	12

(Note: There are problems with taking these statistics from the NTA at face value, they do not reflect a single transition through care in the controlled manner of the NTORS survey. However they do demonstrate the utility of treatment types and emphasise what NTORS demonstrated on outcomes by modality.)

The main argument for the high provision of methadone treatment relies upon retention figures. Detoxification achieved only 8 percent retention whereas residential achieved 35. Both of these compare to GP prescribing and Specialist Prescribing with 68 and 65 per cent retention respectively. However these stark comparisons of course involve more ambitious aspirations for the clients.

The data table below shows each modality with retained figures. It is also important to note that:

"The statistics collected relate to individual episodes of care, they do not follow the individual through the treatment system. The "referral on" category indicates that the individual has been passed on to another part of the treatment system e.g. from prescribing to detox prior to planned treatment completion. The two completed criteria for detox and rehab are relatively high as they are at the traditional end points in the drug treatment journey, and relatively low for prescribing modalities as they are a traditional entry points to the system.[784]"

Table 1: Rates of successful completion and retention in treatment for longer than 12 weeks by treatment modality for completed episodes reported to NDTMS 2003/04

A Treatment modality
B Number of Discharge reasons
C % successful*
D Number discharged
E % retained > 12 weeks

A	B	C	D	E
Inpatient detoxification	2247	40	2557	8
Specialist prescribing	15989	29	16074	65
GP prescribing	2242	38	2187	68
Structured counselling	10840	30	10210	53
Structured day care	2986	25	3139	42
Residential rehabilitation	1163	44	1209	35
Other structured intervention	2167	35	2297	46
Total	37634	31	37673	53
Missing modality	15328	25	15337	47
Total including missing	52962	29	53010	52

76 Summary of the NTA's national prescribing audit. (research briefing 19, 2006)
77 NTA, Communications director 2003/04 figures
78 Ibid

The massive expansion of treatment services has not corresponded to maximising the potential numbers who could benefit from abstinence treatment. It has perfectly fitted headlines statistics that continue to emphasise numbers in treatment. It is undeniable that residential rehabilitation has not fit into this message and has suffered as a result. Nor that outcomes, measured at best by proxy indicators such as 'retention,' 'completion' and 'numbers in treatment' have divorced themselves from progress replacing the demonstration of process with 'real' public health outcomes for the client.

The national needs assessment of tier four services demonstrates a solid demand for residential services:

	Inpatient detoxification		Residential rehabilitati	
	Yes	No	Yes	No
r have needed	70%	30%	71%	29%
en offered	21%	79%	32%	68%
y waiting times	45%	55%	51%	49%
would benefit from	55%	45%	61%	39%
appropriate for needs	58%	42%	63%	37%
en satisfied with post experiences	20%	80%	26%	74%

Experiences and views of Tier 4 services

(Source: NTA, Research Briefing 13 National needs assessment, London, NTA, 2005)

Of the 70% of those who felt they needed Inpatient Detoxification only 21 percent had been offered it, similarly with residential rehab 71 percent felt they needed residential rehabilitation with only 32 per cent having been offered it. Traditional entry points and current provisioning do not seem to meet the treatment desires of users. A low level of experience of inpatient detoxification or residential rehabilitation contrast with a high level of perceived demand[79]. A quantative analysis of treatment accessibility was also carried out:

Number of people reporting satisfaction with accessibility		
	Satisfied	Not satisfied
Methadone prescribing	93%	7%
Buprenorphine (Subutex®) prescribing	78%	22%
Inpatient opiate detox	36%	64%
Inpatient alcohol detox	33%	67%
Residential rehab	48%	52%
Structured daycare	63%	37%

Table 8: Views on availability of drug treatment services

(NTA, Research Briefing 13 National needs assessment London, NTA, 2005)

Treatment accessibility was very high for Methadone and Buprenorphine but inpatient detoxification and residential rehabilitation show very low rates of satisfied access.

At 2003/04 statistics of those who 'completed' treatment left 6 percent abstinent. That means 154,000 people treated in a year 9,240 were drug free in England when they left treatment[80].

It is in this mix up between the criminal justice/public health message concerning cost savings and the benefits of treatment outcomes for the drug user that the target to increase the number of users has continued. The need for consolidation and quality of improvement has been signalled by the NTA: This deficit in abstinence provision and direction was reviewed in the NTA's 'New Drug Treatment Effectiveness Strategy' which refocused the initial expansion of treatment recognising this problem:

> *"Drug treatment should be about lifestyle change. It's not about being abandoned on a maintenance prescription. While we've made good progress on expanding availability, too many people are getting stuck in treatment with limited progress. That's not what service users, their carers or society want or need.*[81]"

In leaving treatment a new aim to expand abstinence provision was set out with the expansion of "detoxification and rehabilitation services as an exit route from treatment[82]"

> *"We will develop a commitment towards abstinence in the treatment system*[83]*",*
> NTA chief executive Paul Hayes

However there has been no commitment to abandoning the treatment targets set till 2008 and it is arguable that these targets continue to drive forward provision. At the same time as our Tier 4 case study demonstrates there continues to be little real commitment to residential services. While talk of capacity building is taking place existing referrals are low and occupancy rates have in places become unsustainable[84]. Despite talks of a commitment to residential rehabilitation as well as the necessity that it plays a major part in the future treatment system, per-

79 NTA, Research Briefing 13 National needs assessment (London, NTA, 2005) p24

80 Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2003 - 31 March 2004 (London, National Treatment Agency, 2005)

81 NTA, New drug treatment effectiveness strategy launched: focus on the service user's journey, (Press Statement, 30th June 2005)

82 Ibid

83 NTA chief executive Paul Hayes, Fashion Victims-Drugs link, Peter McDermott (2006)

84 Case Study, Tier 4 referrals

formance targets that concentrate on numbers in treatment continue to undermine the need to concentrate on quality.

Against this backdrop there will need to be a re-focus on a quality driven agenda. This has been recognised by the NTA. Yet existing targets for departments continue to focus on increasing numerical capacity. These demands have already distorted the structure of treatment provision and it is believed in the Tier 4 crisis they may be diverting valuable funds from services. It is vital for the future quality of the treatment system that targets are re-orientated towards improving performance in terms of outcomes that maximise benefit for the client.

4.2) PSA target 1: Reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the Criminal Justice System.

The overall approach that has been taken to capture harm (the Drug Harm Index) follows from the influential work carried out on behalf of the Home Office by the University of York.[85] Christine Godfrey's work on the economic costings for Class A drug use pioneered the construction of the DHI and a vast range of costings associated with drug harm adopted by the government.

The Measurement systems for reducing harm are the DHI along with a measure of the entrants into treatment through the Criminal Justice System.:

4.21) The Drug Harm Index – explained

The Drug Harm Index (DHI) is the Government's main evaluation of success or failure in terms of harm reduction, the core of its policy.

The Government claims it

> *"Captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single-figure time-series index.[86]"*

As already shown with regard to treatment outcomes statistics:

> *"The DHI does not capture all the harms that illegal drugs might possibly generate, but rather a subset of harm for which robust data are available. As such, this measure is an index indicating change over time, rather than an estimate of the absolute level of harm at any one time[87]"*

The sources of information the DHI capture are:

- The Communicable Disease Surveillance Centre
- The Office of National Statistics report – Drug deaths
- Hospital Episode Statistics
- British Crime Survey
- Crime Statistics
- (New English and Welsh Arrestee Drug Abuse Monitoring) NEW-ADAM Programme

These harms are collected in the common currency of economic social cost and the DHI is constructed by determining the share of total social cost in any one year of each individual harm.

Essentially then the DHI measures using two components each year to calculate social cost:

- The volume of a figure (e.g. HIV cases)
- The unit economic or social cost (the expected cost per HIV case)

These are multiplied together (volume times unit cost) equals social cost and calculated as a percentage of the total yearly costs of all the indicators.

For each harm the percentage share of total cost is multiplied by year on year growth in that harm. The weighted growths are summed together to ascertain an overall change in the year on year growth of overall harm and this is expressed as an index.

In practice unit costs do not change greatly and the main driver of the DHI is the changes in volume figures.

The major weightings are listed in the shift table in the DHI papers Appendix C whereby changes from a single 20 percent shift were weighted against overall DHI change[88].

Description	Change	DHI 2003 Value = 102.9	
		New Value	% Change
Varying Drug-related proportions for all crimes	+ 20%	117.2	13.8
Volume of All Domestic Crimes	+ 20%	111.0	7.8
Volume of All Commercial crimes	+ 20%	109.2	6.0
Volume of All Health Indicators	+ 20%	108.5	5.4
Volume of Drug Deaths	+ 20%	107.4	4.3
Volume of Commercial Burglary	+ 20%	106.7	3.6
Volume of Domestic Burglary	+ 20%	106.1	3.1
Volume of Shoplifting	+ 20%	105.2	2.2
Volume of Robbery	+ 20%	104.9	1.9
Volume of Other Indicators (fear of crime and public perception of the drug problem)	+ 20%	103.8	0.9

84 Godfrey, Christine, The Economic and Social Cost of Class A drug use (London, Home Office Research, Development and Statistics Directorate, 2002)

85 Measuring the Harm from illegal drugs using the Drug harm index, Siggy MacDonald et al (Home office online report 24/05) p v

86 Ibid

87 Measuring the Harm from Illegal drugs (Home Office) p 19

So Drug deaths for example are measured by the loss of output from a fatality. HIV cases would be the cost to the government per case presuming a 15 year treatment span currently £888,753[385].

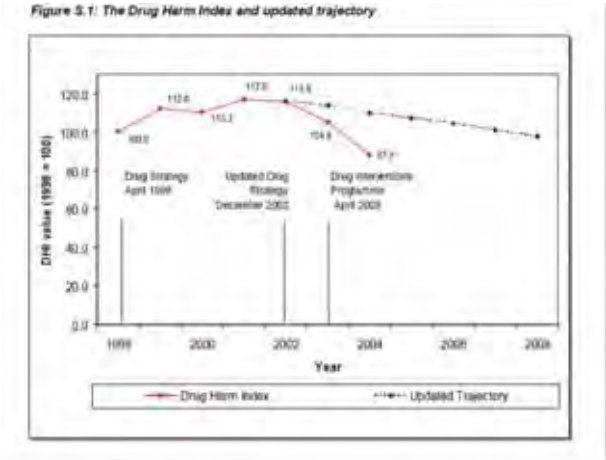
4.22) The Drug Harm Index – A Policy Imperative

The Government claims that "The Drug Harm Index, which measures the harms cause by drug misuse has fallen by 9% since the introduction of the Updated Drug Strategy in 2002 and continues to fall"[89]

Yet the paper explaining the DHI says – "It is unlikely that year on year movements can be attributable to specific policy initiatives.[90]"

Yet a recently released paper updating the DHI showed a drop to 87.9. This is shown in the graph below. Clearly marked are different policy initiatives[388]:

Figure 5.1: The Drug Harm Index and updated trajectory



Despite significant increases in drug deaths, (a 12 rise since 2003 equal alone to just over a 2 percent rise in the DHI) as well as a recorded increase in drug related offences the DHI has dropped significantly this year. The weighted shifts are shown below, clearly the main driver is crime. Ie the reliance on crime figures and the weighted importance attached to them makes the Drugs Harm Index go down whereas common sense might suggest that mortality statistics might be the better measure of chaotic and dangerous drug use.

Table 2.1: Main drivers of change in harm (2003-2004)

Indicator	Growth rate[2]	Weight (%)	Impact on DHI (points)
Drug Deaths	0.13	21.1%	2.71
Domestic Burglary	-0.38	16.5%	-6.24
Commercial Burglary	-0.31	15.6%	-4.77
Shoplifting	-0.23	9.6%	-2.22
Robbery	-0.18	12.4%	-2.19
Other theft	-0.26	7.1%	-1.82
Theft from vehicle (domestic)	-0.27	5.4%	-1.53
Theft of vehicle (domestic)	-0.28	2.9%	-0.81
Theft of vehicle (commercial)	-0.34	1.0%	-0.33
HIV (incl. indirect causes)	-0.13	1.8%	-0.23
Hepatitis C	-0.12	1.8%	-0.22

4.23) Failures in the DHI

1.) Drug related proportions of crime show the highest sample rise and in the Updated DHI their contribution is the the main driver of change. Yet there is no time-series data on the overall proportion of crimes that are drug related. This is drawn from the NEW-ADAM survey which has run between 1999-2002 provides information on the drug use and offending behaviour of arrestees held in 8 police custody suites.[91]

The currently available data provides only two options for trends.

- To assume that a constant proportion of any new category of crime is drug-related
- To use longitudinal convictions data from the Offenders Index to vary the benchmark set by NEW-ADAM. (When NEW-ADAM data is not available)[92]

But in its own methodological note NEW-ADAM states

> *"The sampling method does not provide a nationally representative survey of arrestees, and the results should not be applied generally beyond the specific eight sites and the specific times in which the survey took place.*[95]"

Yet in the absence of other evidence the government uses this to calculate a benchmark for drug crime proportions. The latest update used the Offenders Index, current offender statistics are not considered to be a measure of drug related crime or included as such yet they are used to alter the benchmark proportion set by NEW-ADAM.

88 Measuring the Harm from Illegal drugs (Home Office) p14

89 Tackling drugs changing lives (London, Home Office, 2004)

90 Measuring the Harm from Illegal drugs (Home Office)

91 Measuring the harm from Illegal drugs using the Drug Harm Index - an update (London, Home Office, 2006)

92 Trends in drug use and offending: the results of the NEW-ADAM programme 1999-2002

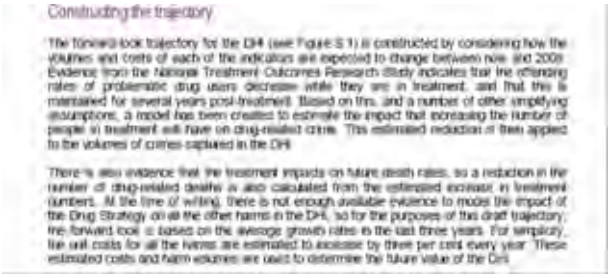
93 Offenders Index: Home Office RDS

94 Trends in drug use and offending: the results of the NEW-ADAM programme 1999-2002

1.) The Persistency of drug related crime is poorly accounted for.

2.) Intangible or difficult to measure social costs are excluded: Health harms such as HIV measured by treatment cost do not include calculations of loss in the quality of someone's life nor the social cost to the families and friends of the individual affected. Neither these or the harms associated with drugs deaths are quantified in or recognised by the HRI. In the case of drug deaths 'loss of output' is measured by the Value of Statistical Life (VOSL) published in a DEFRA paper[96]. VOSL presents a basket of calculations based only on the individual in question and his monetary worth. It is not specific to drug users, does nothing to calculate any associated unique costs borne by drug use, does not include any calculations of the human cost to family friends, parentless children, family breakdown or a number of other knock on effects.

3.) Trajectory constructions show some profound problems with the DHI's assumptions[97] and create a circular and guaranteed positive but deeply misleading conclusion.



Constructing the trajectory

The forward-look trajectory for the DHI (see Figure 5.1) is constructed by considering how the volumes and costs of each of the indicators are expected to change between now and 2008. Evidence from the National Treatment Outcomes Research Study indicates that the offending rates of problematic drug users decrease while they are in treatment, and that this is maintained for several years post-treatment. Based on this, and a number of other simplifying assumptions, a model has been created to estimate the impact that increasing the number of people in treatment will have on drug-related crime. This estimated reduction in them applied to the volumes of crimes captured in the DHI.

There is also evidence that the treatment impacts on future death rates, so a reduction in the number of drug-related deaths is also calculated from the estimated increase in treatment numbers. At the time of writing, there is not enough available evidence to model the impact of the Drug Strategy on all the other harms in the DHI, so for the purposes of this draft trajectory, the forward look is based on the average growth rates in the last three years. For simplicity, the unit costs for all the harms are estimated to increase by three per cent every year. These estimated costs and harm volumes are used to determine the future value of the DHI.

Treatment will lead to reduced drug related crime with an estimated reduction already tabulated into the DHI. This assumption does not occur in the actual correlations of drug related offences shown in the governments own Crime in England and Wales Survey.

Table 2: Trend in the estimated or projected number of individuals in contact with drug treatment services from 1998/99 (England)

A. % increase from previous year
B. % increase from 1998/99
C. Reported figure

	A	B	C
1998/99	-	-	100 0001
1999/00	9%	9%	109 0001
2000/01	9%	19%	118 5002
2001/02	8%	28%	128 2003
2002/03	10%	41%	140,9003
2003/04	9%	54%	154 0004

(NDTMS) Statistics (1 April 2003 - 31 March 2004)
Note: These are NTA figures prior to statistical changes that do not allow proper trend comparisons with past years

Table 2.04 Drug related Crime (England and Wales)

YEAR	Total drug offences
1998-9	135,945
1999-2000	121,866
2000-1	113,458
2001-2	121,393
2002-3	141,101
2003-4	141,060
2004-5	142,338

(Home Office, Crime in England and Wales 2004/05, July 2005, Table 2.04)

Table 4.1: Referrals to treatment agencies (Wales)

Drugs	Number	Crude rate per 100,000 population	European Age Standardised Rate
2001/02	4531	156	166
2002/03	4071	139	156
2003/04	3964	135	151
2004/05	4051	137	152

(Source: Substance Misuse Report on the Welsh Data Supplied to the Department of Health National Drug Treatment Monitoring System (NDTMS) April 2001 – 31 March 2005)

96 Valuation of the external costs and benefits to health and environment of waste management options (London, DEFRA, December 2004) p 24
97 Measuring the Harm from Illegal drugs (London, Home Office, 2005) p 6

The NTA and Welsh treatment statistics show that overall English treatment places have risen significantly while the slightly different Welsh referral rate has remained similar. Yet across same years, of increasing treatment capacity there has been a substantial increase in drug related offences as measured by the only time series indicator of drug related crime, the BCS.

2.) The same is true for drug deaths:
Drug Deaths are measured by the Office of National Statistics (ONS) in a dedicated database. Figures are available since 1993 when 1459 deaths were recorded, with 1427 deaths in 2004.

Trend figures within the ten year government drugs strategy are shown below:

1998	1999	2000	2001	2002	2003	2004
1459	1571	1666	1628	1565	1255	1427

While treatment figures have increased by 54,000 places to 2003 drug deaths have decreased by only 32 deaths since 1998. The assumption laid out by the DHI conjecture that drug deaths would decrease in line with increased treatment has been proved false.

The two solid predictions laid out by the DHI have both been proved false. Its use as a impact model is highly flawed even in those areas in which information is considered to be solid enough to relate associations between trend data these associations do not prove to reflect reality.

4.24) Increasing the number of offenders entering through the CJS

This is a relatively simple target measured from a range of sources listed below:

- Arrest referral
- DTTO
- Youth Offending team
- Probation
- Counselling, Assessment, Referral, Advice and Throughcare (CARAT)
- Baseline: 384 a month in March 2004
- Target: 1,000 a week by March 2008
- Latest outturn: 2,207 in October 2005[98]

Co-aligned with the DHI however the CJS statistics do not give a parallel check for the DHI. The Numbers entering through the CSJ does not associated within a general index. Although it forms an important point for treatments interventions, latent demand which will always form a larger access point will see no decrease in harms from this system of intervention.

So far those referred are on course.

5.) CONCLUSION

The Governments analysis framework fails to properly manage or convey harms, treatment provisions or outcomes. The framework provides a numerical and quantative analysis which prescribes strategic value in delivery documents as well as places demands upon the system it measures.

While the DHI acts as a rather ineffective tool to embellish the public value of the drugs strategy the importance of assessment should not be generalised in its ability to define progress. Targets such as the quantity of provision set in pure numerical terms do not convey in any form the variety or effectiveness of treatment. By the same token point of exit figures for NDTMS do not provide the substantive measure of success that they suggest. Yet in 'real terms' it is very difficult to implement a policy without corresponding drivers for change. The overarching PSA to increase the numbers in treatment has failed and continues to fail to drive quality or to implement an evidence based treatment structure. Furthermore despite a realisation of the need for change to improve outcomes, the failure of the 'effectiveness strategy' to alter the focus of targets towards improving outcomes and quality within the treatment system is a failure to co-align policy with practice. It leaves key drivers absent; channelling resources in the wrong direction, and so makes it is very difficult to implement any improvement in quality.

6.) GLOSSARY

BCS British Crime Survey
CARAT Counselling, Assessment, Referral, Advice and Throughcare
CDRP Crime and Disorder Reduction Partnership
CJS Crime and Justice Survey
DARP Drug Abuse Reporting Programme
DAT Drug and Alcohol Action Team
DATOS Drug Abuse Treatment Outcome Study
DEFRA Department of the Environment Farming and Rural Affairs
DHI Drug Harm Index
DTTO Drug Testing and Treatment Order

98 Home Office Annual Performance Report 2005 PSA 4 (London, Stationary Office, 2005)

EIU Effective Intervention Unit
HMCE Her Majesties Custom and Excise
MMT Methadone Maintenance Treatment
MRT Methadone Reduction Treatment
NCS National Crime Squad
NDTMS National Drug Treatment Monitoring System
NEW-ADAM New English and Welsh Arrestee Drug Abuse Monitoring
NTA National Treatment Agency
NTORS National Treatment Outcome Research Study
OI Offenders Index
ONS Office of National Statistics
PSA Public Service Agreement
PUMIS The Prison Service Planning Unit Management Information System
VOSL Value of Statistical Life

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Briefing Paper 3: A perspective on the Commissioning of Drug Treatment Systems

ANDY HORWOOD

EXECUTIVE SUMMARY

- Despite the establishment of the National Treatment Agency in 2001, examples of the lack of equity, parity and consistency in drug treatment provision persist across the country.
- The introduction of a framework for the development of services has been useful, but the aspiration for a joint commissioning approach amongst Drug Action Team agencies (i.e. health, social services, education, police, probation, etc.) has not materialised. The Models of Care tiered framework has been reviewed in the light of changing practice and shifting strategic priorities. Budgets for, and the relative importance of, substance misuse services are seen as marginal and often irrelevant to mainstream statutory service agendas.
- The commissioning of services has been through Drug Action Teams, with a focus on those services which 'count' towards the target-driven Government approach. This has resulted in a distorted emphasis on 'specialist treatment', which seeks to address only limited aspects of a drug user's life (e.g. the use of substitute medication to reduce the use of illegal drugs). Little emphasis has been given to addressing the underlying issue of dependency.
- The emphasis on 'specialist treatment' as the 'treatment that counts' has served to diminish the potential and actual contributions to be made by generic, community, rehabilitative, and 'low threshold' services.
- The result of this emphasis is an over-dependence on methadone prescribing, with few alternatives or complementary treatments available to maximise any benefits accrued in terms of drug use, health or social functioning.
- As illustration, this paper found significant variation in available budgets to meet the need of drug-using populations – ranging from £478 to £1,183 per anticipated service user per annum.
- In effect, Drug Action Teams are able to commission only 1 treatment option per annum per drug user. This situation severely limits the range of recommended treatments available, from harm reduction and prescribing through to supported housing and residential rehabilitation.

INTRODUCTION

The National Treatment Agency (NTA) undertakes the performance management of local Drug (and Alcohol) Action Teams (D(A)ATs) on a regional basis, aligned to Government Office boundaries of responsibility. The Agency acts both as 'issuing officer' for Pooled Treatment Budget (PTB) allocations and as 'auditor' of quality through the 'signing off' of treatment plans and regular quarterly performance management meetings.

The NTA was established as a Special Health Authority in April 2001 and published its key document 'Models of Care' in December 2002. "Models of care provides the framework required to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in England." The publication of a consultation report in October 2005 aimed to update Models of Care in light of the Audit Commission report Drug Misuse 2004, NHS standards and the rapid expansion of drug treatment.

This paper attempts to present an overview of issues faced by DAATs in implementing Models of Care, and draws upon publicly available information from DAT Treatment Plans for 2005/06 across the South East region to illustrate the lack of equity, parity and consistency in provision across the country.

COMMISSIONING BY THE TIERED APPROACH

It should be noted that DAATs provide breakdowns of funding plans by Tier to the NTA every year, but that these are not directly available for review through the Agency's website.

Models of Care defines a range of generic services as Tier 1 treatment modalities, as illustrated below.

Tier 1 interventions: Drug-related information and advice, screening and referral by generic services

Tier no.	Tier title	Service modality	Commissioning level
1	**Non-substance misuse specific services**	For example: Personal/general medical services (primary care) Non-DM specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-SM specific probation services Vaccination / communicable diseases Sexual health / health promotion Accident and emergency services General psychiatric services Vocational services	Local DAT/ PCT/PCG

The updated Models of Care consultation report refines this definition as below.

Definition	Tier 1 interventions comprise drug-related information and advice, screening, assessment, and referral to specialised drug treatment
Interventions	Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 drug interventions • Drug treatment screening and assessment • Referral to specialised drug treatment • Drug advice and information • Partnership or "shared care" working with specialised drug treatment services, to provide specific drug treatment interventions for drug misusers within the context of their generic services. Specific drug treatment liaison schemes may need to be commissioned to fully realise partnership work Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation). Commissioners should ensure that drug misusers are not marginalised from generic services by developing local strategic partnerships
Settings	Tier 1 interventions are provided in the context of general health (e.g. liver units, antenatal wards, accident and emergency), social care, education or criminal justice settings

The aspiration of Models of Care is for 'joint commissioning' through the local DAAT. Whilst the NTA explicitly acknowledges that "drug treatment services cannot be commissioned in isolation", in reality there are very few examples of commissioners of Tier 1 services (i.e. general medical services, housing) working collaboratively through DAAT mechanisms.

The Tier 1 services arena has generally been viewed as a legitimate area for DAAT expenditure on training, with the aim of engendering collaboration, and complementing any local marketing and communications strategy.

The difficulties faced by most DAATs in developing 'local strategic partnerships' is that, per se, the DAAT is already that partnership, envisaged to perform that very function since establishment in 1995/96. The DAAT is only comprised of statutory member agencies who will necessarily bring their own agendas and priorities to the joint commissioning forum. These priorities are already pre-decided at Government Department level, with specific targets and funding streams which dwarf drug spending. For example, the Pooled Treatment Budget allocation for all Tiers of drug misuse services in 2003/04 was £236,100,000 – less than 6% of the total investment in mental health services in England.

Examples of Tier 1 interventions attempted by local DAATs include A&E liaison posts and dedicated Children & Families workers. In practice a number of areas have appointed to such posts but clinical governance and professional supervision standards have resulted in arms-length management of individual workers within 'generic' teams, frequently resulting in isolation of workers seen as 'specialists' or else 'not part of the team' and consequent staff turnover. Where such posts have been successful it has often been attributable to the professional development ambitions and personal commitment of individual workers.

In the context of 'enhanced targets' for engaging drug users in to 'core' treatment services, and reduced funding available to statutory partners, it is to be expected that this area would be the 'soft target' for cuts.

Tier 2 interventions: Open access, non-care-planned drug-specific interventions

Models of Care defines a range of 'low threshold' services as Tier 2 treatment modalities4, as illustrated below.

Tier no.	Tier title	Service modality	Commissioning level
2	**Open access drug misuse services**	Drug-related advice and information Open access or drop-in services Motivational interviewing/ brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management	Local DAT/ PCT/PCG

The updated Models of Care consultation report5 refines this definition as below.

Definition	Tier 2 interventions comprise drug-related information and advice, screening, assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare
Interventions	Tier 2 interventions which should be commissioned in each local area include: • Screening, assessment and referral for structured drug treatment • Drug interventions which attract and motivate drug misusers into local treatment systems, including engagement with priority groups such as pregnant women, offenders, stimulant users etc. • Interventions to reduce harm and risk due to BBV and other infections, including dedicated needle exchanges and the support and co-ordination of pharmacy based needle exchanges • Interventions to minimise the risk of overdose and diversion of prescribed drugs • Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment) • Brief interventions for specific target groups including high-risk and other priority groups • Aftercare support for those who have left care-planned structured treatment • Liaison and support for generic providers of Tier 1 interventions.
Settings	Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions. Other typical settings to increase access are through outreach (general detached or street work; peripatetic work in generic settings or domiciliary (home) visits) and in primary care settings. Pharmacy settings are important due to their unique role in pharmacy based needle exchange schemes and their role in supervised consumption of prescribed drugs. Criminal justice settings – including police and court settings for criminal justice referral, Drugs Intervention Programmes in community settings, as well as CARATs and prison healthcare provision within the prisons estate.

Both Tier 2 and Tier 3 services have historically been seen as DAAT 'core business', with Tier 2 serving as the 'gateway' to the treatment system through initial assessment and care planning. However, this often-crucial role is not acknowledged within the target-driven approach of the national performance management framework, even if some Tier 2 activities are public health priorities, such as minimising the transmission of blood-borne viruses (BBVs).

The revisions to Models of Care implicitly acknowledge that Tier 2 interventions may be the extent of 'treatment' needed or available to some individuals, i.e. stimulant and/or cannabis users, yet there is no formal monitoring of the impact in terms of health or social functioning.

Brief interventions, motivational techniques, relapse prevention and health education and promotion all sit squarely within the parameters of Tier 2 interventions, and are key to any care-planned approach in providing the 'options appraisal' for those entering the treatment system. Put more succinctly, Tier 2 services engage with those in crisis on the way in to treatment, and the vulnerable on the way out.

Historically, with the exception of pharmacy-based developments, Tier 2 provision has generally been viewed

as best delivered through the voluntary and non-statutory sectors. The rationale for this arrangement includes the added value which such sectors can bring, i.e. lower staff and management costs, access to grant funding and charitable dispensations, and that such activities are not always seen as 'core business' for statutory bodies.

Many examples of local Tier 2 configurations predate DAAT and joint commissioning structures, yet despite the move towards contracts and service level agreements there remains the mode of thinking that voluntary and non-statutory providers should be 'audited' for every penny and encouraged to provide greater value for money. The attitude of paternalism implies that such provision is not 'professional', or at least not as valued as legitimate, monitored 'treatment' options, and contrasts with the national emphasis on monitoring Tier 3 services as the key performance indicators for the success of the national strategy.

In terms of workforce development and rehabilitative options, Tier 2 services are also those most likely to engage ex-users, drawing upon their skills and experiences to make services more empathetic and responsive to service users expressed needs. One evaluated example of best practice is SMART, which is based in Oxford but also provides services in Reading and Milton Keynes. Included in the range of provision is a mentoring scheme which, in addition to meeting aftercare support needs, serves to assess and address education and employment options. The scheme shares may of the characteristics of Tier 3 provision in adopting a care planning and review approach to engaging and retaining service users in their rehabilitative journey.

Tier 3 interventions: Structured, care-planned drug treatment

Models of Care defines a range of structured interventions as Tier 3 treatment modalities4, as illustrated below.

Tier no.	Tier title	Service modality	Commissioning level
3	**Structured community-based specialist drug misuse services**	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services	Local DAT/ Multi-DAT

The updated Models of Care consultation report refines this definition as below.

Definition	Tier 3 interventions comprise community-based specialised drug assessment and co-ordinated care-planned treatment.
Interventions	Tier 3 interventions that should be commissioned in each local area include: • Comprehensive drug misuse assessment • Care planning and review for all in structured treatment, often with regular keyworking sessions as standard practice • Community care assessment and case management for drug misusers • Care co-ordination for those with more complex needs • Harm reduction activities as integral to care planned treatment • A range of prescribing interventions, in the context of a package of care, in line with the "Clinical Guidelines" (DH 1999) and other evidence-based clinical standards including: stabilisation and oral opioid maintenance prescribing; community based detoxification; injectable methadone prescribing; and a range of prescribing interventions to prevent relapse and ameliorate drug-related and alcohol-related conditions • A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour, and also address co-existing conditions such as depression and anxiety • Structured day programmes and care planned day care (e.g. interventions targeting specific groups) • Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health, hepatitis services) • Liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness) • A range of drug treatment interventions for drug misusing offenders including drug treatment elements in Drugs Intervention Programmes, Probation Orders with drug treatment components, and drug treatment provided within prison settings.
Settings	Tier 3 interventions are normally delivered in specialised drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions. Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but drug specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care. Drug treatment interventions for offenders may be delivered in prison settings by CARATs and some drug treatment programmes or within criminal justice teams (e.g. Drugs Intervention Programmes).

As for Tier 2 interventions, Tier 3 services have historically been seen as DAAT, and latterly as NTA, 'core business'. As reflected through the NTA's establishment as a Special Health Authority, the entrusting of Pooled Treatment Budgets to Primary Care Trusts, and the dominant medico-clinical composition of the Models of Care Project Team, the terms of reference for the NTA and Models of Care are firmly within the statutory arena of health and social care in espousing "professional consensus of 'what works best' for drug misusers".

The selection of (1) specialist community prescribing services and (2) care planning and care co-ordination as the themes for improvement review assessments during 2005/06 reflects the dominance of such medico-clinical thinking in strategic planning. The rationale for the selection of these themes includes that there are (1) high volumes of users in contact with prescribing (cited at 106,000) and (2) 'evidence that care planning is not well developed'.

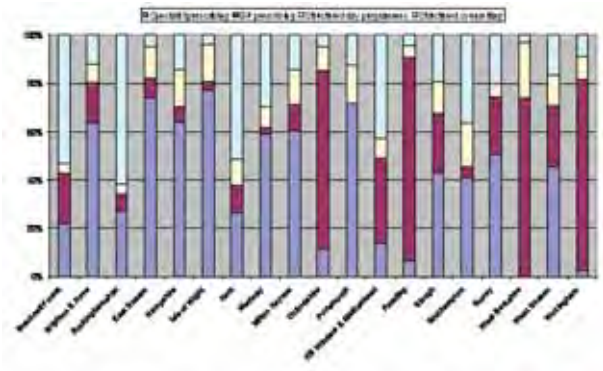
The explicit inclusion within the revised Models of Care of drug treatment and engagement options through the criminal justice system reflects the prevailing Government emphasis on the links between drugs and

crime, but on the ground there is considerable debate and dissension regarding the application of criminal justice funds to treatment and, conversely, the application of health funds to criminal justice objectives. Such confusion has led to the publication of guidance on roles and responsibilities for the Drug Interventions Programme and DRRs (Probation Orders with drug-related requirements), which in itself serves to undermine the concept of partnership working to meet common objectives.

The monitoring of treatment units purchased by individual DAATs does allow for an analysis of the local treatment system in terms of the six key modalities. If national figures are applied (106,000 prescribing interventions for 180,000 drug users engaged) it is possible to estimate that over 58% of drug users access prescribing options. However this overall picture disguises considerable variations across DAAT areas and does not accord with findings that "oral methadone treatment accompanied by some form of non-prescribing intervention is probably more effective than methadone alone".

For example, as illustrated below in Figure 1, across the DAATs in the South East the percentage of prescribing 'units' within the Tier 3 range of services varies between 34% and 90%. The balance in provision, or 'customer choice' in accessing prescribing, also shows wide disparities, with some areas almost entirely reliant on specialist services and others investing in GP prescribing.

Figure 1: Balance of Tier 3 interventions commissioned by DAATs (South East)



Within this range of provision it should be recalled that prescribing options remain predominantly opioid-based, with a long-standing preference for the use of oral methadone mixture as a clinical management tool. Whilst public health arguments regarding safety are valid, methadone serves to facilitate longer-term retention in services by, in effect, replacing one addiction with another. In over fifteen years work in the field I have yet to encounter a single drug user who 'likes' methadone mixture – whilst many will acknowledge that it has enabled them to step out of chaotic use and start to address the underlying issues in their lives, without accompanying interventions it serves only to keep users where they are.

So if prescribing options are 'the treatment' available for up to 90% of problematic drug users, there is precious little capacity for manoeuvre in any care-planned approach for an individuals wider needs, and even less for those whose 'drug of choice' is not an opiate.

It is also suggested that, even within the range of prescribing options available, there should be a balance in favour of GP-led prescribing or 'shared care' arrangements against specialist prescribing. This would be in accord with Department of Health guidelines and targets to increase the role of GPs in care, and also serves to 'normalise' the patients experience and assist in their rehabilitation journey back to the mainstream.

Tier 4 interventions: Drug specialist inpatient treatment and residential rehabilitation

Models of Care defines a range of specialist interventions as Tier 4 treatment modalities4, as illustrated below.

Tier no.	Tier title	Service modality	Commissioning level
4a	**Residential substance misuse specific services**	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services	Multi-DAT/ Regional/ National
4b	**Highly specialist non-substance misuse specific services**	For example: Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services Young people's hospital and residential services providing drug and alcohol treatment services (16 to 21 years) HIV specialist units	Regional/ National

The updated Models of Care consultation report5 refines this definition as below.

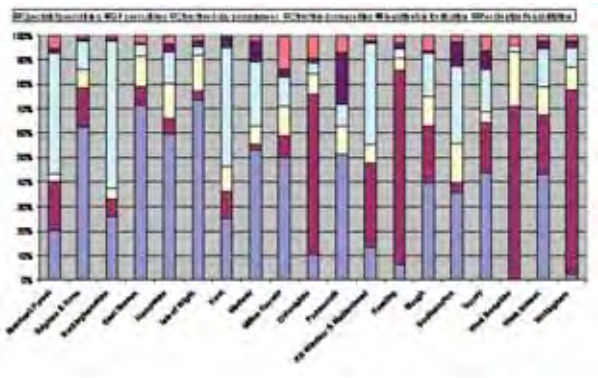
Definition	Tier 4 interventions comprise residential specialised drug treatment which is care-planned and care co-ordinated to ensure continuity of care and aftercare.
Interventions	Tier-4 interventions which should be commissioned to meet local needs include: • Inpatient specialist drug and alcohol detoxification and stabilisation services • A range of drug and alcohol residential rehabilitation units to suit the needs of different service users • A range of drug 'half way' houses or supportive accommodation for drug misusers • Residential drug and alcohol crisis intervention units (in larger urban areas) • Inpatient detoxification provision, directly attached to residential rehabilitation units for some. • Provision for special groups for which a need is identified (e.g. for drug using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). These interventions may require joint initiatives between specialised drug services and other specialist inpatient units.
Settings	Ideal settings to provide inpatient drug detoxification and stabilisation are specialised bespoke inpatient or residential substance misuse units or wards. Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit. Those with complex drug and other needs requiring inpatient interventions may require hospitalisation for their other needs e.g. (pregnancy, liver problems, HIV-related problems) and this may be best provided for in the context of those hospital services (with specialised liaison support). Continuity of care is essential in preserving the gains achieved in residential treatments so there is a compelling argument for providing for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (provided there are adequate medical supports). Other patients will need inpatient detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity), but this still requires significant strengthening of the links with residential rehabilitation provision to ensure the seamless transition of clients between the two. Service users requiring residential rehabilitation or "half way houses" may wish to be located away from their area of residence and drug misusing networks.

Tier 4 interventions have traditionally been the most 'difficult' area for DAATs to commission, having historically

been viewed as either core health (inpatient detoxification) or social services (residential rehabilitation) provision. The original Models of Care envisaged that commissioning would be undertaken at multi-DAAT, regional and/or national level, but in the rush to establish more robust local treatment systems, the needs for Tier 4 provision has been side-lined, with limited progress made.

The resulting picture, as illustrated in Figure 2 for the South East below, is that the balance of Tier 4 interventions against Tier 3 is even more pronounced, with no access to inpatient detoxification in some areas and wide variations in access to residential rehabilitation.

Figure 2: Balance of Tier 3 and Tier 4 interventions commissioned by DAATs (South East)



In the 'worst' areas, Tier 4 interventions are available for only 3% of the anticipated PDU population. This compares to the widespread acknowledgement that about 1 in 10 will require a Tier 4 intervention as part of their care-planned pathway, which is the average level of provision across the region. As a 'rule of thumb', it is suggested that the balance of prescribing provision should be no more than 60% and that Tier 4 provision should be approximately 10% of DAAT spending on Tiers 3 and 4 combined.

WAITING TIMES AND RETENTION TARGETS

Despite the assertion that "outcome measures are the critical indicator of whether and to what extent the programme is meeting its desired goals and what impact this has", and referral to the Effectiveness Review's outcome domains "as 'true' outcomes and the treatment goals to be agreed with the service user at the onset of care", there still exists no systematic analysis of the impact of treatment for service users.

Instead, quantitative measures of entry and retention in treatment services are used to assess progress, with little indication of the content, efficacy or outcomes from the range of treatment modalities which this may encompass. The cited KPIs for drug misuse services include waiting times, new referrals, treatment completions and unit costs, which were anticipated to be required centrally during 2003/04 but for which is still in progress.

The NTA reports "that the target to double numbers in treatment has been met two years early" with "just under 180,000 individuals recorded as in contact with the treatment system during 2005/6".

Similarly, "during 2005/6 56% of individuals had been retained for 12 weeks or longer in their current modality of treatment", with 75% retained within the overall treatment system.

"Waiting times continue to be at historically low levels with 69% of individuals waiting three weeks or less".

Such targets and progress are indeed 'SMART' [Specific, Measurable, Achievable, Realistic and Timed], but they have no bearing on the service user's experience of care, nor can they accurately predict a tangible outcome. It is not possible to compare drug misuse treatment options with operations and consultant diagnostic sessions – there is no 'standard procedure' which can guarantee a percentage chance of success.

At the service provider level the existing performance management framework is often viewed as 'a numbers game' with innovative strategies employed as a result. As well as the intrinsic difficulty of the monitoring criteria, whereby the retrospective waiting time is only recorded once the service has been accessed, examples include:

- the retention of clients "on the books" when no activity is either taking place or has been assessed as unnecessary, with a view to meeting the retention criteria;
- changes in eligibility criteria, which serve to 'shift responsibility' for care to a Tier 2 provider, for example, for whom waiting lists are not monitored;
- closure of waiting lists and de facto closure of waiting lists, so that only those recorded as waiting for, and then accessing, services are monitored (an example of de facto closure is telling clients that there is a standard 13-week wait and allowing potential users to 'withdraw' the request for a service).

EQUITY, PARITY AND CONSISTENCY

All the issues discussed serve to militate against the achievement of "equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in England."

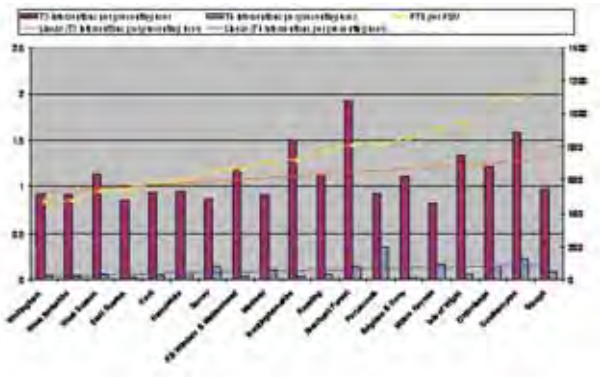
The average Pooled Treatment Budget (PTB) allocation spend per problematic drug user (PDU) across the DAATs in the South East is just over £760. Given the relatively small numbers of PDUs in the population, this equates to roughly £5 per head of population. On average, PTB funds are just over 41% of all funds available to the DAAT.

By contrast the overall investment per head of population in mental health services is £123.

On average across the South East, DAATs commission 1.12 units of Tier 3 interventions and 0.1 units of Tier 4 interventions per anticipated drug user. There is also wide variation either side of the average PTB spend available to each DAAT, within the range of £478 to £1183 per anticipated service user.

In interpreting Figure 3, it is suggested that a 'balanced' treatment system should aim for Tier 3 interventions close to the upper median line and Tier 4 interventions close to the lower median line. However, this assessment only includes the DAATs in the South East region, serving only to compare performance against the other DAATs in the region.

Figure 3: Pooled Treatment Budget and Numbers of Tier 3 and Tier 4 interventions commissioned per Problematic Drug User across DAATs in South East



There appears to be no direct correlation of volumes of treatment or configuration by the amount of funding available. On this analysis, for example, Bracknell Forest would appear to have a relatively well-functioning treatment system, offering almost 2 Tier 3 interventions per service user, balanced between prescribing and non-prescribing options, and Tier 4 provision for 15% of the target group.

CONCLUSION

The proposed amendments to Models of Care are still undergoing consultation, but the inclusion of 'shared care' as a Tier 1 intervention, designating a level of mainstream responsibility, and in accord with Department of Health guidance, is to be welcomed.

There is a similar acknowledgement of the importance of housing provision to any holistic package of care, but there appears to be some confusion as to where responsibility sits. For example, the removal of explicit citation of housing and homelessness services as Tier 1 has been replaced by reference to rehabilitation 'aftercare', whilst 'aftercare' is now explicitly seen as a Tier 2 core activity, 'liaison' with housing services is Tier 3, and drug "half way" houses or supportive accommodation as Tier 4.

Overall, this is useful in emphasising the importance of housing but serves only to blur lines of commissioning responsibility. In the context of cuts in Supporting People commissioning budgets, pressures in the health service, and targets for local authorities which seek to minimise the acknowledgement of homelessness, such a scenario risks losing small effective projects like the Drug Recovery Project in Oxford which could fall between the stools of commissioning responsibility.

The analysis of commissioning practice contained herein shows that, in effect, there is only 1 treatment option per annum available to drug users seeking help. This finding should serve to highlight the imperative for the best use of interventions and the need for throughput in care. The improved emphasis on treatment system retention can assist, but care packages need to be goal-oriented with robust monitoring of outcomes which challenge individuals and the treatment system ethos. Too often the justification for an emphasis on prescribing is that it is "all they want", when in reality it is 'all they can expect, all they are offered'.

Briefing Paper 4: Drug Treatment Services in England (excluding prisons): An Analysis of Capacity, Provision and Efficiency.

RUSSELL WHITE

1.) INTRODUCTION

This paper analyses the Drug Treatment System in England. Specific attention is paid to the structure of the treatment system by looking at outcomes, commissioning and user satisfaction. Though it is noted that service capacity has increased from 85,000 in 1998 to 181,390 clients in 2005/06 existing service provision is not considered optimum for enhancing client outcomes and in particular client recovery. Furthermore within the existing system there is serious variance in regards to practice, provision, data monitoring and research.

2.) FINDINGS

- The Treatment System is weighted towards substitute prescribing.
- Tier 4 provision is inadequate.
- There are serious geographical differences in the provision of services and best practice. Prescribing services have a wide range in their prescribing conditions, widely different levels of dosage and different levels of supervision. Tier 4 services have (depending on their location) differing levels of service provision, care procedures, aftercare arrangements, staffing provision, data collection and research.
- Needle exchange activity is hugely variable and in a substantial number of cases is failing to be much more than a needle distribution network. A widespread failure to provide immunisation and testing facilities is coupled with a failure to provide advice, suitable equipment and to properly safeguard against overdoses. In many cases the largely unregulated distribution of needles without adequate interventions, or risk assessments, will create harms and exacerbate existing ones.
- Outcomes monitoring is changing but is currently largely meaningless and will need in future to be weighted more heavily in terms of the ultimate goal of recovery and not criminal reduction benefits.
- Commissioning continues to suffer from procedural variance, confusion regarding funding streams, inadequate PTB funding notice, narrow approaches and a lack of information, particularly regional service mapping. (This is present both from the Audit Office's research and anecdotal evidence from leading providers.[1])
- Clients aspirations are not met by the structure of the current system. There is a wide gap between aspirations and the dominance of specialist prescribing services. (This is clear both from the NTA's own research but also from DORIS research undertaken in Scotland[2])
- Further data on Structured Counselling and Structured Day Care services need to be collected to determine the adequacy of their delivery (settings and clinical standards), how well they meet needs and the extent to which psychosocial intervention programmes are adequately constructed. There is currently inadequate data to assess the quality, integration or outcomes of these services.
- Aftercare services continue to be poorly linked to clients exit from treatment. There is a significant failure to provide for a range of care services to support clients in treatment and prevent harmful relapses.

3.) EXECUTIVE SUMMARY

The current drug treatment structure has expanded to 181,390 in 2005/06397. This is an increase of 113 per cent since 1998 and a massive step forward in provision. It is heavily weighted towards harm reduction services. Substitute prescribing dominates treatment and needle exchange services are prevalent across DAT areas.

The overall picture of these harm reduction services is not encouraging. Needle exchange facilities are in great need of improvement to deliver a proper range of harm reduction interventions and a large number of clients in treatment are experiencing long term treatment maintained on a static dosage.

Needle exchange services are in many places acting as little more than distribution and collection networks. Distribution is currently inadequate to meet supply, calculations from available data suggesting one syringe is available for every two days. Data itself is very poor and basic harm reduction measures such as risk evaluations, testing, immunisation, basic advice and OD measures

1 Voluntary Sector Committee, Chapter: Voluntary sector work in tackling Addictions.

2 McKeganey, N., Morris, Z., Neale, J., Robertson, M. (2004) What are Drug Users Looking for When they Contact Drug services: Abstinence or Harm Reduction. Drugs: Education Prevention and Policy, Vol 11 No 5: 423-435 October 2004

are poorly provided, or in many cases not provided at all.

An analysis of types of substitute treatment demonstrates a prevalence of methadone treatment constituting some 80 per cent of all substitute prescriptions. Methadone users had high levels of prescriptions after six months of treatment and a high level of maintenance on a static dosage for over six months. Reduction treatment was very much in a minority accounting for only a quarter of methadone treatments. Buprenorphine used in 18 per cent of substitute treatments had a much higher rate of reduction treatments; lower levels of prescribing after six months and lower levels of static dosage over those six months. Clinical practice in regards to supervision and dosage was also variable for both drugs.

Structured Day Care and Counselling services provide interventions at different points in treatment and for differing periods. The evidence base for these types of treatments demonstrate that they can improve success rates in opposition to treatment without any psychosocial or ancillary service support. However, information regarding their delivery within the current system does not extend much beyond numbers. Analysis of intervention standards, the psychosocial balances of treatment interventions and geographical provision is necessary to improve standards, measure effectiveness and draw on best practice.

Tier 4 services are current recognised as under-capacity and under-funded. A wide range of issues concerning provision, clinical practice, admissions practice, data collection and research procedures exist. The cause of these problems stem from the high cost of services blocking incentives for commissioning within the current framework, poorly designed commissioning structures, late announcements of in-year funding allocations and poor data and needs analysis upon which to base strategic planning. A provision of £54.9 million capital development funding for the expansion of Tier 4 services is premature based upon existing funding structures. Consolidation of current services is needed with a long term decline in referrals and occupancy rates (and in particular the recent residential crisis.)

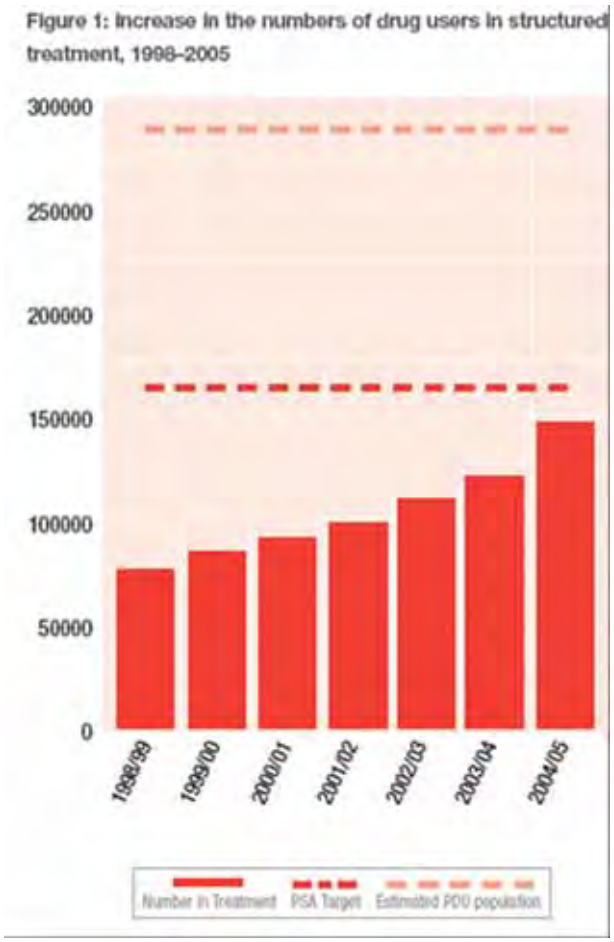
The commissioning of the delivery of drugs services has also come under heavy criticism, particularly their ability to manage their own funding bases. Underspending is coupled with short term planning and current funding streams continue to be too complicated and inflexible. The lack of incentives for commissioning Tier 4 services has to some extent been mitigated by a ring fenced capital development budget. However this has not corrected existing funding insecurities and current services are suffering from the competing demands placed on social services community care budgets. The funding source typically used for referrals has been largely withdrawn this year leading to unsustainable drops in referrals for a large number of services. While government figures (based on BEDVACS) suggest nearly 500 beds are empty the research of the group shows there may be as many as 1,200 beds of the available 2,414 beds lying empty[398]. Either of these occupancy statistics should be deemed unacceptable. The increase in residential funding and referral efficiency (either through ring fenced funds or a reform of the current funding system) could lever large increases in clients treated based on the existing system. In any case it is vital that historic funding difficulties are corrected before expansion takes place.

The NTA reports client satisfaction with services, yet the widespread desire of clients to achieve abstinence is not being supported. The dominance of maintenance treatment is clearly a major issue here. Paths to abstinence need either to be created within the current treatment system to meet these aspirations. This will mean a major role for Tier 4 services and requires further research and analysis of information currently being collated in client care plans. Aftercare linkages need to be consolidated, drug use is a chronic relapsing condition and sufficient support is vital to maximise long term benefits. It is also arguable that the complex structure and commissioning of treatments services needs to be reformed and simplified in relation to new or revised goals. Treatment has expanded massively over the last decade. The need for consolidation and improvement is now vital. Attaining the right balance of interventions, tailored to the client and targeted at eventual recovery is more important than ever. Reform of the system will be needed to maximise client aspirations, expand certain sectors of treatment, (amongst these tier 4 and reduction therapies), raise clinical standards and provide the best aftercare support available.

4.) SERVICE CAPACITY

Service capacity has increased massively from 85,000 in 1998 to 160,453 clients in 2004/05[399] and 181,390 in

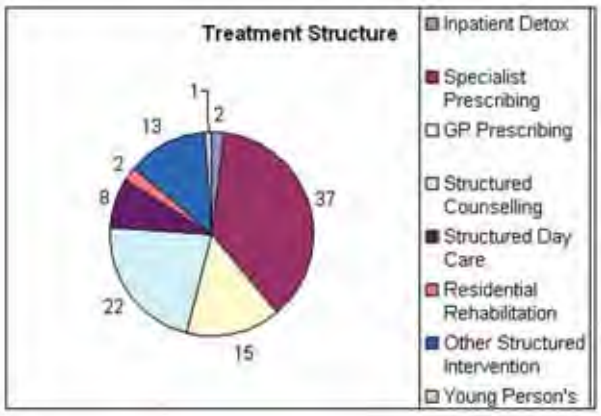
2005/06[3]. The available estimations make this significantly short of PDU estimations but a large step forward in provision[4]:



5.) TREATMENT STRUCTURE

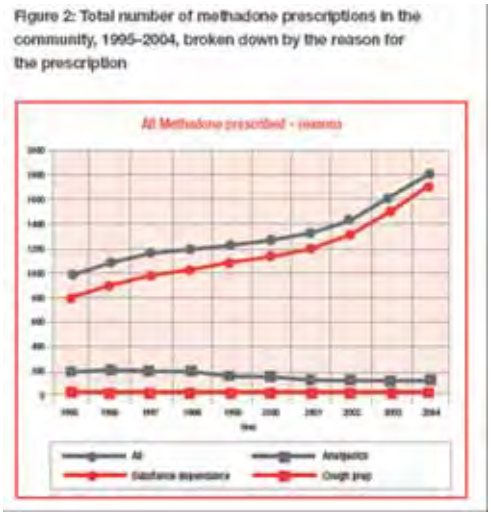
The structure of this treatment system according to the 2004/05 NDTMS detailed statistical analysis is largely concentrated on specialist prescribing, GP prescribing comes second. Structured counselling also forms a significant element of treatment provision.

Trends between 2003/04 to 2004/05 have seen an 11 per cent drop from 63 to 52 per cent prescribing interventions. 'Other structured interventions' account for the majority of this shift. Residential Treatment and Inpatient Detoxification have stayed as a similar small proportion of treatment interventions although Inpatient Detoxification as a proportion of provision has dropped by a further 1 per cent[5].



5.1) Specialist Prescribing (Tier 3)

Specialist Prescribing and GP prescribing (which means the prescribing of substitute drugs, predominately Methadone, Buprenorphine although other drugs are also prescribed including Benzodiazepine, Diazapam, Temazepam, Dihydrocodeine, Morpine salts and others.) are the dominant form of treatment intervention. This means that harm reduction therapies dominate the treatment system. The primary susbstitute medication is methadone. An analysis of PCA (Prescribing Cost Analysis) data shows how methadone prescriptions have grown in use since 1995[5].



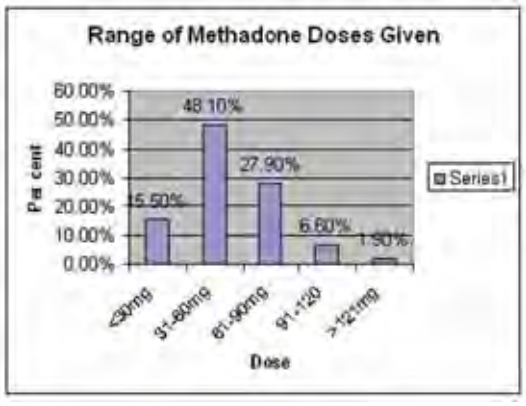
3 Tier 4 drug treatment in England: Summary of inpatient provision and needs assessment (NTA, NHS, June 2005)

4 Detailed Statistics for the NDTMS 2003/04 and 2004/05 (NTA, NHS, 2006)

5 Summary of the NTA's national prescribing audit. (research briefing 19, 2006)

The performance of harm reduction services dispensing specialist medication was reviewed for the first time this year in the NTA's prescribing audit.

- The number of methadone prescriptions in England has increased from 970,900 in 1995 to 1,810,500 in 2004 an increase of 86.5 per cent[6]. The number of oral prescriptions has also increased by 218 per cent[7].
- A review of 38,335 clients found 74.5% receiving substitute opioids as part of their treatment of which around 80 per cent 30,901 clients were receiving methadone[406].
- Three quarters of those were receiving methadone maintenance treatment (meaning a continuation of a same dose prescription) and one quarter were receiving methadone reduction treatment, (a prescription in which the dosage is gradually reduced over time)407.
- The daily methadone maintenance dose was an average of 56.7 mg but dose ranged in services from 6.5mg through to 127mg. The range of dose prescriptions is broken down below[408]:



- There was also marked variation in prescribing conditions after the recommended 12 week period[409]:

In the first 12 weeks supervised consumption standards remained high with 73.2 per cent of services supervising consumption 81-100 per cent of the time with the largest other range being 13.4 per cent at 0-20 per cent supervision. After 12 weeks in the same range only 28.6 per cent of services supervised consumption while the dispersal at lower ranges was more even.

Table 2: Percentage of clients in each service receiving daily supervised consumption of methadone in the first 12 weeks and after 12 weeks

	In first 12 weeks		After 12 weeks	
	Number of services	% of services	Number of services	% of services
0–20%	19	13.4	25	23.8
21–40%	7	4.9	11	10.5
41–60%	5	3.5	23	21.9
61–80%	7	4.9	16	15.2
81–100%	104	73.2	30	28.6
Total	142	100	105	100

- There was also a marked regional variation: 97.8 per cent of clients received methadone daily in the south west region but only 55% did in the North West region[410].
- Predominantly treatment was long term with 60.2 per cent, the majority of clients, receiving a prescription for longer than 6 months. At the same time 'maintenance' for most was also long term with 41.7 per cent of clients receiving their current methadone dose for more than six months. Only 21.7 per cent were on their current dose for less than a month[411].
- A study of buprenorphine treatment (which accounts for approximately 17.5 per cent of substitution treatment) showed a higher proportion of clients on reduction treatment. 60 per cent were on maintenance with 40 per cent on reduction[412].
- Buprenorphine showed a similar geographical variance in treatment provision and clinical practice. There was however more considerable variation in supervised prescribing in the first twelve weeks with well over half after 12 weeks receiving 0-20 per cent supervision.
- Fewer buprenorphine prescriptions lasted over 6 months than methadone with only 39.9 % of clients remaining on the drug more than six months.

6 Ibid
7 Ibid
8 Ibid
9 Ibid
10 Ibid
11 Ibid
12 Summary of the NTA's national prescribing audit. (Research Briefing 19, 2006)
13 Ibid, Authors calculations based on 6,692 clients surveyed for buprenorphine as a percentage of total clients surveyed.

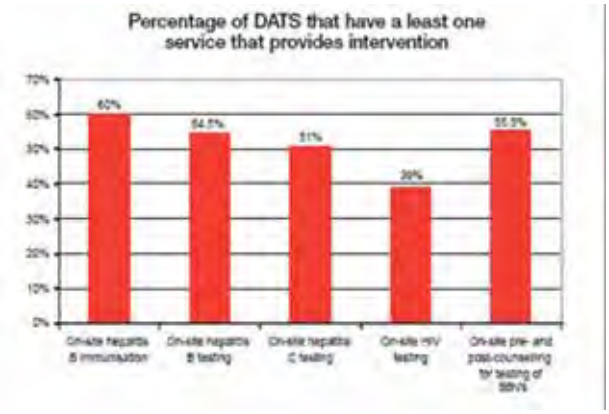
- Buprenorphine reduction regimes averaged at 5.4 months compared to a 7.6 month average for methadone regimes. There was also more variation in dosage with only 24 per cent remaining on the same dosage for more than six months[413].

5.2) Needle Exchange Services (Tier 2)

A recent survey of needle exchange services funded by the DOH looked at service provision across England. Overall pharmacies constituted 80 per cent of needle exchange facilities[414]. There was on average a mixed economy of facilities with two specialist drug services and eight pharmacies in each DAT area[415].

These services were originally designed with the purpose of comprehensively reducing health harms and the spread of BBV (blood borne viruses). However many do not appear to be doing this. The survey showed that[416]:

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



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

There was a wide range of differences between services and pharmacy schemes. These included variability in access to facilities, the number of facilities per DAT area and in the equipment and paraphernalia provided. Geographical variations were not explained by urban and rural differences, patterns of access and accessibility suggested that it was local commissioning of services that determined provision. But very poor data collection and management of needle exchange activity could also account for some of the differences. The lack of audit information on throughput and activity must have hindered strategic planning.

5.3) Structured Counselling (Tier 3)

Provision and Capacity

NDTMS data recorded 52,796 interventions in 2004/05.[417] The NTA's research briefing 11 outlines the effectiveness of psychological interventions and also charts effectiveness of treatments on different clients[418]. However information and analysis of provision within the current system concerning differing clinical standards, geographical variability, needs assessments and meaningful success rates is not available.

Interventions are delivered in individual or group settings and can consist of:

- CBT (Cognative-behaviour therapy)
- Coping skills training
- Relapse Prevention Therapy
- Motivational Interventions
- Contingency Management
- Community reinforcement approaches
- Some family approaches

Treatment setting and delivery

Structured counselling and day care are defined psychosocial interventions delivered as part of a client's care plan. These interventions are normally time limited and delivered by practitioners. Regular clinical supervision to a treatment model takes place.

Setting: These can be community or residential.

413 Ibid
414 Findings of a survey of needle exchanges in England (NTA, May 2006)
415 Ibid
416 Ibid
417 Detailed Statistics for the NDTMS 2004/05 (NTA, NHS, 2006)
418 The effectiveness of psychological therapies on drug misusing clients (NTA, June 2005)

5.4) Structured day care programmes (Tier 3)

Provision and Capacity

Structured day care programmes account for 18,069 interventions or 8 per cent of treatment according to NDTMS 2004/05 statistics[419]. Although there is evidence of their effectiveness, little information has been collated to inform a needs analysis of provision within the current system, differing clinical standards, geographical variability, or meaningful success rates.

The set timetable of work includes:

- Group work
- Psychosocial interventions
- Educational and life skills activities

Treatment Setting and Delivery

In this setting a client must attend 3-5 days per week. Interventions tend to be on a fixed or rolling programme or an individual timetable, according to client need and address drug and alcohol misuse, health needs, offending behaviour and social functioning.

Setting: Clients attend the programme as a follow-on, or a precursor to other treatment types. They are normally community-based services, set in centres that have been specifically designated for the programme.

5.5) Tier 4 Services

An analysis of the provision of services by modality demonstrates the significant place for substitute prescribing while provision for residential and inpatient services remain small. A previous paper has already discussed the growth in treatment provision by modality resulting in the underdevelopment of inpatient services[420]. The NTA themselves highlighted this with the 'effectiveness strategy' further to their survey of inpatient drug services.

The Inpatient drug survey was the first major survey designed to provide a snapshot of service provision. The survey used DAT commissioning records, the Drugscope and NTA directory and specialists in the field to attempt to map all services. It estimated that there were approximately 800 beds available in the year 2003/04 across the whole of England purchased for drug detoxification. This caters for 10,771 admissions with the range of patient visits between 4-77 days[421]. The broad identifiers were termed 'specialist', "non-specialist" and "rehab." The main findings of the survey highlighted a number of issues[422]:

Admittance

- Most inpatient provision in services were aimed at 18-64 year olds, with very few admitting people under 16 or over 64 years of age.

The table below shows the services available for under 16's broken down by type of service with the percentage catered within that sub group. Clearly all type of treatment service require significant expansion to meet need[423]:

	No. that admit under 16s (% of sub-group)	No. that admit over-65s (% of sub-group)
Specialist (n=28)	3 (11)	18 (64)
Non-dedicated (n=45)	1 (2)	23 (51)
Rehab (n=18)	1 (6)	8 (44)
Section 1.01 Overall (n=91)	5 (5)	49 (54)

Table 7: Admissions by age range

- Very few services made specific provision for minority groups.

The table below shows the number of services offering treatment specifically for women and the number in which children are admitted. The epidemiological data analysed on women in drug treatment services (NTA research briefing 6) suggested that there was no under-representation. However the low levels of services which admit parents with children does present a significant barrier to entry for many parents who need treatment[424].

	No. offering services specifically for women (%)	No. where children are admitted with parents (%)
Specialist (n=28)	5 (18)	2 (7)
Non-dedicated (n=45)	7 (16)	1 (2)
Rehab (n=18)	3 (17)	3 (17)
Overall (n=91)	15 (16)	6 (7)

Table 8: Services for women and parents

419 Detailed Statistics for the NDTMS 2004/05 (NTA, NHS, 2006)

420 The UK drugs policy a critical review (SJPG, 2006)

421 A national survey of inpatient drug services in England (NTA, NHS, June 2005)

422 Ibid

423 Ibid

424 Ibid

Services

- Beds were located in a variety of physical settings, which were not always suitable for the client group.
- Services tended to be geared around opioid misuse and there is a lack of provision for poly-substance and stimulant misusers.
- One third of services do not require patients to have an aftercare plan in place prior to admission. Only one third are discharged to residential or day care rehabilitation services.
- There are huge disparities between services, in terms of input from specialist staff. Staff shortages are also a significant problem.

The means and ranges recorded demonstrate variability between services and within the services themselves[425]:

	Mean number of WTE nursing staff (range)	Mean number of qualified nursing staff per day shift (range)	Mean number of qualified nursing staff per night shift (range)	Mean % nursing posts unfilled (range)
Section 1.62 Specialist (n=28)	11.1 (0.5-26)	2.4 (0-12)	1.3 (0-5)	10.4 (0-50)
Non-dedicated (n=32)	12.7 (3-28)	2.5 (1-7)	1.5 (1-3)	8.0 (0-50)
Rehab (n=16)	3.6 (0-14)	1.1 (0-3)	0.6 (0-2)	1.5 (0-20)
Overall (n=76)	10.0 (0-28)	2.2 (0-12)	1.3 (0-5)	7.7 (0-50)

WTE = "whole-time equivalent"

Table 10: Numbers of nursing staff working in each service type

The average of 36 per cent lacking appropriately trained staff is a testament to the reported difficulty within the sector of recruiting staff. Alongside this, those with full staffing levels across service are relatively low, although rehab looks in both tables to be achieving higher staff compliments[426]:

	Number where lack of appropriately trained staff affects services offered (%)
Specialist (n=27)	15 (56)
Non-dedicated (n=39)	19 (49)
Rehab (n=14)	2 (14)
Overall (n=80)	36 (45)

Table 13: Number of services reporting unsatisfactory services as a result of staff shortages

	Number with a full staff complement (%)
Specialist (n=28)	15 (54)
Non-dedicated (n=43)	26 (61)
Rehab (n=17)	15 (88)
Overall (n=88)	56 (64)

Table 14: Staffing levels by service type

- Once admitted the range of services on offer was very variable and the average length of admission for detoxification ranged from four to seventy seven days.

The tables below shows the number of services offering therapies by type within group and individual settings. There is a wide variability between provision.

- Patients are likely to experience differences in the amount and variety of structured psychosocial treatment on offer.

Geographical Variances

- There was no uniformity across the country in terms of patients' access to inpatient services.
- Inpatient services in England are extremely variable in terms of their scope, physical location, staffing and clinical practice.

Research

- Very few services could provide good-quality audit or research data on their work.

Nearly half of services have not conducted audits in the last year. Alongside this 44 per cent had not collected electronic admissions data and only around a third had participated in research or evaluation[427]:

	Number of services that have conducted audit projects in the past year (%)
Specialist (n=28)	21 (75)
Non-dedicated (n=42)	23 (55)
Rehab (n=18)	4 (22)
Overall (n=85)	48 (57)

Table 36: Services which have conducted audit projects in the past year

	Number of units that have taken part in evaluation or research projects in the past year (%)
Specialist (n=27)	19 (70)
Non-dedicated (n=42)	5 (12)
Rehab (n=17)	3 (18)
Overall (n=86)	27 (31)

Table 37: Units participating in evaluation or research

	Number collecting data on admissions using an electronic database (%)
Specialist (n=28)	23 (82)
Non-dedicated (n=45)	27 (60)
Rehab (n=18)	10 (56)
Overall (n=91)	60 (66)

Table 38: Services which collect electronic admissions data

Lead clinicians were asked what they considered to be their greatest additional needs. Capacity ranked highest along with additional staff.

Identified needs	No. of agencies
Additional resources / more beds	12
Staff training / improved specialist input	12
Need for a dedicated specialist unit	11
Wider range of services / therapeutic inputs	10
Better joint working / improved communication	9
More adequate aftercare provision	6
Better physical environment	5
Improved access / reduced waiting times	4
Protection or ring-fencing of drug treatment beds	4
Alternative or complementary therapies	2

Table 4: Additional needs expressed by lead clinicians completing IPD questionnaire

425 Ibid
426 Ibid
427 Ibid

In depth research concerning the state of buildings, staff, admissions practice, aftercare, psychological interventions and outcomes was undertaken though questionnaires. From this analysis a number of issues were identified:

- Buildings – Access for patients in wheelchairs was not available in one-third of services and nearly a quarter had no dedicated clinical room for examining patients.
- Staff – All the services surveyed were providing detoxification however nearly 20 per cent of services were unable to identify a medical clinician. Staff shortages were also a significant problem in both specialist and psychiatric ward-based inpatient services. Overall 9 services (12 per cent) identified at least one shift during the previous months where no permanent staffs were available. In one service this occurred 24 times in 30 days[428].
- Admissions – Specialist and rehab services had the greatest control over who is admitted to their beds. Over 90 per cent of responders required patients to sign a treatment contract on admissions. Urine testing was common in determining infractions and all services were able to respond identifying common behavioural reasons for disciplinary action.
- Aftercare – Detoxification is considered the first step in the treatment process. However, only 68 per cent of specialist units that responded and 70 per cent of non-dedicated services required patients to have an aftercare plan in place prior to admission. The question "how satisfactory is the current arrangement for the aftercare in your service? Was asked:

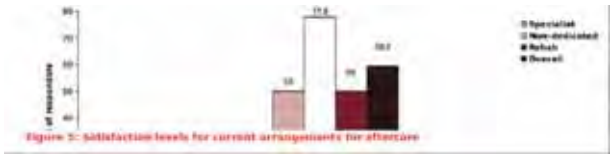


Figure 5: Satisfaction levels for current arrangements for aftercare

The low levels of specialist and rehab satisfaction is not encouraging given the clients that are engaged in these services are the most in need of satisfactory aftercare arrangements.

A survey of residential rehabilitation providers identified 105 RR services of which sixty one per cent responded[429]. Together an average of 58 drug admissions annually equated nationally to 6,090 residential rehabilitation episodes during 2003/04. The NDTMS calculated 4,601 residential admissions[430].

The ranges of bed occupancy rates were one to 211 while bed occupancy rates ranged between 40-98 per cent. The average bed occupancy rate was reported as 74 per cent[431].

All sources, commissioners' estimates, survey information, theoretical systems models and feedback from users and carers used in the report pointed to insufficient RR services and wide regional variation. The under-provision was such that there was little relationship between PDU's and Tier 4 provision location[432].

Region	PDU estimate	NDTMS total treatment group	Total no. in Tier 4 according to NDTMS	Estimated need for IPD in 07/08[3]	Estimated need for RR in 07/08[4]
East Midlands	25972 (9.0%)	9132 (7.1%)	239	1164	582
East of England	21846 (7.6%)	9050 (7.0%)	715	1147	574
London	45501 (15.8%)	22165 (17.2%)	2979	2819	1410
North East	15769 (5.5%)	6948 (5.4%)	590	885	443
North West	48715 (16.9%)	27630 (21.5%)	2207	3524	1762
South East	30943 (13.9%)	11659 (9.1%)	978	1492	745
South West	27580 (9.6%)	12964 (10.1%)	1147	1655	827
West Midlands	28700 (10.0%)	12986 (10.1%)	877	1655	827
Yorkshire & Humber	33650 (11.7%)	16111 (12.5%)	338	2049	1025
National total:	287676 (100%)	128645 (100%)	10068	16390	8195

Table 1: NDTMS estimates of 2003/04 provision and demand-based predictions of 2007/08 need

The provision against PDU estimates and NDTMS treatment groups were calculated with estimates of penetration at 3.5 per cent of PDU population. Significant expansion in service expansion will therefore be needed to meet demand[433].

	Number in T4	Total number in treatment	Estimated PDU population	T4 as % of total treatment	T4 as % of estimated PDU
East Midlands	239	9132	25972	2.6%	0.9%
East of England	715	9050	21846	7.9%	3.2%
London	2979	22165	45501	13.4%	6.5%
North East	590	6948	15769	8.5%	3.7%
North West	2207	27630	48715	8.0%	4.5%
South East	978	11659	30943	8.4%	3.4%
South West	1147	12964	27580	8.8%	4.2%
West Midlands	877	12986	28700	6.8%	3.1%
Yorkshire and Humber	338	16111	33650	2.1%	1.0%
National total:	10068	128645	287676	7.8%	3.5%

Table 12: Regional variations in proportions of PDU and structured treatment group in Tier 4 services in the previous year

The main factors identified were historical commissioning patterns and differing beliefs on the role of Tier 4 treatment.

Focus group findings highlighted the weakness in client preparation, assessment, throughcare and aftercare as well as perceived inflexibility in matching provision to individ-

428 Tier 4 drug treatment in England: Summary of inpatient provision and needs assessment (NTA, NHS, June 2005)
429 Ibid
430 Ibid
431 Ibid
432 Ibid
433 Ibid

ual client needs. This is clearly demonstrated by the gap between client desire and service delivery and is shown in the table below:

	Inpatient detoxification		Residential rehabilitation	
	Yes	No	Yes	No
Felt they have needed	70%	30%	71%	29%
Have been offered	21%	79%	32%	68%
Put off by waiting times	45%	55%	51%	49%
Feel they would benefit from	65%	45%	61%	39%
Feel are appropriate for needs	58%	42%	63%	37%
Have been satisfied with past experiences	70%	80%	26%	74%

Table 9: Experiences and views of Tier 4 services

Tier four services both inpatient detoxification and residential rehabilitation are in significant need of expansion. The Tier 4 needs assessment calculated a 90 per cent IPD increase and a 34 per cent RR increase[434]. Alongside the modelled increases a range of issues highlighted need to be addressed. Developing minimal standards, common practice, lower attrition rates between assessment and referral and better outcomes are all important. The lack of geographical coherence and a regular system for mapping services also need to be addressed effectively. Standards need to increase as well as capacity. The NTA BEDVACS system is an important start, yet it only provides partial information on tier 4 services and is not sufficiently comprehensive for strategic planning. A new system of data collection will need to be developed upon which provision can be mapped, needs assessed and gaps in coverage dealt with.

6.) OUTCOME MONITORING: BEYOND PROXY INDICATORS: (FOR EXAMPLE NUMBER/RETENTION IN TREATMENT)

A previous paper has already analysed the ability of the NTA to measure outcomes in a meaningful way[435] and concluded that the current system of a '12 week' retention target, waiting times and 'broad' outcomes monitoring at point of exit is not adequate. These proxy measures have long failed to measure actual outcomes. The 2006/07 NTA business plan showed some recognition of this failure:

> *"Stakeholders are becoming increasingly impatient with the drug treatment systems reliance on process to suggest the success or failure of treatment and are demanding that the NTA find ways to measure real outcomes.[436]"*

It was noted that this trend would increase once users begin to set their own goals.

In response the NTA has announced the development of a new outcome "measurement tool" which will focus on 'real' outcomes and has commissioned. The National Addiction Centre to develop it.

The four key domains to be included will be drug and alcohol use, health, social needs and criminality. The aim is to integrate these new measurements in the outcome monitoring for the NDTMS by April 2007.

The aspiration of large numbers of clients to become abstinent as the end goal of treatment is only likely to be achieved if this is built into a treatment system geared more towards health and recovery than to the cost and benefit savings of crime reduction and public health harms.

7.) COMMISSIONING

7.1) Commissioning Structures

Commissioning continues to be the bedrock of service provision.

The National Treatment Agency recently initiated a series of reviews of treatment provision in England. One is concentrating on whether drug treatment services are prescribing drugs safely and appropriately. A second is focussing on whether there is good treatment planning and co-ordination of services. The detailed national analysis of these results has not as yet been published; however a pilot report for the programme which took place across 14 sites has highlighted serious problems both with commissioning procedures and finance. It concluded that

> *"Substance misuse commissioning posts were usually poorly resourced and isolated from strategic management.[437]"*

> *"Where historical mental health spend on substance misuse was not clarified it was found to pose problems for responsive and accurate commissioning, as well as capacity planning.[438]"*

The initial results for the improvement project were released in September 2006 and stated that:

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434 Tier 4 drug treatment in England: Summary of inpatient provision and needs assessment (NTA, NHS, June 2005)

435 The UK drugs policy a critical review (SJPG, 2006)

436 NTA Business Plan 2006/07 (NTA, NHS, September 2006)

437 Pilot report of joint improvement reviews between the Healthcare Commission and the National Treatment Agency for substance misuse (NTA, 2005)

438 Ibid

Local Drug Partnerships, including Primary Care Trusts, need to improve their commissioning of drug treatment.

- The four tier ranking structure employed by the review ranked 63 per cent of services as 'weak' or 'fair' when it came to assessing the detail of their specifications for community prescribing interventions[439].

This mirrors the highlight critical NAC report changing habits which highlighted:

> *"Weaknesses in commissioning and resource allocation. Poor service planning, low levels of commissioning expertise and the funding framework make it difficult to improve current performance and to ensure that local provision is 'fit for purpose'.[440]"*

Lessons that were re-itterated in the 2004 national audit commission report on Drug Misuse:

> *"Local partnerships had yet to demonstrate that they can manage their resource base effectively[441]. In some cases over 40 per cent of PTB funding remained unspent and by the end of the financial year (2003) there was an average under-spend of 11 per cent. They concluded that a major underlying cause was 'short term planning which was encouraged by short term funding[442].*

Furthermore the LDP's are still experiencing problems that should have been learned from the 2004 NAO report:

> *"Local drug partnerships are still uncertain about their funding position from year to year….At best, local drug partnerships only know their full allocation of earmarked funding at the start of each financial year. Moreover, the Government continues to give short notice of in-year funding.[443]"*

The latest PTB funding allocation has caused massive controversy. Firstly the allocation of resources has failed to meet expected amounts and secondly the details were announced so late that funding partnerships had to tear up their strategic plans[444]. (This contrasts with other government services planning, notably NHS local delivery planning, where funding allocations are announced in the middle of the previous year, rather than the start of the current year).

Local drug partnerships were also criticised in the audit office report for failing to act within mainstream services and having approaches which are 'narrow, separate from each other and short term'.

7.2) Commissioning of Tier 4 Services / Current Developments

A case for expansion has been made by Dr. David Best (lead author of the needs assessment) He highlighted serious gaps in provision and reform of the commissioning system which has been criticised for a "spot purchase culture, often sitting outside local strategic commissioning processes.[445]"

An allocation of £54.9m of capital funding to Strategic Health Authorities (for the development of residential services) has been announced by the NTA The process of allocation is subject to the outcome of a strategic bidding process[446]. A commencement target of the 1st April has caused tight deadlines for statements of priorities on regional forums. The NTA has justified this in terms of aiding 'partners in being able to maximise the strength of their bids' mainly by getting feedback[447].

November 10th remained the deadline for a full bid being submitted.

The allocation of additional funds earmarked for Tier 4 services has altered the prior incentives towards underprovision of Tier 4 services. The lack of growth in services did lie in poor incentives for commissioning.

A previous analysis conducted for the Addictions Working Group has described how the push for numbers in treatment has effectively resulted in a programme of methadone maintenance and community prescribing treatment to meet performance targets[448]. The sustainability of current treatment services remains in question. Tier Four services have consistently suffered in respect to their position in funding streams. One example highlighted in the NAO 2004 Drug Misuse report was that, 'the position of funding residential care placement decisions is determined by a weekly cost limit, not the cost and value of a complete course.[449]'

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439 Improvement review into substance misuse services, (Healthcare commission, September 2006)

440 National Audit Commission: Changing habits (NAC, 2002)

441 Drug misuse 2004, (NAC, NAO, 2004)

442 Ibid

443 Drug misuse 2004, (NAC, NAO, 2004)

444 DDN site:www.ddn.co.uk

445 Update Issue 10 (NTA, NHS, 2006)

446 Capital development programme for inpatient and residential rehabilitation substance misuse (drug and alcohol) services 2007/08 and 2008/09: Application Guidance Notes (DOH, 2006)

447 Ibid

448 The UK drugs policy a critical review (SJPG, 2006)

449 National Audit Commission Drug Misuse 2004 (NAO, November 2004)

In an article published by Drink And Drug News Brian Arbery, the Chief Executive of ADAPT, complained that some occupancy rates were down to below 40 per cent due to poor referrals and outlined the reasons for this:

> *"It is believed that the underlying reasons for this situation may stem from a withdrawal of community care funds, theoretically committed by social services departments, which have traditionally been used to fund residential placements. This has been accompanied by a similar cut in PCT allocations. Local DAT's, DAATs and partnerships have failed to make up the shortfall by using Pooled Treatment Budget monies, probably because to do so would prevent them meeting their targets in other tiers.*[450]"

In October this year four providers ADAPT, Clouds, RAPT and Phoenix House in association with EATA have taken the issue of a poor number of referrals and empty beds to the NTA.[451]

They described a crisis that is reported by BEDVACS to have led to nearly 500 beds empty in England. The unreliability of BEDVACS has highlighted the possibility that there may be much lower occupancy rates. Analysis of an EATA study shows occupancy as low as 61 per cent with a drop in referrals of 22 per cent this year. This suggest that there may be as many as 1,200 empty beds across the county out of a total of 2,441 beds[452].

The NTA responded by acknowledging that serious problems were occurring stating that it was of concern to the NTA that:

> *"Despite this additional investment, the use of Tier 4 services in general, and the use of residential rehabilitation in particular, appears to have declined when the direction of both policy and investment would have suggested an increase.*[453]"

However it was unable to respond beyond issuing two guidance documents, despite the fact that there was a clear acknowledgement that policies are currently failing to deliver adequate referral rates:

In areas it stated that:

> *"budgets are not appropriately aligned, use of Tier 4 is declining, and waiting times are at unacceptable levels.*[454]"

The current referral issues are just one example of how complex funding streams have plagued the cross departmental drugs and alcohol initiative since its growth in the late 90's. The effective resource use analysis of the National Audit Commissions 2004 report welcomed the "rationalisation of drugs strategy funding streams, reducing the number of streams from 18 to 8 in England for 2004/05.[455]" It also highlighted a number of other problems amongst drug commissioners, amongst them short term planning, uncertain funding positions, local partnerships operating in isolation with narrow and separate approaches that didn't interlink into mainstream treatment goals.

Given all these concerns and the recent problems encountered by a number of prominent residential services it seems premature for the NTA to be planning to build capacity before basic funding structures are reformed; before referrals are improved and current capacity is properly utilised.

8.) TREATMENT SATISFACTION

8.1) Survey results

53,000 questionnaires sent out last year by the NTA across 900 drug treatment services capturing the views and experiences of 6,770 users.

The majority of clients, 88%, were reported as having received some kind of counselling; over half, 53.1%, reported receiving medical treatment; one third, 30.7 %, reported using complementary therapies. A quarter, 25.7 per cent said they had received advice about injecting and 20.7 per cent had used a needle exchange scheme. Around a fifth, 19.2 per cent, received community detoxification,

450 Ibid

451 DDN 25th September 2006 Comment

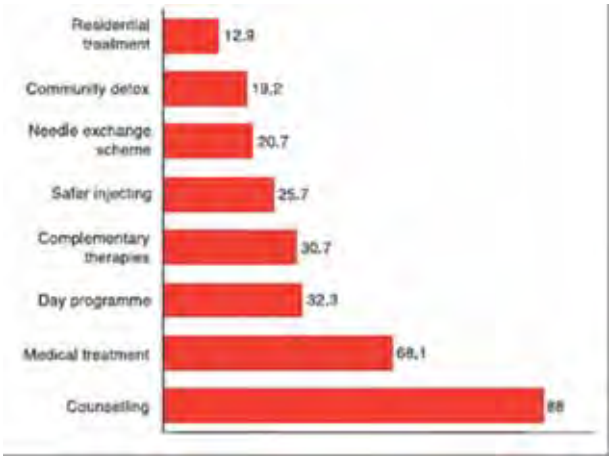
452 See Residential Referrals Case study

453 Commissioning of Tier 4 drug treatment services Letter to DAT chairs, JCG chairs, Directors of Adult Social Services, DAT coordinators and JCMs, 3 November 2006

454 Ibid

455 National Audit Commission Drug Misuse 2004 (NAO, November 2004)

12.3%, inpatient detoxification and 12.9 per cent of clients had attended residential rehabilitation[456].



8.2) Broad Satisfaction

The following table showed that by and large the majority of the clients appear to be satisfied with the services they received.

	Strongly agree	Agree	Don't know / no answer	Disagree	Strongly disagree
The staff are efficient	46.8%	44.1%	4.5%	2.5%	0.6%
am satisfied with the programme	45.0%	46.4%	4.8%	3.0%	1.0%
receive plenty of counselling	43.8%	43.6%	6.8%	4.2%	1.4%
The programme is well organised	41.9%	47.6%	6.8%	3.5%	0.0%
The location of the service is convenient	41.7%	46.5%	2.9%	6.8%	2.3%
have had enough say in treatment decisions	37.5%	48.6%	6.9%	6.0%	1.0%
Time schedules are convenient	34.8%	54.1%	5.3%	5.1%	1.2%
The service promotes responsibility and self-discipline	31.2%	50.5%	13.6%	3.9%	0.9%
am only attending because nothing better is available	10.6%	16.4%	11.3%	36.1%	23.5%
families and partners do not get enough support	10.0%	16.9%	30.0%	28.1%	12.9%

8.3) Aspirations

But the same survey highlighted a number of areas for improvement. It revealed that clients aspirations to reduce their drug use or come off altogether were not being met.

- Heroin users were most likely to be unhappy with current levels of drug use with 81.2 per cent wanting to stop completely using heroin. Only 6.8 per cent wanted to reduce their use and only 12 per cent were happy with current levels of use.
- Cocaine and crack users were similar in their desires to come off drugs completely with 76.6 per cent reporting this as an aim while only 14.8 per cent were happy to continue using at their current levels.
- Half of methadone users also wanted to stop use completely
- By contrast only 24.1 per cent of cannabis users and 28.9 per cent of alcohol users wanted abstinence as an aim[457].

In conclusion the majority desire abstinence as an aim of treatment.

The Drugs outcome research study in Scotland is a further source of information for client aspirations. Participants recruited from a total of 33 drug treatment agencies located in rural, urban and inner-city areas across Scotland were interviewed using a core schedule with 1007 drug users starting a new treatment episode in Scotland[458].

- The findings identified widespread support for abstinence as a goal of treatment with 56.6 % of drug users questioned identifying 'abstinence' as the only change they hoped to achieve on the basis of attending the drug treatment agency.
- Much smaller proportions of drug users identified harm reduction in terms of their aspiration from treatment, 7.1% cited 'reduced drug use', and 7.4% cited 'stabilization only. Less than 1% of respondents identified 'safer drug use', or 'another goal', whilst just over 4% reported having no goals.

Abstinence was consistent across treatment setting, gender, type of treatment (with the exception of those receiving methadone) and severity of dependence.

To deliver aspirations the NTA will need to oversee a significant alteration in the treatment system to deliver treatment paths which meet this need. High levels of methadone maintenance treatment are not geared towards this. At the same time low levels of abstinent outcomes with methadone maintenance are occurring. According to NTORS, 24.7 % (abstinent from all drugs) at two years and the latest DORIS study 6.9 % (including cannabis) 4.1% (excluding cannabis) on methadone maintenance. The poor outcomes, especially in the latest Scottish study in light of aspirations should certainly be of concern[459]. The gap between service user's aspirations and treatment delivery is a major one.

456 The NTA's first User Satisfaction survey 2005 (NTA, 2005)

457 Ibid

458 McKeganey, N., Morris, Z., Neale, J., Robertson, M. (2004) What are Drug Users Looking for When they Contact Drug services: Abstinence or Harm Reduction. Drugs: Education Prevention and Policy, Vol 11 No 5: 423-435 October 2004

459 McKeganey, Who becomes Abstinent on the Basis of Drug Abuse Treatment In Scotland: Results from the Drug Outcome Research Study In Scotland.

8.4) Aftercare services

Despite the aim of a seamless transition to aftercare the NTA's satisfaction survey demonstrated that this, in many cases, continues to be poorly provided.

A large minority of respondents (nearly a third) who asked for housing assistance were not referred for help, similarly the link up with education referrals, employment training and financial support was not as good as it could have been.

It would make sense for the prevention of relapses to be a core aim of treatment services. It is clear that aftercare services are key to ensuring this outcome.

A consultation in progress by Addaction interviewed 350 individuals of these 197 drug users described their previous experiences of being released from prison, completion of an order or a community residential rehabilitation programme in a negative light. The negative response was related to the aftercare support services available during a period of high risk and the lack of support around relapse and overdose. It is important to note that this reflects the 90 per cent of the sample who had experience of prison and that a number of interviewees described more than one experience of leaving prison or completing treatment, all of which was included in the analysis.

However the analysis identified a number of key themes, ninety five comments were received from interviewees describing scenarios where they relapsed immediately or soon after release, completion of an order or leaving a community residential rehabilitation order.

When asked about past experiences of leaving prison, completing a DTTO or residential programme a significant number of participants mentioned housing as being a critical step in the process. At the same time 42 individuals highlighted a negative experience related to not having housing in place following release from prison/treatment completion. Of these 42, 12 discussed their stay in hostels/temporary accommodation at this critical time. A further 29 of the forty two individuals highlighted that housing was an issue for them and a key area they required support around at the time of consultation[460].

Seventy five interviewees reported that in the past, they had not received any support from specialist services following their release from prison, completion of an order or a community residential rehabilitation programme[461].

26 interviewees highlighted the perception that the length of their sentence had affected the level of support they received on their release with six believing a longer stay would have provided additional support on exit[462].

In contrast to these complaints 77 comments from 73 interviewees were received describing their experiences as being positive upon being released from prison, completion of an order or a community residential rehabilitation project.

24 interviewees identified having accommodation set up upon release and a key message of this was that nineteen interviewees indicated that these links included having appointments set up prior to release with a worker, or having links with other agencies arranged. 21 interviewees highlighted the benefit of having appointments set up and Sixteen interviewees were positive about there DTTO following release from prison[463].

Both the Addaction and NTA survey demonstrate there is room for drastic improvement in services to expand access and provide benefit and support to the full range of clients.

9.) CONCLUSIONS

Treatment capacity has seen a significant expansion over the last decade. Treatment satisfaction within a limited range of questions is good and data collection and research has seen a vast improvement, particularly after the final realization of a need for a treatment effectiveness strategy. Structures of delivery are in place and funding has been sustained and growing.

Despite this the expansion in provision has taken place at the expense of quality of service. In places this sacrifice has been severe. Specialist (substitute) prescribing is dominated

460 Aftercare Consultation 2005: The service user perspective (Addaction, 2005)

461 Ibid

462 Ibid

463 Ibid

by maintenance therapy, not reduction and although research data does not exist to chart the length of maintenance (beyond six months) it is believed that there are a significant majority of users who are maintained indefinitely.

It is important to note that continuing to maintain clients in treatment represents a massive and unsustainable barrier to exit in the treatment service, as well as presenting a sustained long term cost. Maintaining the system in its current structural form would become impossible in the long term without continued re-investment in drugs services to expand capacity. Otherwise blockages will begin to occur, waiting lists will expand and the current treatment system will have to place quotas on new entrants into treatment.

While new research in Scotland similar to the National Treatment Outcomes Research Study highlights that abstinent outcomes may be significantly less common than NTORS suggests; an array of studies conducted by both the NTA and in the DORIS study reinforce the point that client aspirations are clearly geared towards recovery from drug use and towards abstinence. In this context the need to provide a route to abstinence should be reiterated, the treatment structure that exists to realise this is far from adequate.

Within the existing system there is also a widespread need for an improvement in quality. Though some agencies are outstanding examples of service provision, the NTA's own research evidence demonstrates there is a substantial need for improvement:

Needle exchange services are failing badly in many cases to deliver even the most basic harm reduction interventions. They do not currently provide an adequate capacity to cater for the demands made upon them by users, on top of this adequate harm reduction interventions are lacking in a huge number of areas.

A proper understanding, data collation and research surrounding the current state of counselling services is lacking.

Tier 4 services are hugely under-resourced and under-capacity, even those that exist are being consistently failed by commissioning issues. The current crisis threatens to fatally undermine existing expansion plans and has produced a confused financial backdrop for announcements of capacity building.

Aftercare service linkage still needs to be improved, levels of dissatisfaction with the service mirror the investigations of the group concerning the inadquate support offered after treatment programmes are completed. Aftercare services are key to preventing common relapses.

Finally, 'outcomes monitoring' is only finally going beyond relatively meaningless proxy indicators that have existed to drive service development over the past decade. Quality not just quantity will need to play a key part in the new measure of outcomes.

10.) GLOSSARY

BBV Blood Borne Viruses
BEDVACS Bed vacancies
CBT Cognitive-Behaviour Therapy
DAT Drug Action Team
DORIS Drugs Outcome Research Study in Scotland
DDN Drink and Drug News
DOH Department of Health
EATA European Association for the Treatment of Addiction

Modality Definitions – Outlined by MoCAM
Tier 1 – Provision of Drug related information and advice, screening and referral to specialised drug treatment.
Tier 2 – Provision of drug related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (incuding needle exchange) and aftercare.
Tier 3 – Provision of community- based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liason
Tier 4 – Provision of residential specialised drug treatment.

NAO National Audit Office
NDTMS National Drug Treatment Monitoring System
NTA National Treatment Agency
OD Overdose
PCA Prescription Cost Analysis
PDU Problem Drug User
PTB Pooled Treatment Budget

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RUSSELL WHITE

INTRODUCTION

This paper identifies major problems with the Government's supply reduction strategy:

- An improper use of existing data sets for supply reduction purposes.
- A continuing inability to analyse impacts.
- Seizure targets which have consistently failed to be met despite substantial redefinition of the public service agreement target. Decreases in both the 'number' of seizures of drugs and in total CIDA 'quantities' have occurred.
- Structural defects in HMRC mobile deployment
- Underperformance in the ARA's completed cases.

The extent to which these problems are the result of administrative problems or resource problems goes beyond the remit of this paper.

A number of issues are identified that highlight the difficulty of supply reduction strategies. The flexibility and adaptability of drugs barons, the need for a package of comprehensive measures and the cyclical nature of cultivation incentives are all powerful forces. Low risk takers are funded and high risk takers encouraged by high markups and the willingness of users to pay. Seizure levels have never reached the levels required for breakdown even in a low case year. At the same time a number of mechanisms are identified which provide an ability for the supplier to alter his own profit margins either passing on costs or using bulking agents to increase product volume.

EXECUTIVE SUMMARY

The core aim of any supply reduction strategy is to reduce the availability of drugs. The Government has tried to measure this through a series of interconnected public service agreements. Nevertheless seizures, disruptions or dismantlement's and asset recovery does not reflect varying levels of drug importation. Attempts to assess the market size for seizures to benchmark against have failed and consequently figures largely reflect police performance not actual availability. The actual performance of these figures is variable, seizures have fallen short of targets despite continual redefinition yet asset recovery and criminal disruptions have recently exceeded targets.

The structures and organisations responsible for delivery of the strategy are experiencing a number of problems. While SOCA is welcomed and its development this year promises much the ARA is not performing anywhere close to expectations and HMRC has recently come under fire for its mobile deployment of teams.

While the delivery of these targets remains important, data sets do exist in the form UNODC and IDMU wholesale and street price information. At a time of rising demand a falling price clearly demonstrates that supply is plentiful. Furthermore the FSS annual surveys of seizures demonstrates rising or consistent wholesale purity. This clearly shows a lack of impact across the supply chain.

The impact assessments of the HMG strategy unit also suggests that a forty per cent breakdown (just for a low case year) has never been achieved. That profit margins are enormous and remain profitable to the tune of 26 per cent for an Afghan drug trafficker even in a low case year of high seizures and low yield[464]. Increasing route sophistication, weight and purity distortions and a willingness to subsume the cost of seizures within their own profit margins has resulted in drug barons absorbing the impacts of drug enforcement with relative ease. At the same time interventions within the producing country have proved difficult, even with a clear mandate in Afghanistan doubts remain over the UK's strategic ability to impact the market.

Overall despite successes in increasing disruptions and asset recover the supply market is sophisticated. Heroin and Cocaine targets themselves do not even come close to producing breakdown in supply. While interventions at every level of the supply chain have been employed the UK has not been able to halt falling drug prices or inhibit availability substantially. At best enforcement has acted as a cost to the drug business not a major threat.

464 Drug Strategy Unit Report Phase 1, SU unit, 1993

SECTION 1: GOVERNMENT TARGETS AND PERFORMANCE

Summary

The Government's policy as defined in 1998 had three prongs: the first was to reduce the availability of Class A drugs into the country by 50% by 2008; the second was to increase drug related asset recovery; the third was to increase the number disruptions / dismantlements of criminal gangs.

By 2002 it became clear that the core PSA supply target was over ambitious. The 'aspirational' 1998 supply target was significantly modified in 2002. But the picture of what was actually happening remained confused. Indeed failure to assess market sizes means proper performance analysis has still not been carried out.

Between 1998 and 2002 the quantity of Class A drugs seized rose by 43 per cent with some fluctuations[465] and the number of doses of ecstasy type drugs seized also rose substantially. Since 2002 statistics published by Concerted Inter-Agency Drug action group, (CIDA – the agency in charge) which from this point are limited to the measures of heroin and cocaine seized, show a fall below baseline levels. Even on the assumption that the market size stayed at the original level which is unlikely (since a significant growth in the production of opiates has occurred in Afghanistan) the latest published CIDA figures (2004/05) are still 50 per cent below take out targets for heroin for 2004/05 and 15.7 per cent below for cocaine[466].

Statistics for the number of Class A drug seizures show a drop of 4,510 to 2002 or 11.8 per cent[467]. Total drug seizures between 1998-2002 similarly show a drop of nearly ten per cent. (14,410 seizures) This drop largely occurred between 1998 to 2000 following a six year period in which the number of drug seizures rose[468]. The latest England and Wales statistics for 2003 show a further significant fall in drug seizures post a temporary rise.between 2000 and 2002.

The second and third prongs of government policy would seem to have been more effective. Disruption/dismantling of criminal groups has risen significantly above targets with 299 in 2004 against a target of 211, although under previous definitions performance has been erratic[469]. The value of criminal assets in 2004/05 also significantly exceeded the annual required target of £21 million achieving £33.3 million. Yet it remains difficult to assess impacts without any quantification of the effects of market forces at a strategic level.

Targets

Responsibility for reducing Drug Supply and Availability was laid out by PSA targets and devolved to HM Customs and Excise (now HMRC).

The 1998 PSA set was to:

- Reduce the availability of Class A drugs by 25 per cent by 2005 and by 50 per cent by 2008.
- By the 2002 review this target was dropped. The updated drugs strategy stated that:
- "The 1998 target to reduce Class A drug use by 50 per cent by 2008 was aspirational. The Government's review found that this target was not achievable.[470]"

The key PSA target replacing it is now designed to:

1 Reduce the availability of illegal drugs by increasing the proportion of heroin and cocaine targeted on the UK which is taken out

The baseline is 2001/02 for these figures, drugs taken out were 3379 kg for heroin and 10931 kg of cocaine. Calculations of estimated supply were 33 tonnes and 51 tonnes respectively, this provides the baseline of 10% and 21% of total .

The established target will be met if, by March 2006, the proportion of drugs taken out increases from 10% to 16% for heroin and from 21% to 26% for cocaine. These are far less ambitious targets than the original 1998 strategy which required a 20 per cent higher take out between 2005 and 2008.

Other measurement targets include:

2.) The disruption/dismantling of those criminal groups responsible for supplying substantial quantities of Class A drugs to the UK.

The baseline for this is 2002/03 was 182 groups with a rise to at least 211 groups annually to 2005/06.

3.) The recovery of drug related criminal assets.

The baseline for this figure is 2001 / 02 with CIDA figures of £19 million. The target for 2005/06 is £21 million annual seizures.

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465 Calculated from Table 2.4:Drug seizure and Offender Statistics 2004 (London, Home Office, 2004)

466 Calculations from: HMCE Annual Report and Accounts 2004-05 (London, HM Revenue and Customs, 2005) Target 3

467 Ibid

468 Ibid

469 Treasury: Public service performance target 90 site: http://www.hm-treasury.gov.uk/performance/targets/perf_target_90.cfm

470 Updated Drugs Strategy (London, Home Office, 2002)

Interestingly the targets set for the CIDA group are very specific, targets for heroin and cocaine are not totally consistent with Government policy of targeting Class A drug use. Figures for total take out of Class A use are not published by CIDA.

PERFORMANCE

CIDA is the abbreviation for Concerted Inter-Agency Drugs Action group. This was formed in 1999 and brings together those agencies responsible for combating the supply of drugs to the UK.

CIDA includes:

- Her Majesty's Custom and Excise
- National Crime Squad
- National Criminal Intelligence Service
- Association of Chief Police Officers
- Scottish Drug Enforcement Agency
- Security and Intelligence Services
- Home Office
- Cabinet Office
- Metropolitan Police Service
- Foreign Office
- Ministry of Defence

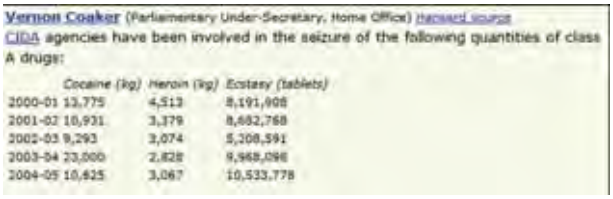
CIDA is chaired by HMCE which has lead responsibility for tackling the supply of drugs to the UK. The CIDA group amalgamates and co-ordinates the work of all different Government agencies involved in reducing the supply of drugs to the UK. Its activity ranges from law enforcement initiatives in production and transit countries to policing U.K borders. The CIDA groups strategy recently in April 2001 refocused resources upon the drugs that 'cause the most social and economic harm in the UK.' This is why specific Heroin and Cocaine targets exist.

1.) Reduce the availability of illegal drugs by increasing the proportion of Heroin and Cocaine targeted on the UK which is taken out

The original promise for the Heroin and Cocaine statistical targets set in PSA agreements has encountered some problems since its conception. The theoretical basis for the sizing of the UK market was supposed to be based upon the work of Edward Bramley-Harker (National Economic Research Associates.) Their RDS paper *Sizing the UK market for illicit drugs* was designed to lay the theoretical basis for future research. However no information has yet been published for the PSA target of the CIDA group as provided by the Treasury, and no details on the progress of this target currently exist. The exact details are summarised below:

> *"Full data is not yet available. Work on sizing the UK heroin and cocaine markets to assist us in assessing progress against the proportion targets is continuing. Data from initial work was inconclusive and identified a gap in information on recreational cocaine consumption. A new methodology is being developed.*[471]*"*

This project has been underway since the target was announced. The theoretical paper was published in 2001 and the methodology has been a continuing aim of HMCE. Nevertheless we have obtained CIDA quantities for drug outtakes through a parliamentary question to the minister of drugs and crime[472].



Vernon Coaker (Parliamentary Under-Secretary, Home Office) Hansard source

CIDA agencies have been involved in the seizure of the following quantities of class A drugs:

	Cocaine (kg)	Heroin (kg)	Ecstasy (tablets)
2000-01	13,775	4,513	8,191,908
2001-02	10,931	3,379	8,682,768
2002-03	9,293	3,074	5,308,591
2003-04	23,000	2,828	9,968,096
2004-05	10,625	3,067	10,533,778

(Please note: an additional 6.3 tonnes of estimated UK supply taken out through Afghan eradication programme in 2002/03.)

Despite large rises in drugs taken out in 2002 due to the Afghan eradication programme and the large annual take out in 2003/04 of cocaine levels, annually levels of supply taken out across most years have stayed constant. The take out of Heroin and Cocaine in 2004/05 is actually lower than 2000-2001.

2) The disruption/dismantling of those criminal groups responsible for supplying substantial quantities of Class A drugs to the UK.

2004-05, 299 trafficking groups disrupted / dismantled against a 2004-05 target of 201[473].

The 2004/05 target was far exceeded. However successive redefinitions and no reworking of past HMRC annual reports leaves the area particularly difficult to analyse. Outturn information from a 2003 PSA treasury graph

471 HMCE PSA Target 3, HM Treasury Site: http://performance.treasury.gov.uk/T090_I0148.pdf

472 Vernon Coaker, Written Parliamentary Answer: Thursday 20th July 2006

473 HMRC Annual Report and Autumn Performance Report 2004-05 (London, HRMC, 2005)

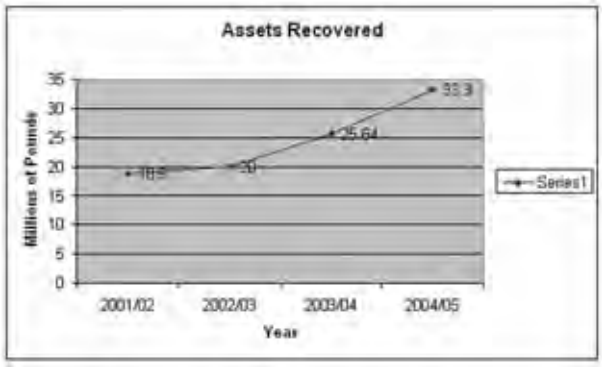
474 IBID

shows a fall from 2002 from 288 to 175 in 2003/04 although the baselines were redefined in the 2004 HMCE technical PSA targets.

3) The recovery of drug related criminal assets.

33.3 million was seized in 2004 against a target of 21 million. Latest achievement to September 2005 is 13.2 million suggesting the 22 million target for 2005-06 will be exceeded474.

A sustained rise in asset recovery is welcome and has far exceeded targets.



(Source http://performance.treasury.gov.uk/T090_I0151.pdf and HMRC Annual Report and Autumn Performance Report 2004-05 (London, HRMC, 2005)

SECTION 2: STRUCTURES AND ORGANISATIONS, ISSUES AND PERFORMANCE

Summary

Soca

The Government has recently changed the administrative framework in the UK for dealing with supply and has created a new responsible organisation, SOCA, (Serious Organised Crime Agency). This is an amalgamation of a number of agencies into one core with the aim of providing a coherent structure beyond CIDA's steering group role. A more intelligence led approach has been promised by the Government : a dedicated intelligence directorate using embedded officers in other agencies and a commitment to more resources devoted to covert collection methods. The aim is to try to measure impacts in a way that CIDA quantity targets have failed to. As of yet no detailed measurement systems have been announced but the annual plan announced by SOCA suggests impact assessment will form a core aim.

ARA

The asset recovery agency has achieved a high level of financial restraint yet failed to complete a large number of cases. Its civil/tax concluding actions totalling only 4.6 million in 2005 have produced another disappointing result well below targets.

HMRC

Lord Carlisle recent criticism of mobile border teams bear fruit in a number of documents submitted to parliament. Inadequate provisions have clearly resulted in a number of gaps, permanent staff reduction at major ports continue to present a clear opportunity for drug smuggling.

SOCA and the New Structure

HMCE took the lead in the fight against drug trafficking until the 1st of April 2006. Upon this date the Serious Organised Crime Agency (SOCA) was set up. SOCA is an amalgamation of the National Crime Squad, the National Criminal Intelligence Service, those from HM Revenue and Customs dealing with drugs trafficking and associated criminal finance, and some of those dealing with organised immigration crime in the UK immigration service. It is directly funded by the Home Secretary.

The priorities are Class A drugs and organised immigration crime, in that order. The annual plan specifies operational efforts broadly set out in the following way[475]:

- Drugs trafficking, primarily Class A 40%
- Organised Immigration Crime 25%
- Individual & private sector fraud 10%
- Other organised crime 15%

The structure is split into four directorates described below[476]:

- Intelligence, which gathers and assesses information and uses it to produce the best understanding of organised crime. The directorate ensures that all activity is knowledge-led and directed towards agreed priorities, and that SOCA builds strong working relationships with other agencies, including other law enforcement partners;
- Enforcement, which provides a flexible operational response to threats, building high quality criminal cases against key targets and organised crime groups;

475 SOCA Annual Plan, 2006/07 (London, SOCA,2006)

476 Ibid

- Intervention, which aims to make life harder for serious organised criminals, with a particular focus on attacking criminal assets and working with the private sector. Intervention also houses the international arm of SOCA;
- Corporate services, which supports, facilitates and develops SOCA's capabilities. The staff of SOCA will operate from almost fifty sites in the UK, as well as overseas.

SOCA's integration into Northern Ireland and Scotland will include work in partnership along the lines provided by the NCIS previously.

SOCA will be performance measured by a system which "bears as closely as possible to the reality of outcomes that matter to the people of this country.[477]"

Its main measures will be

- The quality of knowledge and understanding of serious organised crime
- Criminal asset performance, where SOCA will contribute to Government wide asset recovery targets. (under review)
- Dislocation of criminal markets, assessed through evaluation of the impact of SOCA's activity, with an aim of generating evidence of that impact in the form of upward pressure on the price of criminal goods or services, a reduction in UK availability or quality, or evidence that criminals are finding the UK a less attractive market
- The quality of SOCA's relationship with others, which will be measured through regular structured surveys.

Beyond concepts the presented measurement objectives will probably replace existing targeted PSA's when they expire.

The Asset Recovery Agency

The Assets recovery Agency was established under the Proceeds of Crime Act 2002 and co-ordinates activity across the UK in recovering unlawfully obtained assets. Figures to date show total restraint of 85.7 million478.

Despite this completed cases are far less impressive.

The 2006 annual report states spending as shown below[479]:

2003/2004 (Actual)	12,085,000
2004/2005 (Actual)	13,851,000
2005/2006 (Projected)	16,784,000
Total	42,720,000

Latest figures show the agency, since its inception has completed 35 cases with a recovery value of approximately £9.1 million and has realised receipts of around £8.34 million.[480]. These seizures are significantly below the cost of the agency itself.

Annual targets are broken down below:

Table 2. Assets Recovery Agency: value of realised assets received from civil recovery/ tax cases (2005-06 figs are to the end of March)[481]

	Total	England and Wales	Northern Ireland
2003-04	-	-	-
2004-05	4,142,285.32	3,688,998.65	453,286.67
2005-06	4,338,513.01	3,567,952.56	770,560.45

Even against the annual 2005-06 target, "to obtain recovery orders/voluntary

A budget. settlements and issue tax assessments to the minimum value of £15.5 million (equivalent to ArA baseline budget).[482]" the target achieved was only 4.6 million[483].

Furthermore figures on the number of cases completed are disappointing:

	Total	England and Wales	Northern Ireland
2003–04	[17]0	—	—
2004–05	12	10	2
2005–06[18]	23	20	3

Notes:
(16) Those cases that have reached final actions i.e. recovery order, final assessment or settlement.
(17) There were no completed cases in 2003–04 as this was the first full operational year of the agency.
(18) 2005–06 performance figures are to end March 2006. Final year-end performance figures are yet to be finalised[484].

Speaking with the BBC director Jane Earl (director of the ARA) spoke of disappointing results.

"We are disappointed that cases have not come to fruition as quickly as we had first hoped.[485]" The completion of only 35 cases is far from encouraging.

The timeframe involved is a serious problem, in a written answer to a parliamentary question the following was also given:

477 Ibid
478 Annex A, Detailed Financial Tables, Assets Recovery Agency Annual report 2005-2006, (The Assets Recovery Agency, London)
479 Annex B, Detailed Financial Tables, Assets Recovery Agency Annual report 2005-2006, (The Assets Recovery Agency, London)
480 Goggins, Response to Parliamentary Question, 8, 25 Apr 2006 : Column 1026W http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060425/text/60425w16.htm
481 Coaker, Response to Parliamentary Question, 8 Jun 2006 : Column 807W. http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060608/text/60608w0830.htm
482 Annex A, Detailed Financial Tables, Assets Recovery Agency Annual report 2005-2006, (The Assets Recovery Agency, London)
483 Ibid
484 Goggins, Paul, Response to Parliamentary question, 25 Apr 2006 : Column 1026W http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060425/text/60425w16.htm
485 BBC News site:http://news.bbc.co.uk/1/hi/uk_politics/5077846.stm

"Civil recovery cases in the High Court can take over two years to complete litigation. This period is longer where respondents seek to use all their rights of appeal. The impact of legal challenges, although inevitable with new legislation, has delayed the progress of cases in the High Court.[486]"

HMRC - BORDER CONTROL STRATEGIES

In 2003 customs officials moved to a system of mobile deployment. Permanent staff at ports were moved to mobile teams.

Following this change in strategy recent reports have highlighted the inadequacy of permanent provision at ports. Lord Carlisle most notably recently criticised current policy stating, "I remain of the view that Customs officers in particular are thinly spread.[487]"

The BBC further reported the remarks of a senior police officer

> *"The service is very unhappy about the approach of Customs. You can have a major port with no coverage at all because they are mounting operations up the coast. It leaves gaps and gateways completely open, and Special Branch officers are unhappy.[488]"*

A customs official working in mobile teams was questioned,

> *"Asked whether there was ever specific intelligence about a smuggling operation on a particular ferry but there were no customs officers to respond, he said it happened quite often, and that there are regular examples of hard drugs being found around the coastline of the south-west by children.[489]"*

The Public and Commercial Services Union which represents 84,000 staff working in HMRC released a Parliamentary Briefing on the 21th of June 2006 calling for an enquiry into the deployment of mobile teams.

The briefing warned that the deployment of mobile teams to cover huge geographical areas is "wholly inadequate in the fight against smuggling.[490]"

The briefing highlighted a 'lack of permanent customs cover across hundreds of miles of UK coastline, notably in Devon and Cornwall, where permanent Customs cover was removed in 2003, and along the Welsh coastline, where there are no uniformed front line Customs officers from Cardiff to Holyhead, or from Holyhead to Liverpool.[491]'

Furthermore mobile teams which focus on 'uncanalised' work across entry points in thousands of marinas, coves, ports and airstrips around the coastline have been disbanded. There is now no system in these areas where members of the public are channelled through security or Customs screening.

A number of other key points were raised:

- Due to lack of staff resource no coastal work around the 900 miles of Welsh coastline is currently carried out. The offices in Swansea, Newport, Chester and Pembroke were closed in 2003 and staffing was reduced by 50%.
- Falmouth used to seize more firearms than any other port in the UK, for instance in 2000 customs staff based at Falmouth seized 1 CS gas baton, 1 .303 calibre Springfield rifle, 1 Police special pump action firearm, 1 semi-automatic rifle and 1 .4 calibre pistol plus 500 rounds of ammunition for a variety of firearms. Since 2003, when front line customs cover was removed, there have been no seizures.
- At present North Wales is covered from Birmingham. Since the team in Chester was removed there have been no significant seizures in North Wales.
- The estimated amount of smuggled cigarettes on the streets of Wales has risen from 19% to between 25% to 30%. This comes at a time when the number of staff addressing this work has decreased significantly. There are now 5 staff allocated to this work in South Wales to cover a target population of over 2 million[492].

Welsh cuts were highlighted in evidence submitted to the select committee on welsh affairs in June 2003. The PCS submitted the following points regarding reductions following restructuring:

REDUCTION OF CUSTOMS STAFF IN WALES

The Custom and Excise business plans equate to a 50% reduction in front line anti-smuggling staff in Wales. Under the proposals, all anti-smuggling officers in Swansea, Chester and Pembroke will be removed perma-

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486 Coaker, Response to Parliamentary question, 8 Jun 2006 : Column 807W http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060608/text/60608w0830.htm

487 Ford, Richard, Warning of security holes in UK borders (The Times) 19th June 2006

488 Ibid

489 Bomford, Andrew, Customs Staff fear port security (The Times) 12 June 2006

490 PCS Press Briefing, Union calls for Inquiry into open backdoor for smugglers, 20 June 2006

491 Ibid

492 Ibid

nently, reducing the number of offices operating in Wales to just two locations; Cardiff and Holyhead. Staff in the closing offices will not be redeployed in Wales, effectively cutting Customs staff in Wales by 40%. Last year Customs and Excise in Wales did not fill any vacant posts in the uniformed detection area. These losses, along with proposed staff reductions mean that since April 2002 there will have been a loss of over half the front-line anti-smuggling staff in Wales. This places remaining staff under intolerable pressure and Welsh security under serious threat.

Customs have indicated that they intend to remove the Wales Investigation Team from Cardiff. This follows the removal of front-line anti-smuggling staff and the plain clothed intelligence teams from Wales earlier this year. Cardiff investigation staff will be redeployed to Bristol, and have been told that they cannot expect to work regularly in Wales. In North Wales the Customs investigation team are understaffed and also under threat of redeployment outside Wales. Investigation teams will remain in Scotland, Northern Ireland and in many English towns. The three million people of Wales will thus be unique in Britain in not having any serious investigative team available in their area. The result of these reductions will be the abandonment of any meaningful law enforcement presence in Wales.

Nationally Customs and Excise propose a reduction of 500 front-line anti-smugglers which equates to around 10% of the staff[193].

SECTION 3: TRENDS IN SEIZURES

Summary

Trends in Class A seizures have shown a rise in the quantity of seizures between 1998-2002. The latest England and Wales seizures paper shows in 2003 9810kg of seizures with a drop in 2004 to 6,886kg of Seizures[494].

Trends in the number of Seizures of all drugs however dropped in the UK since 1998 with a small rise since 2000. Post England and Wales statistics will be relatively commensurate with these trends and demonstrate this rise has not been sustained across England and Wales with the latest 2004 figures similar to 2000 levels.

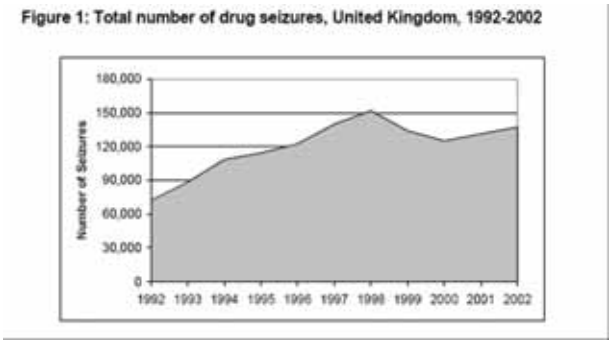
The number of Seized Class A drugs has also dropped since 2001 similar to 2000 levels.

Though rates are important they can either be linked to police performance or drugs entering the country. Without impact assessments or market sizing it is impossible to determine relative impact.

Trends in Seizures (1998-2002) UK

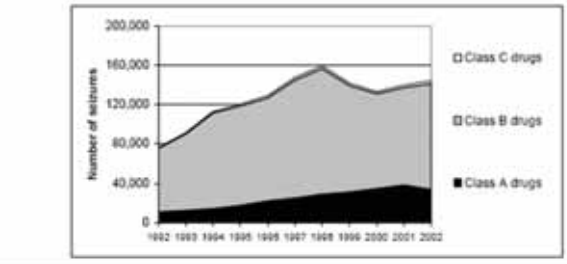
Sustained rises in drug seizures reached a peak in 1998. The number of drug seizures dropped dramatically between 1998 to 2000 with rises since then.

Figure 1: Total number of drug seizures, United Kingdom, 1992-2002



Class B and C drug use follows overall trends while Class A use has experienced sustained rises in the number of seizures since 1992 with falls in seizures from 2001.

Figure 2: Drugs seized by Class, United Kingdom, 1992-2002



(Source: Drug Seizure and Offender Statistics 2002 (London, Home Office, 2004) p7 and 8

The England and Wales Data shows additional trend data from 2000 although this is not strictly comparable to UK data.

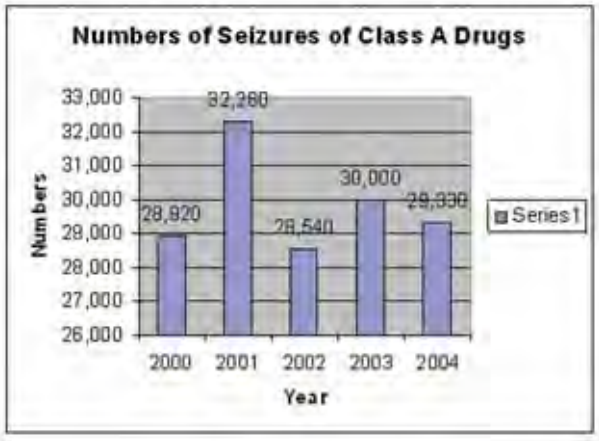
Trends in seizures (2000-2004) England and Wales

The numbers of Class A drug seizures since 2000 have

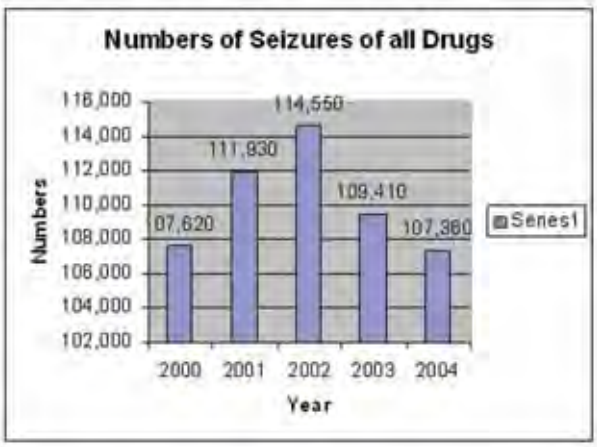
493 Select Committee on Welsh Affairs Minutes of Evidence, June 2006

494 Calculated from: Seizures of Drugs in England and Wales 2003 (London, Home Office, 2005) Table 2 and Seizures of Drugs in England and Wales 2004 (London, Home Office, 2006) Table C

varied with 2003 seizures levelling off slightly above the 2000 baseline.



Total seizures have increased since 2000 although they have decreased substantially since 2002 back almost 2000 levels.



Trends clearly show a drop in the total number of drug seizures since 1998. Figures from the England and Wales paper also do not show any significant change though fluctuations occurred with rises in seizures between 2000-2002.

Trends in the Quantity of Drugs Seized

Seizures measured in quantities present a variable problem. As has already been mentioned in the European report:

> *"Quantities seized may fluctuate widely from one year to the next, for example if in one year a few of the seizures are very large. For this reason, the number of seizures is considered by several countries to be a better indicator of trends*[495]*"*

Focusing on Class A drugs (bearing in mind the exclusion of LSD and Ecstasy-type drugs due to weighting units) the amount seized has increased from 4,530kg to 6,490kg in 2002[496]. Most of the increase took place between 1998-2000 with drops in the quantity seized between 2000 and 2002.

Total weight by kg of drugs seized

Year	1998	1999	2000	2001	2002
Weight	4,530	5,480	7,530	6,980	6,490

(Source: Calculated from Drug seizure and Offender Statistics 2004 London, Home Office, 2004)

Trends in LSD use show a drop of 20 thousands seized while a rise of 3,722 doses of Ecstasy-type drugs took place[497].

Those drugs for which a rise in quantity seized has taken place since 1998 include: Cocaine, Crack, Heroin and Ecstasy-type.

A fall in quantity seized occurred in LSD, Methadone, Morphine and other Class A drugs.

Methodology

Supply reduction strategies focus on reducing the availability of drugs, a core evaluation of this occurs against seizure targets. Rising seizures are not a measure of availability, although to some extent they can be said to indicate either increasing police performance or activity, they may also indicate that increasing amounts of drugs are entering the country.

SECTION 4: RISING AVAILABILITY

Summary

Since the early and mid nineties the UNODC (United Nations Office of Drugs and Crime) and IDMU (Independent Drug Monitoring Unit) has noted widespread falls in the street price of drugs. This has occurred against a pattern of rising consumption.

At the same time the UK FSS (Forensic Science Service) has noted a rise in HMRC purity for Crack and Heroin and a relatively consistent level for Cocaine. Amphetamine levels do not contain enough information to calculate.

495 The State of the Drugs Problem In Europe: Annual Report 2005 (Luxembourg, UN, 2005)

496 Drug Seizure and Offender Statistics 2002 (London, Home Office, 2004) Table 2.4

497 Ibid

At police levels lower in the supply chain bulking agents are increasingly used for Cocaine and Crack while trends suggest Heroin is not cut post importation.

At a time when the price is falling and purity remains high it appears to be the case that drugs are readily available, supply reduction strategies have had little impact and if anything have only succeeded slowed the decline in price.

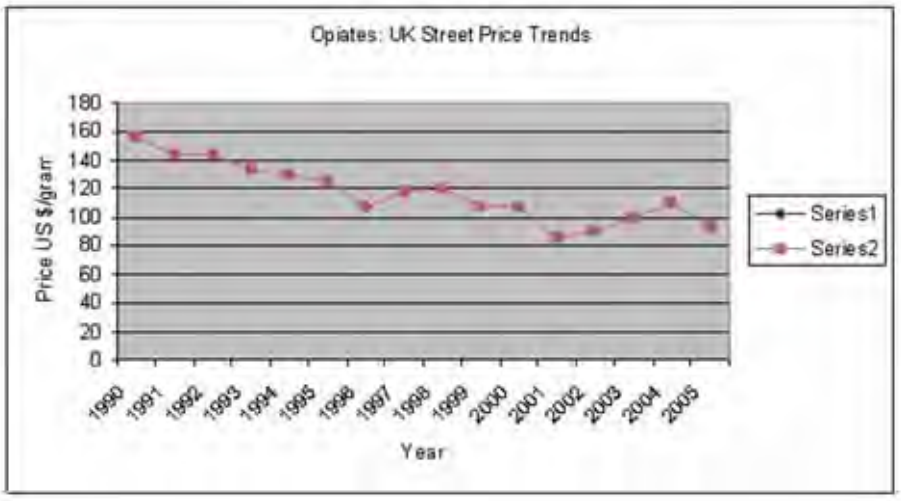
The Street Price

The United Nations Office on Drugs and Crime published the above figures for the retail price of Opiates since 1990. The graph below shows a substantial fall in UK drug prices[498].

Retail prices (street price), US$/gram

EUROPE	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005**
Austria	270	250	203	132	138	100	87	70	94	57	75	44	92	68	75	74
Belgium	80	105	105	77	75	75	56	37	41	41	37	27	29	31	32	32
Denmark	287	265	151	139	220	191	157	108	147	175	146	111	128	121	94	88
Finland	800	686	770	724	606	453	414	257	254	250	207	121	188	195	195	195
France	145	153	150	125	144	170	156	113	139	111	32	34	43	57	68	69
Germany	105	75	95	74	91	80	74	51	47	45	39	31	38	46	49	45
Greece	120	135	63	44	105	88	77	80	55	55	55	54	45	66	53	51
Italy	167	148	140	29	55	41	115	90	120	95	71	68	58	63	69	65
Luxembourg	172	150	130	150	172	202	136	141	133	124	69	67	67	45	76	70
Netherlands	49	50	55	49	55	61	48	35	34	30	35	43	35	40	57	57
Norway	1,680	525	510	275	249	200	202	190	186	166	120	157	155	190	148	148
Ireland	164	376	374	407	280	480	377	372	372	372	372	372	372	372	372	372
Portugal	88	82	72	60	65	79	56	55	74	37	45	45	48	54	52	52
Spain	175	195	190	120	182	120	112	58	82	75	59	57	61	75	81	80
Sweden*	225	220	195	180	165	137	146	115	130	126	112	129	132	128	119	92
Switzerland	312	321	248	126	164	150	116	91	95	107	53	45	39	42	42	40
United Kingdom	157	144	142	134	129	125	100	118	120	108	107	86	91	109	110	82
Ireland	286	160	180	260	167	179	275	228	213	264	176	170	179	170	240	252
Average unweighted in US-$	290	222	210	165	179	179	167	141	128	124	99	93	100	105	100	104
Inflation adjustment in US-$	437	318	292	228	235	229	208	160	134	146	113	102	109	111	112	104
Weighted average in US-$	173	149	147	107	113	119	113	93	94	87	64	59	62	70	75	71
Adjusted for inflation in US-$	259	214	208	144	158	158	146	114	112	102	72	55	68	68	76	71
Weighted average in Euro	136	126	112	91	100	91	92	82	84	81	69	46	64	62	61	57
Adjusted for inflation in Euro	196	165	149	116	123	110	110	95	96	91	76	71	70	65	62	57

Source: UNODC ARQ and EMCDDA. ** Data available till November 2005

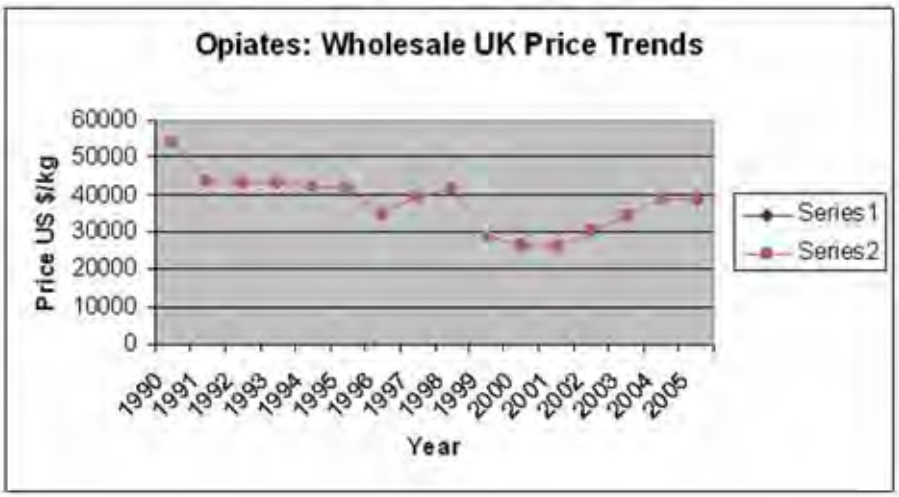


498 UNODC, World Drug Report 2006, (United Nations Publications, New York, 2006) Chapter 5

The UNODC also published wholesale price trends since the 1990's.

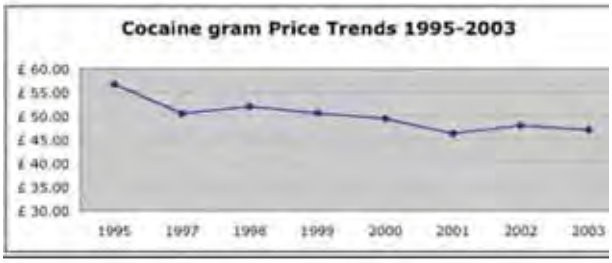
The UK has again seen a significant drop in wholesale price499.

Wholesale, US$/kg																
EUROPE	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005**
Austria	55,244	46,145	63,000	36,000	37,752	30,491	30,222	28,831	34,565	31,087	25,026	19,553	23,547	33,900	37,260	36,168
Belgium	30,000	30,000	28,500	26,600	29,586	32,500	24,307	21,761	20,847	18,557	18,360	20,292	22,229	20,960	23,040	23,336
Denmark	110,000	100,000	85,000	95,000	117,625	106,805	86,806	100,465	65,691	61,507	23,505	32,889	20,800	41,770	32,820	37,741
Finland	353,774	353,774	353,774	353,774	353,774	353,774	221,586	198,442	197,856	194,357	161,024	44,840	51,804	51,000	68,314	69,192
France	180,000	72,250	80,000	63,750	75,000	66,025	46,003	32,230	35,805	25,596	22,158	26,906	23,547	28,250	31,050	31,450
Germany	45,244	36,145	41,667	35,206	36,448	35,256	27,090	25,606	25,600	24,770	20,263	17,816	20,325	21,510	25,723	25,765
Greece	90,000	70,000	35,000	28,000	29,536	34,362	29,090	28,775	21,020	20,714	17,320	16,592	17,425	18,050	17,540	14,782
Italy	67,500	60,000	100,000	42,501	47,690	35,706	48,152	37,795	36,459	36,094	31,163	32,979	33,669	29,830	30,109	30,496
Luxembourg	86,000	75,000	75,000	49,500	86,000	57,079	59,852	54,706	52,630	50,360	48,000	50,369	50,369	24,700	42,473	31,450
Netherlands	23,850	25,000	26,550	23,850	23,850	24,384	20,572	13,810	14,056	16,905	14,703	15,757	29,199	17,730	17,730	17,720
Norway	220,000	200,000	212,500	151,099	101,744	85,000	72,520	62,209	64,910	49,872	44,561	35,874	37,676	48,234	52,790	52,790
Portugal	50,000	55,000	46,667	31,500	32,420	43,171	45,902	38,041	30,403	29,339	25,390	31,310	25,839	31,000	34,075	34,512
Spain	160,000	125,000	122,500	91,000	74,418	79,800	84,395	63,800	52,755	53,820	43,596	32,000	41,202	48,420	46,350	47,055
Sweden*	140,000	120,000	115,000	95,000	117,625	62,655	64,829	65,771	63,190	61,022	41,626	33,702	34,738	41,900	31,640	28,620
Switzerland	124,000	153,000	228,875	47,460	52,823	54,850	41,665	37,234	34,294	33,422	29,560	16,082	19,149	22,340	23,500	27,741
United Kingdom	53,940	43,940	43,500	43,210	42,500	42,004	34,846	39,491	41,667	29,126	26,718	25,926	30,620	34,340	39,041	39,041
Ireland	63,940	53,940	53,500	53,210	52,500	51,479	77,643	36,531	34,396	43,470	37,600	36,441	36,441	30,510	30,510	33,967
* Calculation for Sweden is based on brown heroin price (80%) and white heroin price (20%)																
Average unweighted in US_$	109,029	95,082	101,120	74,514	77,135	72,094	66,287	52,208	48,019	45,936	37,099	28,784	30,505	32,100	34,415	34,014
infLadj. in US-$	162,918	137,487	140,760	100,710	101,650	92,388	82,510	63,528	57,534	53,849	42,075	31,742	33,116	34,088	35,581	34,814
Weighted average in US-$	93,052	68,208	77,441	54,923	56,301	52,570	48,000	39,481	36,529	34,283	28,509	25,809	28,196	30,340	32,326	32,737
Inflation adj. (kg) in US-$	139,940	97,805	107,880	74,231	74,300	67,369	59,747	48,042	43,767	40,109	32,333	28,461	30,610	32,203	33,421	32,727
Inflation adj. (gram) in US-$	140	98	108	74	74	67	60	48	44	40	32	28	31	32	33	33
Weighted in Euro (g)	74	55	60	47	47	40	38	35	33	32	31	29	30	27	26	26
Inflation adjusted in Euro (g)	106	75	79	60	59	49	45	40	37	36	34	31	32	28	27	26
Source: UNODC ARQ and EUROPOL																



499 Ibid

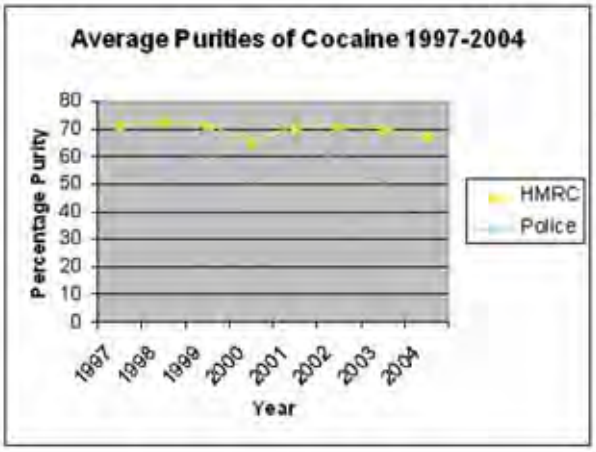
The IDMU (Independent Drug monitoring unit) also published a series of drug price trends. They demonstrated a fall in the price of Heroin, Ecstasy and Cocaine and a rise in the price of LSD[500].



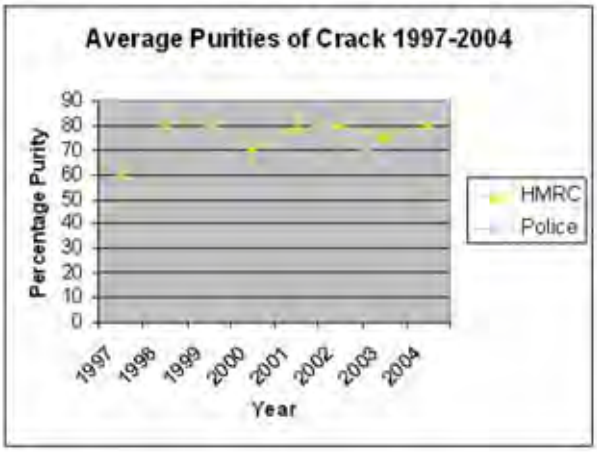
When the original 1998 strategy document promised to reduce the availability of drugs by 50 per cent there were no data sets that supported this objective. Since the targets more general terms where introduced in the 2002 review street prices have remained unevaluated. The three government objectives do not provide a measure of street availability. UNODC and IDMU price data does suggest that drug availability is increasing, drawn from common supply and demand price analysis.

Purities

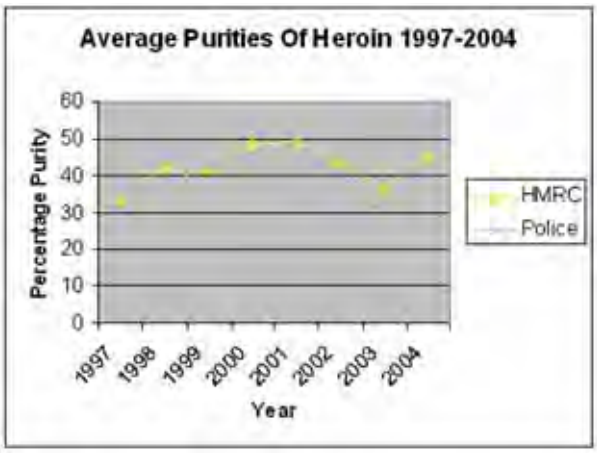
Other than price analysis, there is limited available data that bears direct relation to drug availability. However drug purity published by the FSS (Forensic Science Service) from Seizure statistics does not demonstrate any significant reduction in purity. Data is available for Cocaine, Crack, Heroin and Amphetamines[501].



While HMRC seizures have remained relatively consistent in purity police seizures have dropped in purity, particularly since 2002 suggesting that the use of bulking agents is increasing post importation.



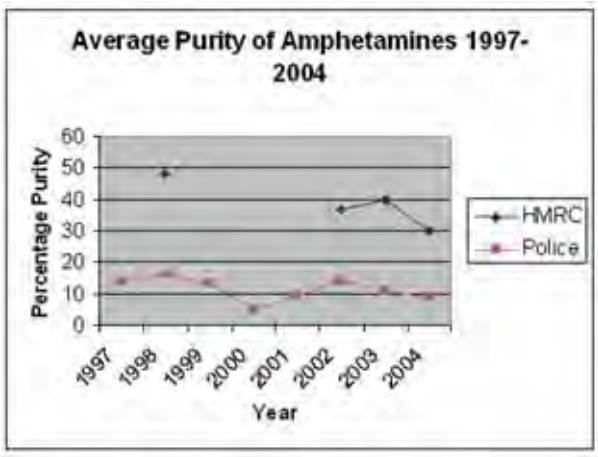
A rise in purity at the higher stages of supply has been seen. At the same time police seizures have dropped in purity by around 20 per cent suggesting increased cutting post importation.



500 IDMU, Drug Price Trends 1995-2003, site: http://www.idmu.co.uk/drugpricetrend9403.htm

501 Calculated from Drug Offender and Seizure statistics 2001-2002: Tables 2.7a and 2.7b (London, Home Office RDS, 2004) and Seizures of Drugs England and Wales 2004 (London, Home Office RDS, 2006) Table A. Note 1997 figures are calculated from 3 quarters. Amphetamine figures below 3 quartile returns are not calculated.

Heroin purity has risen for both police and customs purity in a commensurate pattern. This suggests that after import heroin is not generally cut post importation.



Amphetamine HMRC purity lacks information of more than three quartiles prior to 2002 for any year except 1998, therefore it is unreliable to observe trends. Police seizure purity has fallen slightly though remained relatively consistent since 1998.

A general picture of consistent or rising availability remains. Perhaps more significant were large rises in HMRC purity for Heroin and Crack while dilutions lower down the supply chain for crack and cocaine suggest the increased use of bulking agents in the cutting process. The increase in coca cultivation as well as opiate production, the relatively low percentage and constant level of seizures and HMRC consistent or rising purity levels and across the years in which drops occurred suggest this is more through choice than supply pressures.

SECTION 4: SUPPLY ROUTES AND ENFORCEMENT IMPACTS

Summary

There is a wide diversity of routes available to traffickers and techniques available to disguise and alter routes. Deterrence is low due to a high price mark-up and willingness to take risks. Seizure rates are not high enough to deter substantial profits and costs can be passed down where appropriate to the user or borne by the supplier.

Low case seizure figures of 40 per cent have been calculated to shut down an Afghan supplier. Current targets of 16 per cent have not been achieved and are far too low to achieve this aim anyway.

At the supply country a range of measures are made difficult by common characteristics, unstable governments, anti government forces and widespread corruption. Eradication can lead to displacement, cyclical effects that produce incentives for re-plantation and common concealment techniques. A range of measures are needed to bring about long term change including reconstruction and viable alternatives for farmers.

The situation in Afghanistan provides the opportunity to vastly affect the heroin supply to this country. However

Table 27: Importation routes of some illegal drugs entering the United Kingdom

Drug	Origin	Importation route	Major regional hubs	Further details
Cocaine	Mainly Columbia, Peru and Bolivia	Shipped across the Atlantic to the Iberian Peninsula, the Netherlands or increasingly to Central and Eastern Europe. Shipments are concealed in heavy goods vehicles and routed overland to the Channel and North Sea ports. It is also smuggled into the UK by air couriers and by post, direct from South and Central America, and from the Caribbean.	London in particular but also Birmingham, Bristol and Merseyside.	Many of those involved also import and distribute other drugs, as well as cigarettes.
Crack cocaine	It was thought that it was produced in the UK in small street-level quantities but there is now intelligence that it is being imported from the West Indies.	Evidence suggests the involvement of British Caucasians, West Africans and South Asians working both independently and collaboratively.	In particular Birmingham, Liverpool, London and Wolverhampton but also Bristol, Nottingham and Leeds.	Intelligence indicates that the UK crack trade is becoming complex and dynamic, and that crack is often sold with heroin.
Ecstasy-type substances	Eighty per cent of MDMA distributed internationally is produced in the Netherlands and Belgium but some ecstasy and other synthetic drugs are produced in the UK.	Ecstasy enters the UK market through the ferry ports, airports and the Channel Tunnel.	Birmingham, Bristol, London, Manchester and Merseyside.	Ecstasy is exported to Australia, Malaysia, South Africa and locations popular with British clubbers e.g. Ibiza.

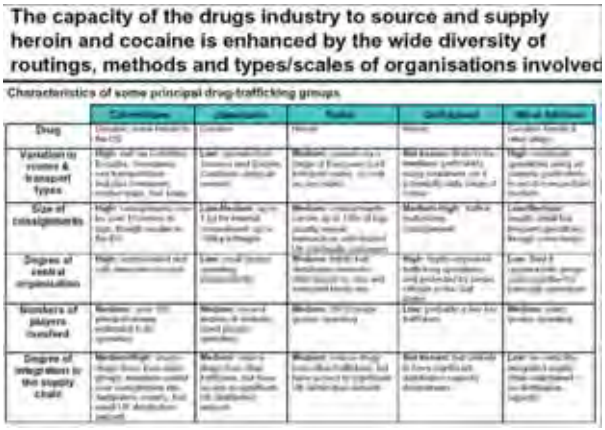
clearly reconstruction is a vast task, a range of measures are required including both a necessary force distribution and civic reconstruction. At the same time there should be awareness that drug barons will commonly work with anti government factions, through direct or indirect association British troops clearly threaten the drug trade and will be treated as such.

Supply Routes

Source: The State of the Drugs Problem In Europe: Annual Report 2005 (Luxembourg, UN, 2005)

A government strategy unit also analysed the characteristics of Cocaine and Heroin supply routes and in its phase one report identified the routes outlined on the following page[502]:

502 Drug Strategy Unit Report Phase 1, SU unit, 1993


The capacity of the drugs industry to source and supply heroin and cocaine is enhanced by the wide diversity of routings, methods and types/scales of organisations involved

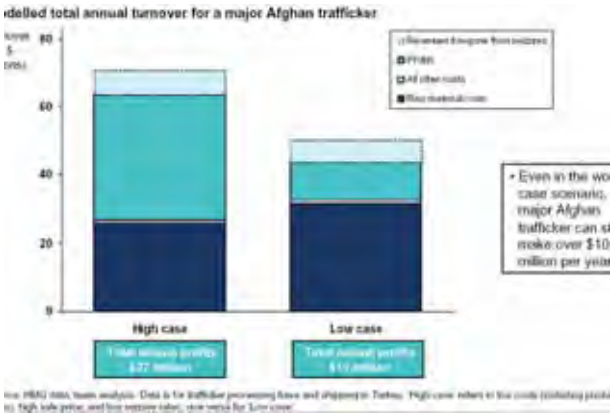
Characteristics of some principal drug-trafficking groups

Drug					
Variation in routes & transport types					
Size of consignments					
Degree of central organisation					
Numbers of players involved					
Degree of integration in the supply chain					

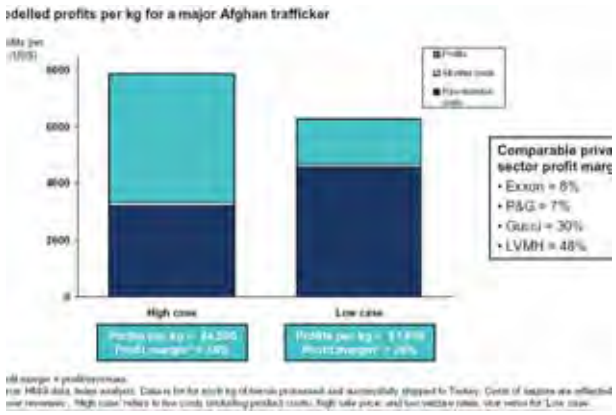
THE EFFECTIVENESS OF SUPPLY INTERVENTIONS

Innovation and variable approaches are figurative of a sophisticated industry increasing lead by intelligence and undeterred due to profitability factors. HMG analysed prices in the graph below: Risk is factored across a product markup. Against a willingness by the user to pay high prices rewards are substantial.

Supply interventions have never been proven to put the distributor out of action. High and low case interventions still turn over significant profits.

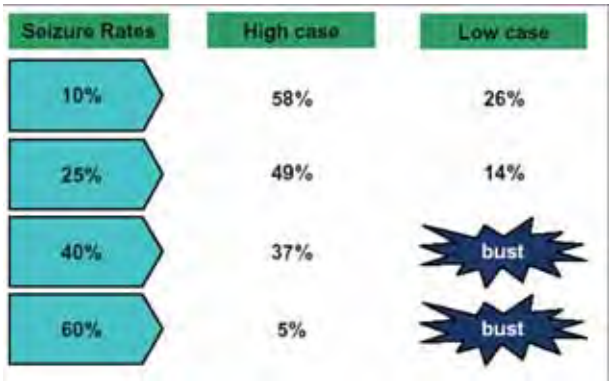


HMG calculated significant profit margins from even a low case year.



Compared to even the most sophisticated and successful commercial firms profits are huge even in a low case year.

Supply interventions against a distributor inhibit costs but still do not deter lucrative profits. HMG calculated a sustained seizure rate of approximately 60 per cent would be required in a high case year and in the hardest cases 80 per cent may need to take a user out of action. Low case breakdown would be achieved at around 40 percent[503].



Current interventions would not do enough to breakdown profit margins, 10-25% of market share targets are also unlikely to be met.

Interventions at the Producing Country

Interventions at the source country, are difficult. The common characteristics of production countries include unstable governments with a lack of central control in production areas, anti government movements and widespread corruption. In many cases producers can work with anti government movements such as is the case with FARC in Colombia. The profits of the drug industries make them difficult to tackle and further drive political destabilisation.

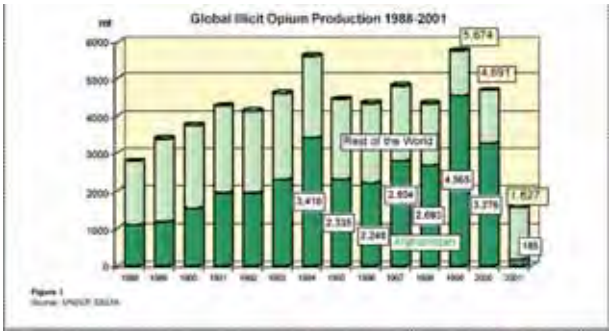
Eradication alone fails to meet drug underlying problems. The production cycle drives prices up with eradica-

503 Drug Strategy Unit Report Phase 1, SU unit, 1993

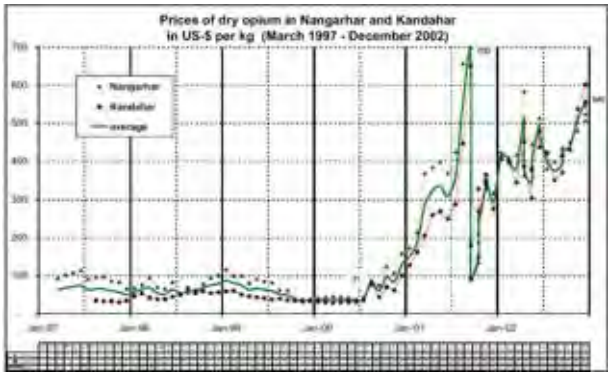
tion further encouraging farmers to return to drug cultivation. Commonly displacement and cultivation techniques also result in overall supply restoration. Best case studies in Thailand and Pakistan show comprehensive alternative policy which address underlying problems with eradication can work.

Where variation in drugs supply do exist examinations of the effect on supply can take place. One of the best examples of this is the result of the Taleban cultivation ban imposed shortly before the invasion of Afghanistan in 2002.

The prominence of Afghanistan in worldwide supply saw a massive drop in worldwide supply with the ban[504]:



Following the enforcement of a ban on opium cultivation prices in Nangarhar and Kandahar rose massively[505].



UNODC estimates that prices by 2002 amounted to an income for farmers in poppy concentrated regions of a few thousand dollars. Previous years would see an average of between 400-600 US dollars[506]. This produces a vicious cycle providing the incentives to cultivate again. 2002 profits supply exceeded even the 2000 pre-ban gross production.

Trafficking saw rises in prices across South West Asia.

In the meantime upstream shortages can be borne by the distributor. The SU analysis saw a morphine price rise of 150 per cent in Turkey with price margins cut to see a 25 per cent rise in the UK price[507].

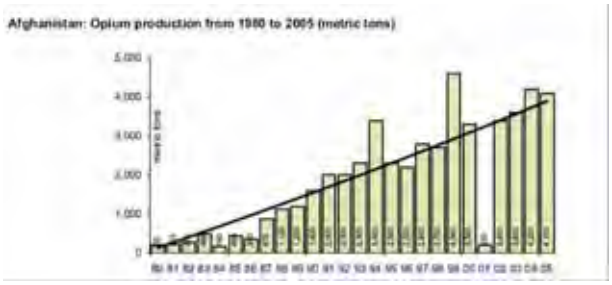
Afghanistan

The NCIS estimates:

> *"Afghanistan probably accounts for more than three quarters of the world's illicit opium production, and at least 95% of UK heroin comes from Afghan opium.[508]"*

The United Nations Annual Opium survey found that sustained rises had taken place from 2004-2005 with a drop in 2005 of 1,000 metric tonnes.

The following graph below shows Opium production from the 1980's to now:



(Source:Afghanistan Opium Survey 2005 (Afghanistan, UN, 2006)

Since late 2001 US and British forces have occupied Afghanistan. Concerted efforts are now being made by the UK to tackle drug barons in Afghanistan with a significant commitment. Initial efforts to tackle the drugs trade show little progress. The new deployment of 3,300 British soldiers in Afghanistan's southern Helmand province testi-

504 UNODC, Global Illicit Drugs Trends, 2002
505 UNODC, Global Illicit Drugs Trends, 2003
506 Ibid
507 Drug Strategy Unit Report Phase 1, SU unit, 1993
508 NCIS UK threat assessment: The threat from serious and organized crime 2004/05 - 2005/06 (London, Home Office, 2006)

fies to this. The province accounts for 26,500 hectares of land used for poppy cultivation in Afghanistan 25 per cent of total supply output[509]. Their mission will be to restore stability and to tackle the drugs trade:

> *"The UK is the G8 lead nation with responsibility for assisting the Government of Afghanistan in pursuing a counter-narcotics policy. MoD told us that it had chosen to deploy to Helmand Province specifically because it was an area containing continuing threats to stability from the narcotics trade, the Taliban and other illegally armed groups.[41] MoD plans, over the "medium term", to build the capacity of the Afghan National Army and Police with a view to transferring responsibility to them for countering these security threats.[510]"*

The deputy chair of the addictions group asked the Secretary of State for Defence to make a statement concerning the role of British forces in Afghanistan's counter-narcotics campaign. Des Browne replied:

> *"Troops deployed as part of the NATO-led International security assistance force (ISAF)—including British forces deployed as part of the Helmand Task Force—are authorised to provide support to Afghan counter-narcotics forces, including training, and they will help the Afghans create a secure environment in which economic development and institutional reform—both essential to the elimination of the opium industry—can take place."*

Given the extent of opium production in Afghanistan and its predominance in supply to the UK success of the UK's new three year commitment is key to effectively constraining supply to the U.K. The United Nations World Drug report clarifies this stating unequivocally "Afghanistan will determine the size and development of the world's main opiate markets…[511]"

Although the achievability of the British mission in Afghanistan is not within the scope of this paper, recent concerns over the strategic capacity of British forces to achieve their objectives should be noted. The consistency of offensive American operations in the east, the concept that "We hope we will leave Afghanistan without firing a single shot[512]" and the continuing idea that countering the narcotics trade through providing stability without acting as 'narcotics police' are of some concern. A coherent plan for delivery of change is has not been presented, arguments between the army and DfID (Department for Internation Development) over redevelopment are worrying[513]. It is clear drug barons are a serious threat and will continue to fight British troops, they have both plentiful recruitment and money for the task and will continue to present a threat whether directly tackled or not.

CONCLUSIONS

Reducing the supply of drugs into the country is difficult, it requires action at a variety of levels across the supply chain and in a number of countries. Movement against suppliers that are sophisticated, cunning and well resourced is difficult. They have incentives, profit margins and market mechanisms that allow them to survive numerous seizures and disruptions.

At the same time the effectiveness of policy and even the current state of play with regards to supply into the United Kingdom is difficult to measure. A variety of data systems reflect trends within the United Kingdom, yet best guess market sizing's have proved very difficult and without them the impact of seizures is impossible to gauge. At the same time it is clear that disruptions have never reached the level where breakdown is caused. A continuing level of purity and a drop in price reflect a readily available product.

Even in places where interventions can take place such as Afghanistan the task is by no means easy. Reconstruction efforts must accompany eradication in a manner which demonstrates a viable alternative for farmers to opiate production. The disruption caused by drug barons in the meantime, whose industry is clearly threatened is intense. This mirrors suppliers actions elsewhere (FARC in Colombia.)

At a domestic level the use of data sets for impact assessments is highly difficult to link to outcomes. SOCA has already highlighted that "Law enforcement has tended to be judged on easily quantifiable measures, such as the number of groups disrupted or amount of illegal commodity seized, which are simple to measure but very hard to connect with outcomes that matter to communities[514]" Despite clear commitments to reduce availability (now by an unspecified amount) there is no clear way of measuring this. Structural issues with existing data sets link directly to police performance and do not give an accurate picture of supply. Prices and purity seem to do this best yet do not form part of the government's assessment.

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509 Afghanistan Opium Survey 2005 (Afghanistan, UN, 2006)

510 Commons Defence select committee: fifth report (London, Parliament, 2006)

511 World Drugs Report 2005 (Vienna, United Nations Office of Drugs and Crime, 2006)

512 Reid, John, Quoted: Beware Afghanistan, First Basic Rule site: http://news.bbc.co.uk/1/hi/world/south_asia/5141310.stm

513 Burke, Jason, Fear battles hope on the road to Kandahar (London, The Observer, 2006) 25th June 2006

514 SOCA Annual Plan 2006/07 (London, SOCA, 2006)

In terms of Organisations responsible for implementing the strategy structural issues are apparent. The ARA has made it clear that laws are proving difficult to implement. Despite freezing of assets, concluded cases are very low. Deployment considerations at HMRC and current budget allocation for SOCA amalgamation highlighted by the PCS are all serious considerations.

The UK is not winning the war on drugs, though it could be said that seizures and disruption reduce profit margins they do not act as much of a deterrent. Against a pattern of rising consumption the price of drugs has fallen purity has remained high and traffickers continue their business.

GLOSSARY OF TERMS

CIDA Concerted Inter Agency Drug Action Group
EMCDDA European Monitoring Centre for Drugs and Drug Addiction
FSS Forensic Science Service
HMCE Her Majesty's Customs and Excise since 2004 now HMRC Her Majesty's revenue and Customs.
IDMU Independent Drug Monitoring Unit
MoD Ministry of Defence
NCIS National Criminal Intelligence Service
NCS National Crime Service
Outtake, Take out Measurement units taken out of Supply
PCS Public and Commercial Services Union
PSA Public Service Agreement
RDS Research Development Statistics
SOCA Serious Organised Crime Agency
UNODC United Nations Office Of Drugs and Crime

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IDMU, Drug Price Trends 1995-2003, site: http://www.idmu.co.uk/drugpricetrend9403.htm
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EMCDDA UK Focal Report (Luxembourg, UN, 2005)
Commons Defence select committee: fifth report (London, Parliament, 2006)
NCIS UK threat assessment: The threat from serious and organized crime 2004/05 – 2005/06 (London, Home Office, 2006)
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Briefing Paper 6: A perspective on Drug Interventions in the Criminal Justice System

ANDY HORWOOD

EXECUTIVE SUMMARY

- The modern drug strategy in England and Wales reflects the historical basis of concern regarding substance misuse in terms of health and criminal justice.
- The emphasis on 'harm reduction' is despite the consensus that interventions to address drug misuse should be effective across a range of outcomes, which include health and crime but also wider needs, including relationships, employment and housing.
- The responsibility for commissioning treatment is co-ordinated locally through Drug Action Teams. Significant funding for treatment has been channelled through the National Treatment Agency, a special health authority established in 2001. Additional funding from the Home Office since 2003 has sought to focus on drug-using offenders, channelled through Regional Government Offices.
- A more explicit focus on the crime implications of drug use has dominated recent strategic planning, supported by Home Office research findings that criminal justice costs account for two-thirds of reactive Government expenditure, and that 'every £1 spent on treatment saves £9.50 in criminal justice and health costs'.
- The National Treatment Agency began by measuring the 'success' of treatment through waiting times for specific treatments. Monitoring now includes counting the numbers of patients still in contact after 13 weeks. There is a stated ambition to monitor the outcomes of treatment by March 2007.
- The evidence base for focussing on drug-using offenders is still emerging, with the majority of research commissioned by the Home Office since 1999. One of the earliest key papers concludes that the link between drug use and crime is complex, and that for the majority criminality predates drug use. This view of drug use as a 'sub-set' of criminality is supported by research findings that as few as 7%, and as many as 37%, of individuals under probation supervision are Problematic Drug Users (PDUs). Of these, only "a minority can be helped and succeed in changing drug use and offending behaviour".
- Regardless of the evidence, the Home Office intends that drug work in the criminal justice system will become "the normal way of working". The National Audit Office has noted that the effectiveness of such interventions should be judged on the quality of outcomes for individuals rather than meeting targets.
- Emerging research indicates that young people and males may benefit more from interventions. In practice, younger people are less likely to be placed on a Drug Treatment and Testing Order and females more likely. For those who 'successfully complete' a court order, over half are convicted of further offences in the following two years.
- This paper concludes that the current emphases of treatment and crime serve to 'treat the symptoms' of drug use without seeking to address underlying causes. A cost benefit analysis is required to assess the impact of the current strategy. 'Treatment' needs to include the wider needs of individual drug users, their families and communities.

STRATEGIC CONTEXT

In April 1994, Department of Health Ministers set up a Task Force to review the effectiveness of services for drug misusers in England.

In May 1995 the Government published the White Paper "Tackling Drugs Together" which set out a three year strategy, with the following statement of purpose:

To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:

- Increase the safety of communities from drug related crime
- Reduce the acceptability and availability of drugs to young people; and
- Reduce the health risks and other damage related to drug misuse.

The Task Force Report[515] was published in July 1996, stating that "treatment, whilst primarily aimed at reducing

515 Task Force to Review Services for Drug Misusers (1996) Report of an independent review of drug treatment services in England, London: DH

the health risks of drug misuse, also contributes significantly to the strategy as a whole".

As part of the review process the Task Force commissioned a programme of research studies, the largest of which was the National Treatment Outcome Research Study (NTORS), a longitudinal, observational study of more than 1,000 drug users experience of methadone programmes, residential rehabilitation and in-patient units.

In drawing upon the range of available evidence at the time, the Task Force established a set of measures against which the outcomes of services could be assessed. Implicit in this acknowledgement of key outcome areas is that drug users, and the wider community, will experience harm in the areas detailed.

Outcome Domain	Measure
Drug use	1. Abstinence 2. Near abstinence 3. Reduction in quantity consumed 4. Abstinence from street drugs 5. Reduced use of street drugs 6. Change in drug-taking behaviour from injecting to oral consumption 7. Reduction in the frequency of injecting
Physical and psychological health	1. Improvement in physical health 2. No deterioration in physical health 3. Improvement in psychological health 4. No deterioration in psychological health 5. Reduction in sharing injecting equipment 6. Reduction in sexual risk taking
Social functioning and life context	1. Reduction in criminal activity 2. Improvement in employment status 3. Fewer working/school days lost 4. Improved family relationships 5. Improved personal relationships 6. Domiciliary stability/improvement

The three 'outcome domains' may be observed to cover the continuum of:

- impact upon the individual (through drug use itself),
- through the impact on both self and others (through physical, psychological and public health concerns), to
- the impact on families and the wider community (through associated lifestyle issues including offending, relationships, employment and housing).

This range of acknowledged harms and potential outcomes to be achieved from treatment served to set the parameters for the initial inter-agency work under the auspices of the newly established Drug Action Teams.

Following the election of 1997 the new Government developed a 10-year national drug strategy "Tackling Drugs to Build a Better Britain"[516] seeking to give direction and coherence to initiatives being undertaken separately across Government. This strategic document built upon the predecessor strategy "Tackling Drugs Together" which had established Drug Action Teams as the responsible bodies, drawing together senior representatives of health, social services, criminal justice, education and housing agencies.

The national agenda to improve the quality and capacity of drug treatment was heavily influenced by wider developments for improving health and social services in general. In 1998, drug treatment services were identified for the first time in NHS Priorities and Planning Guidance. The establishment and development of the National Treatment Agency (NTA) in 2001, and the subsequent publication of Models of Care[517], were with the NHS guidelines and the NHS Plan (2000) with its ten-year action plan to put patients at the heart of the health service.

The implementation of the national drug strategy was accompanied by significant investment as part of the Government's Comprehensive Spending Review cycles, supporting the delivery of local action plans by the 149 Drug (and Alcohol) Action Teams across England across the four aims of the National Strategy:

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

Historically, the substance misuse field has been characterised by substantial geographical variations in the availability, structure, processes and outcomes of treatment. This history has been reflected by the Audit Commission's national report[518] "Changing Habits", which sets out a number of specific recommendations for Drug Action Teams. These included the need for clear arrangements for joint commissioning in order to deliver a coherent approach to drug related problems. The identification of the needs and profile of substance misusers within the DAT area, including service user satisfaction with the content and impact of services provided, and the need to establish information systems were key recommendations.

516 Great Britain Cabinet Office (April 1998) Tackling Drugs to Build a Better Britain: The Government's 10-year strategy for tackling drug misuse, Stationery Office, London

517 NTA (2002) Models of care for the treatment of drug misusers, available at http://www.nta.nhs.uk/publications/MOCPART2/mocpart2_feb03-old.pdf

518 Audit Commission (2002) Changing Habits: The commissioning and management of community drug treatment services for adults. An executive briefing is available at http://www.audit-commission.gov.uk/publications/pdf/brchanginghabits.pdf

The establishment of the NTA as a Special Health Authority in April 2001 accompanied the disbursement, and performance management of, new funding to support the expansion and enhancement of drug treatment. This is in the form of a Pooled Treatment Budget (PTB), which can only be spent with the agreement of the DAT. Most DATs have established a Joint Commissioning Group consisting of the commissioners and budget holders from each member organisation. Their role is to coordinate their spend of mainstream resources as well as work on behalf of the DAT to administer the Pooled Treatment Budget.

The Updated Drug Strategy[519] saw further Government commitment to additional expenditure up to March 2005, to include a greater emphasis on targeting resources towards drug-misusing offenders with more referrals from the criminal justice system, greater involvement of GPs and developing services for users of crack/cocaine.

The Updated Strategy has seen a renewed emphasis upon routing Problematic Drug Users (PDUs) into treatment through their engagement with the Criminal Justice System.

The Home Office[520] has undertaken research into the financial costs of Class A drug use, drawing upon the findings of NTORS[521]. This provides a unit costing approach based upon a drug user's level of engagement with services, arriving at an average cost per drug user in the key areas of health, criminal justice and victim costs.

The report concludes:

> *"Criminal justice costs are estimated to be the largest component of reactive government expenditure accounting for 67% of the total. In terms of social consequences, victim costs of crime dominate at 88% of the total. The reactive government expenditure per person is estimated at £10,402 and the total social cost at £35,455 per person using the medium estimate. Total economic costs or reactive expenditure...equates to some £1,927 averaged over all Class A drug users. Social costs equate to £6,564 per year averaged over all Class A drug users."*

In 2005, the national strategy was again 're-badged' as "Tackling Drugs, Changing Lives" and is now promoted as a 'a cross-Government programme of policies and interventions that concentrate on the most dangerous drugs, the most damaged communities and problematic drug users'[522].

To accompany this renewed emphasis, the NTA's treatment effectiveness strategy[523] was launched on 30 June 2005. The strategy places a strong focus on the adult service user's experience of treatment, with the following aims:

- provide speedy access to treatment (i.e. access to first episode of treatment within three weeks, with local investigations if a client waits for more than six weeks)
- retain clients in treatment long enough for them to benefit (i.e. over 12 weeks)
- enable them to access the range of drug treatment and social care (e.g. housing support) they need to improve their lives. These services should be integrated through individual care plans which are developed and regularly reviewed in partnership with the client.

The strategy also states an emphasis on improving rehabilitation and routes out of treatment, looking to maximise gains made through treatment by more effectively linking into aftercare services, including social support, housing, education and employment.

A tranche of Research Briefings was published by the NTA to coincide with the launch of the strategy, including a summary of findings from the Tier 4 needs assessment commissioned in summer 2004, a review of the role of psychological therapies, and the results of a survey of retention factors in residential rehabilitation resources.

The treatment effectiveness strategy cited the national picture (based on data for 2003/04) as 52% of clients being retained in treatment for at least 12 weeks. Figures for 2005/06 highlight that 76.5% of new clients are retained for 12 weeks, although this measure of retention has changed from that reported in previous years.

This is balanced by the ambition that local treatment systems seek to achieve longer term and on-going improvements in health and social functioning. This ambition is to be monitored through the incorporation of outcome monitoring in care plans by March 2007. Stated outcomes include drug use, health, public health risks, offending, housing status and employability.

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519 Home Office Drugs Strategy Directorate (2002) Updated Drugs Strategy 2002, London, available at http://www.drugs.gov.uk

520 Godfrey C., Eaton G., McDougal C & Culyer A. (2002) Home Office Research Study: The economic and social costs of Class A drug use in England and Wales, 2000, Home Office Research, Development and Statistics Directorate

521 available at http://www.doh.gov.uk/ntors.htm

522 http://www.drugs.gov.uk/drug-strategy/

523 NTA (2005) Press statement, available at http://www.nta.nhs.uk

Work undertaken by the National Drug Evidence Centre (NDEC)[524] suggests that retention in good treatment significantly enhances the chances that positive treatment outcomes will be achieved. Retention has been built into mainstream health performance management systems, including Primary Care Trusts' Local Delivery Plans and the star rating of mental health trusts by the Health Care Commission.

Donmall et al.[525] have found that waiting times, the current measure of performance utilised by the NTA, did not predict uptake of treatment. Neither did they predict retention in treatment at three or six months. The study found that retention at three months was closely correlated with the following service user-related factors[526]:

- The longer they had been using opiates
- If they were also problematic alcohol misusers
- If they received a daily pick-up of methadone

The NDEC study[527] reports a wide variety of retention rates across agencies:

"At the best performing agency, only nine percent of new entrants to treatment dropped out in the first two weeks, and only 24% dropped out within the first six months following assessment. In other words, at this service, just over three quarters (76%) were still in contact six months after the first contact."

The study also comments on the correlation between retention and the types of treatment modalities available, concluding that "prescribing embedded within a package of psychosocial support (most commonly, counselling), is most likely to be effective in retaining clients in treatment".[528]

All of the above has had an impact on the NTA's projected workplan for Tier 4 service provision, including inpatient detoxification and residential rehabilitation. Strong indications[529] that regional commissioning of such services would be in place by December 2004 are still awaiting fruition. Assurances that "Tier 4 arrangements will be reviewed during 2005 with a view to improving resources, access and capacity in inpatient and residential service provision"[530] are expected to inform the treatment planning for 2006/07.

DRUG TREATMENT AND TESTING ORDERS (DTTOS)

From October 1998 to March 2000 a new community sentence called a drug treatment and testing order (DTTO) was piloted in three areas in England, following the Crime and Disorder Act 1998.[531]

It was subsequently established in legislation through the Powers of Criminal Courts (Sentencing) Act 2000. In June 2000 the government announced in a probation circular[532] the arrangements for implementing the new sentence throughout the whole of England and Wales with effect from 1 October 2000.

The new order gave courts the power to require an offender to undergo treatment as part of a community sentence in cases where there is a clear link between drug abuse and offending. In addition, the offender has to undergo regular drug testing and undertake a high level of supervised activity (15 hours per week minimum). The court regularly reviews the offender's progress.[533] The order was also to be enforced to the same standard as other community sentences.

The basis of justification for the roll-out of DTTOs (and, more recently, the Drug Interventions Programmes) primarily relies on DPAS Paper 2[534], which engaged with 272 service users of Criminal Justice Drug Work projects originally established in 1996, and reported findings in 1999. This study focused on the outcomes of innovative schemes in Brighton, Derby and South London, which relied on significant referrals from, and collaborative working with, the police and probation services.

Underpinning the focus of such work is the "clear evidence that treatment works: for every £1 spent on treatment, at least £9.50 is saved in criminal justice and health costs."[535]

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524 National Drug Evidence Centre (2005) Treatment effectiveness: demonstration analysis of treatment surveillance data about treatment completion and retention, NTA, London, available at http://www.nta.nhs.uk/publications/docs/Treatment_effectiveness.pdf

525 Donmall, M., Watson, A., Millar, T. and Dunn, G. (2005) Outcome of waiting lists (OWL) study, NTA, London, p.1, available at http://www.nta.nhs.uk/publications/docs/RS5%20Donmall.pdf

526 Donmall et al. (2005) ibid., p.4

527 NDEC (2005) ibid., p.4

528 NDEC (2005) ibid., p.5

529 NTA (2004) NTA Briefing: current action to reduce waiting times for Tier 4 treatment services (March 2004), NTA, London

530 Dale-Perera, A. (2005) ibid., p.3

531 'A long way in a short time …' Inspection of the Implementation of Drug Treatment and Testing Orders by the National Probation Service, 2003, available at http://inspectorates.homeoffice.gov.uk/hmiprobation/inspect_reports/thematic-inspections1.html/drug-treatment-testing-report.pd?view=Binary

532 Home Office Probation Circular 43/2000: Drugs: Advice on national roll-out of DTTOs.

533 HMIP Annual Report 2002/2003, available at http://inspectorates.homeoffice.gov.uk/hmiprobation/docs/hmiprobar02031.pdf?view=Binary

534 Edmunds, M., Hough, M, Turnbull, P.J. and May, T. (1999a) Doing Justice to Treatment: Referring offenders to drug services, Home Office, available via http://www.drugs.gov.uk/publication-search/dpas/DPASPaper2.pdf?version=1

535 Source: NTORS at two year: changes in substance use, health and criminal behaviour two years after intake. Dept of Health, see http://www.homeoffice.gov.uk/crime-victims/reducing-crime/drug-related-crime

The authors of the Paper estimate a population of 130,000 problem drug users at the time of the report, acknowledging that "for the 97% of people who engage in casual or recreational drug use there is little evidence of clear links between drug use and acquisitive crime. For the three per cent of problem users, the evidence of a link is overwhelming – even if the causal sequence is complex."[536]

However, there must be some concerns regarding the way that findings from the full DPAS Paper 2 report are presented as 'headline statements' in the Briefing Paper[537] produced to accompany it.

For example, the Briefing Paper refers to the "2,078 referral/assessment records" reviewed, and the "322 interviews with drug using offenders", but makes no reference to the actual sample sizes engaged in the exercise. The impact assessment engaged with 205 (75%) of the original cohort of 272. These were, primarily, drug-using offenders assessed by CJDWs through Arrest Referral schemes (number=128), individuals on probation treatment orders 1A(6) (number=35), and other probation referrals (number=42).

Of this number, interviews were undertaken with the "sample of 178 users at liberty", for whom there are observed "large overall falls in the prevalence of illicit drug use, all highly statistically significant ($p<.01$), and small increases in licit drug use – i.e. prescribed methadone and alcohol. The latter difference is statistically significant ($p<.05$)." [538]

Of the 205 individuals only 77% were referred to drug services, and only 103 entered treatment.

Fifty respondents were re-interviewed six to nine months after initial contact with CJDWs. At the time of interview, 22% of the 103 who had entered treatment services had completed treatment. Fifty two per cent were still in treatment programmes, 14% had left of their own accord and 3% were asked to leave. A minority (10%) had disengaged from the agency for other reasons, including some who were imprisoned for their original offence.[539]

The abbreviated Briefing Paper makes reference to "a large minority – two in five" never having had previous contact with any drug services. Analysis of 623 assessment records from the South London project shows that only 27% had had no previous contact with services[540].

The Briefing Paper concludes that:

> *"For most of the respondents, drug use got out of control in their early twenties, long after their criminal careers were established. The majority then embarked on lengthy parallel drug and crime careers."*[541]

This reflects a subtle difference to the conclusions in the full report:

> *"For example, criminal and drug-using careers may develop in parallel; acquisitive crime can provide people with enough surplus cash to develop a drug habit, and the drug habit locks them into acquisitive crime. (This is not to deny the wide range of other causal factors which may underlie both drug use and offending – from early childhood experiences to current employment and housing opportunities.)*[542]

The full report includes the conclusion that "the biggest long-term gains may come from focussing" on young problem users[543].

The Briefing Paper states that most "programmes involved some form of counselling, and half included substitute prescribing". Actual figures from Paper 2 cite 44% as receiving substitute prescribing, and two-thirds as in receipt of counselling. It should be noted that this was prior to the publication of Models of Care, when 'counselling' as a term was used much more loosely, incorporating what would now be termed motivational interviewing, brief interventions and 'low threshold support'.

In line with the study's remit, the focus remains on drug use and offending, although the initial interview processes revealed "no significant changes in employment status, accommodation or personal relationships". The study concludes:

> *"Given our research design, we cannot say with certainty that the work of CJDWs triggered reductions in drug use and in drug-related crime, but we think that the weight of evidence points to this."*[544]

536 Edmunds et al. (1999a) ibid. p.7

537 Edmunds et al. (1999b) DPAS Briefing Paper 2: Doing Justice to Treatment, Home Office, available via http://www.drugs.gov.uk/publication-search/dpas/DPASbriefing2.pdf?version=1

538 Edmunds et al. (1999a) ibid. p.28

539 Edmunds et al. (1999a) ibid. p.26

540 Edmunds et al. (1999a) ibid. p.20

541 Edmunds et al. (1999b) ibid.

542 Edmunds et al. (1999a) ibid. p.24

543 Edmunds et al. (1999a) ibid. p.4

544 Edmunds et al. (1999a) ibid. p.2

WIDER EVIDENCE BASE

In addition to the Home Office commissioned research, South Bank University has also been commissioned by the National Audit Office to review the evidence of criminal justice interventions[545]. This research draws upon lessons in Australia and the US, as well as the UK and Europe. It is noted that a significant minority of offenders subject to community supervision have been identified as problem drug users in English probation areas, ranging from 7% to 37%, and that a quarter of men and one third of women report the use of heroin or crack cocaine in the year before imprisonment.

Previous studies are cited to have observed four common points of intervention: arrest; trial and sentencing by a court; imprisonment; and release from prison.

Overall, the review concludes that:

> *"The CJS [Criminal Justice System] provides a valuable opportunity to contact problematic drug users who have had little previous exposure to treatment and helping services. Evaluations measuring the effectiveness of different interventions aimed at helping and treating this group within the CJS have shown mixed results. It would appear that a minority can be helped and succeed in changing drug using and offending behaviour. The majority however will fail. Whether such interventions are therefore cost effective is not yet known."*

In terms of the political drive to implement DTTOs, and the range of other CJS-focussed initiatives, Her Majesty's Inspectorate of Probation[546] (HMIP) observes that implementation was undertaken in the most difficult circumstances when the then local Probation Services were preparing for their absorption into a National Service, for which there was as yet no national directorate. There was neither a national project plan in place to implement this decision, nor a minimum infrastructure for either devising or realising such a plan within the prescribed timescale.

Local health authorities were shortly to be reorganised into Primary Care Trusts, and with the absence of any visible lead at the centre in the health service during the original planning stage, probation areas experienced a wide range of responses from local health service partners.

In terms of the implications for quality, HMIP noted that the casefile audit [238 cases] showed an unacceptably low level of achievement of the DTTO National Standard. Whilst progress had been made towards the rapidly implemented targets, with the National Probation Service meeting 81% of the target by the end of 2001/02, it was noted that only 14 of the 42 individual probation areas (33%) had achieved their area contribution.

Additionally, HMIP note that financial arrangements "were always going to be complicated, with criminal justice money being used to fund heath service treatment for work with offenders".

Parallel to the HMIP consideration of DTTOs, the National Audit Office[547] also undertook an assessment of the lessons learned, on the basis that "by increasing the capacity to identify and treat drug misusing offenders, from the point of arrest through to community sentences or custody and release, the Government's aim is to break the link between drug misuse and crime".

The NAO report observes that between 36% and 66% of people charged with acquisitive crime offences test positive for heroin, other opiates or cocaine[548], and that criminal activity can introduce offenders to drugs. The obverse comment would be that only between one-third and two-thirds of suspected criminals use Class A drugs.

By December 2003, 18,414 Orders had been made. In 2003-04, the Home Office allocated £53.7 million to probation areas and treatment services in support of the Order in England and Wales.

During 2003, the year in which the fieldwork for the NAO report was completed, 44 per cent of terminated cases were revoked due to non-compliance and a further 22 per cent were revoked for conviction of an offence - either an offence committed before the start of the Order or one committed while on the Order[549].

On this evidence, the effectiveness of DTTOs may be summarised as "if it works for one, it won't work for two". Little analysis has been made to assess the correlation between previous experience of drug services and 'success' on a DTTO.

The NAO concluded that now that the Order has become established, the focus of performance management should shift from achieving commencements towards improving the effectiveness of the Order in delivering positive outcomes.

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545 McSweeney, T., Turnbull, P.J. and Hough, M. (2002) Review of criminal justice interventions for drug users in other countries, available at http://www.nao.org.uk/publications/nao_reports/03-04/0304366_international.pdf

546 HMIP Annual Report 2002/2003, available at http://inspectorates.homeoffice.gov.uk/hmiprobation/docs/hmiprobar02031.pdf?view=Binary

547 Report by the Comptroller and Auditor General (2004) The Drug Treatment and Testing Order: early lessons, available at http://www.nao.org.uk/publications/nao_reports/03-04/0304366es.pdf

548 Evaluation of drug testing in the criminal justice system in nine pilot areas, Home Office Research Findings 180, 2003

549 The remaining 6 per cent of terminated cases were terminated for other reasons, including ill-health or death.

Whilst the emphasis for outcomes remains on drug use and offending, it is useful to note that the NAO found that, after 12 months on a DTTO, nearly 70% were still testing positive for opiates.

Research into the effectiveness of treatment more generally suggests that some misusers will continue to misuse drugs. For example, NTORS found that about 40% of people treated in residential or community methadone programmes in 1995 were still using heroin at least once a week four to five years later.

As Edmunds et al. [550] have noted, in any definition of 'problem drug use', it is not possible to imply some

"categories of illegal drug use are problem-free, or that so-called 'recreational' drug misuse is unproblematic. In the first place, the illegality of drugs covered by the 1971 Misuse of Drugs Act cannot simply be brushed aside, even by those in favour of amending the legislation, so long as it remains on the statute book. No less important, casual drug users expose themselves to a variety of health risks, some more firmly established than others."

TARGETS AND STANDARDS

The Home Office initially set the probation service a target to achieve 6,000 commencements a year with effect from April 2001. In December 2002 it announced a new target to achieve 12,000 commencements a year on high intensity Orders by the end of March 2005.

In December 2003 the Home Office issued a new National Standard and guidance for the implementation of the Order with a lower intensity treatment plan. These were subject to a separate target to achieve 1,000 commencements in 2004-05, rising to 4,000 in 2005-06. In January 2004 the National Probation Directorate introduced a new target for probation areas for 2004-05 to achieve 35 per cent successful completions.

Available figures[551,552] on DTTO commencements and completions to December 2005 show a rising trend in all

	2003	2004	2005
Ran full course	25%	26%	32%
Terminated for good progress	4%	6%	7%
Terminated for failure to comply	31%	28%	22%
Terminated for conviction	35%	35%	33%
Terminated for other reason	6%	6%	6%

court orders (131,493 in 2003; 135,296 in 2004; 140,391 in 2005), but fluctuations in the numbers of DTTOs made (7,006 in 2003; 8,488 in 2004; 5,885 in 2005).

Terminations of DTTOs rose over the same period, with some indication of increasing success in the management of Orders, but still demonstrating significant attrition, as illustrated below, with at least a third of Orders being terminated for convictions.

This situation is reflected by Home Office commissioned research findings that "completion rates for DTTOs were low: 30% finished their orders successfully and 67% had their orders revoked"[553].

Figures for 2005[554] show DTTOs used as a court order for 5.7% of females and 3.9% of males. Such practice is counter to research findings on who may be likely to benefit most from such provision. The meta-analysis undertaken as part of the Home Office commissioned review of evaluations[555] showed that males allocated to the treatment programme under investigation were twice as likely as those allocated to no treatment or an alternative treatment to reduce their offending. However, there was no difference among females in terms of their rate of offending following treatment.

The NAO also found that younger people, aged 18 to 21 years, may be less likely to be placed on the Order. This situation, and qualitative feedback from staff as part of the HMIP review that the Order may be of more benefit to older drug users, conflicts with international findings. The quantitative review undertaken as part of the Home Office commissioned review[556] showed that younger people (the age categories varied across studies) were more responsive to interventions than older people, and that

550 Edmunds et al. (1999a) ibid. pp.8-9

551 NOMS (2005) Offender Management Caseload Statistics Quarterly Brief, July to September 2005, Home Office available at http://www.homeoffice.gov.uk/rds/pdfs06/omcsq305.pdf

552 NOMS (2006) Offender Management Caseload Statistics Quarterly Brief, October to December 2005, Home Office available at http://www.homeoffice.gov.uk/rds/pdfs06/omcsq405.pdf

553 Hough, M., Clancy, A, McSweeney, T. and Turnbull, P.J. (2003) The impact of Drug Treatment and Testing Orders on offending: two-year reconviction results, Home Office Findings 184. Home Office, London

554 NOMS (2006) ibid.

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

556 Holloway et al. (2005) ibid.

probation and parole supervision have shown to be particularly successful for juveniles.

In practice and application, commencement rates themselves are subject to the vagaries of existing partnership arrangements between local courts and probation services, whilst numbers of completed Orders are likely to reflect on the efficacy of local treatment systems. An example of the former is that probation service authors of Pre-Sentence Reports have to 'sell' the Orders to courts and informally talk of the 'hit rate' as indicating the relative success of PSR proposals. Court confidence in making the orders will also be impacted on by the number of revocations made against observed successful completions.

One unpublished study[557] undertook a 'snapshot' of this process across three neighbouring court areas served by different configurations of treatment services and found wide variations in 'hit rates' (i.e. correlation between PSR proposal and Order made) from 20% to over 60%, with a pattern of correlation to revocations made (i.e. the more revocations seen by the court, the lower the hit rate).

COSTS

The National Audit Office identified supervision and treatment costs at the time of the fieldwork as equating to between £25 and £37 a day, compared with a cost of custody of £100 a day. Other costs were not included, some of which are associated with being on a community sentence rather than in custody, include residential treatment, housing and benefit costs for the offender and the wider cost to society if new offences are committed.

In 2003 there were 86 breaches for every 100 starts on the Order, a figure which will include more than one breach for some offenders and will not necessarily lead to revocation of the Order, but will have a significant impact on court and probation service resources, in addition to the court review hearings which are a feature of the Order.

The NAO note that "as greater numbers of Orders begin to be completed, further research will be needed on the costs and benefits of the variety of sentences and Community Order options available following the introduction of the Criminal Justice Act 2003, taking account of the sustainability of any reduction in drug taking and reduction in criminal activity."[558]

One evaluation commissioned by the Home Office[559] following up offenders who had been put on the Order during the initial pilots found that 80% of those who could be traced had been reconvicted for at least some offence in the subsequent two year period. For those who had completed their Order, the reconviction rate was significantly better at 53%.

This serves to question the definition of success attributed to DTTOs. When applied to 2005 figures, when 'successful' outcomes are attributed to almost 40% of DTTOs, the available evidence suggests that a sustained reduction in offending may only be achieved by 1 in 5 of those sentenced to a DTTO, and that only 1 in 9 of those sentenced to a DTTO will have ceased using opiates.

Even at the time of the NAO fieldwork there were observations that the implementation of DTTOs was creating a 'two-tier system' of treatment provision. "Our fieldwork suggested that treatment continued to be available to offenders beyond the end of their Order but often not at the same intensity, an issue that was of concern to some offenders making progress on the Order." These concerns are supported by evidence that high intensity programmes were 50 per cent more likely to bring about a reduction in criminal behaviour than low intensity programmes. Thus, intensive programmes are more likely than non-intensive programmes to reduce crime[560].

The NAO concluded its report with recommendations regarding 'fair access to treatment services', particularly for people in the 18 to 25 age group, women, ethnic minorities and those who are homeless, and the need for consistent outcome monitoring, particularly in terms of abstinence and reduced drug use, and for re-offending.

DIP National Context

The Updated Drug Strategy[561] built upon the findings of the 10-year strategy Tackling Drugs to Build a Better Britain (1998). The Strategy arose from a review conducted by the Home Affairs Select Committee, which found that while the Government's drug policy covered the right areas, a stronger emphasis was needed on preventing and stopping problematic drug use, reducing the harms from drug misuse, and more focused and measurable targets.

The Drug Interventions Programme[562] (DIP) is part of this strategy to break the cycle of drugs and crime.

It began in 2003 as a three-year programme to develop and integrate measures - known as "interventions" - for helping adult drug-misusing offenders out of crime and

557 Doyle Training & Consultancy Ltd. (2004) Review and Audit of North Essex Substance Misuse Services, commissioned by Essex DAT

558 Report by the Comptroller and Auditor General (2004) ibid.

559 The impact of Drug Treatment and Testing Orders on offending: two-year reconviction results, Home Office Research Findings 184, 2003

560 Holloway, K. et al (2005) ibid.

561 Available at http://www.drugs.gov.uk/publication-search/drug-strategy/updated-drug-strategy-2002.pdf?version=1

562 Further information available at http://www.drugs.gov.uk/drug-interventions-programme/

into treatment. The Home Office intends to continue to fund DIPs across the country for the foreseeable future, with funds of around £165 million a year. "The processes developed will gradually become the normal way of working with drug-misusing offenders across England and Wales".

Nationally, DIP is intended to have a key impact for the Communities outcome of the National Drug Strategy, i.e. to reduce the harm that drugs cause to communities. The KPIs, and data collection responsibilities, are as follows:

1 Proportion of adult/young people offenders testing positive at drug tests (Police)
2 Numbers entering treatment via the Criminal Justice System (DH)
3 Number of DTTOs made as a percentage of target (NPD)
4 Proportion of target group re-offending.

The two key elements of any local treatment system, upon which the DIP will rely, are Throughcare and Aftercare. Throughcare is the system that seeks to promote continuity of approach from arrest through to sentence, and beyond; Aftercare is the holistic package of community-based support, which provides access for clients to wrap-around services such as housing, employment and education. These elements are both dependent on effective case management of drug misusing offenders in the criminal justice system or leaving the criminal justice system and those leaving treatment.

Whilst Aftercare, in the context of DIP, has been defined as "comprehensive support for those reaching the end of a treatment programme"[563], in application to the wider needs of substance misusers it is increasingly acknowledged to be a critical element in successful rehabilitation for a range of 'problematic' alcohol and drug use. The support package includes not only treatment in specialist and primary care settings but support for issues which may include social care and support, housing, finance management and benefits, mental health, family issues, self help, education and employment.

The aim of the DIP Programme is to reduce drug-related offending by moving drug misusers through criminal justice interventions whilst retaining them in drug treatment. Funding to support the DIP is allocated through the Regional Government Office Drug Teams, separately to the Pooled Treatment Budget. One of the major conditions of the funding is that it should not be used to purchase 'treatment', which remains within the NTA's performance management framework, but should be applied to enhance Tier 2 Throughcare and Aftercare services, enabling a greater level of case management and monitoring of the target group, that of drug-misusing offenders.

DIP Implementation

Government guidance acknowledges the difficulties caused in the conflation of ideologies of health and criminal justice, without seeking to address the underlying causes of substance misuse:

> *"In some areas, the different roles and responsibilities have become blurred, particularly where CJITs [DIP delivery teams] and Probation are working in partnership to the point where they are indistinguishable within fully integrated teams… The roles and responsibilities have been merged or changed without proper attention to funding, commissioning, contract management or compliance. This has led to concerns for workers and managers, as well as policy leads in DIP, Probation and NTA"* 564

It may be noted that this is an on-going concern, with guidance issued in July 2006 superseding that issued in April 2006, and with further guidance anticipated.

Whilst the currently available guidance prescriptively describes the principles that must be applied, it is not clear how this approach fits with the NTA's stated activities of 'improving knowledge', 'promoting best practice' and 'improving performance'[565].

CONCLUSIONS

The most thorough overview of available evidence known to this reviewer is Home Office Online Report 26/05[566], which undertook a systematic review of 69 English language evaluations utilising experimental and control groups in pre-test and post-test conditions and studies that randomly allocate subjects to experimental and control conditions. In line with other Home Office commissioned research, the main objective was to determine the effectiveness of drug treatment interventions that aim to reduce drug use and/or drug-related crime.

The review concludes that "there is strong evidence that the most effective interventions to reduce drug-related crime are therapeutic communities and drug courts."

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563 Centre for Public Innovation, Making Sense of Throughcare and Aftercare, available at http://www.publicinnovation.org.uk/?page=how/publications.html

564 CJITs and DRR/DTTO Clients: Case Management and Monitoring and Research Issues - Q&A Guidance issued by DIP, Probation, NOMS-DSU and NTA, July 2006, available via http://www.drugs.gov.uk/publication-search/dip/CJITDRR_FINAL?version=1

565 See http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/about/main.htm

566 Holloway, K. et al (2005) ibid.

"The results show that some interventions are more effective than others, although some of the difference may relate to the quality and intensity of the programme.

- The results of both the quantitative review and the meta-analysis show that methadone treatment, heroin treatment, therapeutic communities, and psycho-social approaches are effective in reducing drug-related crime.
- Additionally, the review has shown that drug courts and probation and parole supervision are also effective in reducing drug-related crime.
- Unfortunately, very little evaluation research has been undertaken looking at the effectiveness of supervision and aftercare. Therefore overall, robust conclusions cannot be drawn from this review. Additionally, there is no clear evidence that routine monitoring drug testing works."

This reviewer maintains that the problems of, and potential outcomes for addressing substance misuse, were well described by the Effectiveness Review, and that to seek to address individual elements demonstrates a short-sighted, piece-meal approach to policy.

In particular, a cost benefit analysis is needed for the current configuration and focus of spending on criminal justice focussed and prescribing interventions. There is little or no evidence available to assess the impact on the range of other elements of the 'social functioning and life context' outcome domain described by the Effectiveness Review, which are the areas of impact for families, the wider community, and the substance misusers own self-esteem. These include improvement in employment status; fewer working/school days lost; improved family relationships; improved personal relationships; and domiciliary stability/improvement.

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