

A FRESH APPROACH TO DRUGS

The final report of the
UK Drug Policy Commission.

October 2012



The UK Drug Policy Commission is an independent charity that provides objective analysis of the evidence concerning drug policies and practice. UKDPC is principally funded by the Esmée Fairbairn Foundation, and will finish its work in December 2012.

We bring together senior figures from policing, public policy and the media, along with leading experts from the medical and drug treatment fields, to encourage the formulation and adoption of evidence-based drug policies.

Our work has included reviews of:

- Employment issues for recovering drug users
- The extent, nature and impact of stigma towards drug users
- Support for families of drug users
- Programmes for drug-dependent offenders
- Efforts to tackle drug markets and distribution networks
- Harm reduction approaches to drug law enforcement
- Options for controlling new drugs
- The impact of drugs on Minority groups
- Impact of localism and austerity on drug interventions
- How drug policy is made in the UK.

All UKDPC reports are available for free download at: **www.ukdpc.org.uk**.

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We hope that our work has been useful in helping policymakers as they seek to address the problems associated with drug use. We are grateful to the parliamentarians and civil servants across the UK who have helped us in developing work that is as relevant and useful as possible.

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FOREWORD

Drug policy is currently a mix of cautious politics and limited evidence and analysis. This is coupled with strident and contested interpretations, both of the causes of problems and the effects of policies. In fact, for as long as there has been a drug policy, there have been gaps in the evidence as well as uncertainty about how to understand and act on the evidence that we do have.

The UK Drug Policy Commission was set up six years ago as an independent organisation with the remit of analysing the evidence about what works in drug policy. We have come to the conclusion that drug policy may struggle to address current and emerging challenges if it carries on as it is.

We can make some progress by improving existing programmes, for example through enhancing drug treatment and recovery efforts, by promoting disease prevention measures, and by prosecuting members of serious and organised criminal networks.

But we need a new approach if we are to go further.

We need to focus on the twin goals of how society and government can support and enable people to behave responsibly, and how they can stimulate and help individuals recover from drug dependence. And we need an evidence-based approach which puts at the forefront the need to find out what promotes such goals.

Our research has pointed towards a number of areas where this approach can help make UK drug policy better able to meet existing and future challenges.

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ABBREVIATIONS

ABC – the system of classification that categorises controlled drugs into class A, class B or class C

ACMD – Advisory Council on the Misuse of Drugs

ACPO – Association of Chief Police Officers

ASB – Anti-social behaviour

CARAT – Counselling, Assessment, Referral, Advice and Throughcare

CJS – Criminal Justice System

DARE – Drug Abuse Resistance Education

DCRs – Drug Consumption Rooms

DMI – Drug Market Intervention

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

FIPs – Family Intervention Projects

IDTS – Integrated Drug Treatment System

IDUs – Injecting Drug Users

INCB – International Narcotics Control Board

LGBT – Lesbian, Gay, Bisexual and Transgender

MDA – Misuse of Drugs Act

MHRA – Medicines and Healthcare Products Regulatory Agency

NICE – National Institute for Health and Clinical Excellence

NIHR – National Institute for Health Research

POCA – Proceeds of Crime Act

PSA – Public Service Announcement

RIOTT – Randomised Injectable Opioid Treatment Trial

ROA – Rehabilitation of Offenders Act

SOCA – Serious Organised Crime Agency

UKDPC – UK Drug Policy Commission

UNODC – United Nations Office on Drugs and Crime

WHO – World Health Organisation

EXECUTIVE SUMMARY

We all have an interest in knowing which policies work in tackling problems associated with drug use. Many members of the public, and many politicians, believe that our drug policies are not working. But the debate about how we address the challenges of mind-altering drugs is polarised, with an added emotional and moral aspect that is not seen in most other policy areas.

The UK Drug Policy Commission was established to address these problems in a different way. Our aim has been to show how independent scrutiny of evidence can produce both better results and value for money in drug policy and practice. We believe that our projects - and their results - demonstrate how this can help to overcome the challenges which we now face.

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Existing drug policies have struggled to limit the damage drug use can cause. Yet the rapid creation of new drugs is changing the drugs market too quickly for the traditional methods we use to control drugs. People can now use the internet, both to find out about new

substances and to purchase a ready supply. The economic crisis may have an impact on the nature of drug use and drug problems in the UK, and with fewer resources, the capacity to respond will be limited further. Added to that, the speed and scale at which services are being devolved to a local level may mean there are increasing and unpredictable variations in the kind of services offered in different parts of the country.

In this report we identify a fresh approach to drug policy, with both a recasting of how we structure our response to drug problems, and an analysis of the evidence for how policies and interventions could be improved. The chapters cover where we are now; the need for a fresh approach and what this could look like; potential barriers in policymaking and delivery; and finally, our recommendations for the future.

WHERE WE ARE NOW

For most people, illicit drug use is something that happens in their teenage years or young adulthood. As they grow up they stop using, largely without any problems. People who do develop drug problems do so for a range of complex reasons. These include their own personality traits, their personal history, their genetic/biological makeup and their social circumstances, including how much they are exposed to illicit drugs and how easy it is to get hold of different substances. The consequences of using a substance are likewise influenced by context.

Contrary to popular opinion, levels of drug use have actually been declining in the UK over recent years. Injecting drug use, and the numbers with heroin and crack problems, have recently started to decrease in England. This has been driven by a fall

Levels of drug use have actually been declining in the UK over recent years.

in numbers in the younger age groups using heroin. Cannabis is still the most commonly used drug, yet its use has also been declining for several years. Overall stimulant use has remained steady although the drugs in fashion may change. Yet despite these encouraging falls in numbers, a higher proportion of people in the UK appear to consume drugs than in many other countries.

At the moment, drug policy in the UK is based on taking measures to reduce the supply and demand for drugs, and increasing the rates of recovery of those dependent on drugs. There have been some important successes. For example, rates of HIV among injecting drug users are amongst the lowest in the world thanks to harm reduction approaches, such as needle and syringe exchanges. The number of people receiving treatment for drug problems has also steadily increased.

Yet there are policies where there is very little evidence that they work or they have been cost-effective. This is not to say that they do not work, but that we do not have sufficient information to make an informed judgement. Some policies also end up having counter-productive effects. For example, sending drug users to prison without appropriate support either inside or on their release, may lead to a higher risk of death, reduced risk of recovery because their treatment is disrupted or they have nowhere suitable to live afterwards, as well as the impact on their families.

THE NEED FOR A FRESH APPROACH

While UK government drug policies have delivered some real successes in recent years, there is still a lot to do to address the remaining challenges, and to respond to new ones. The way that the UK makes and implements drug policy may also mean policy is not cost effective and does not manage to fully address the problem, especially in an era of austerity.

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The UK's approach appears simplistic in several ways. Seeing all drug use as invariably problematic can reduce the cost-effectiveness of policy. Equally, drug problems need to be seen and addressed within their wider social and economic context; entrenched drug problems appear to be significantly linked to inequality

and social exclusion. Finally, separating drugs from alcohol and tobacco use is difficult to justify when their relative harms are considered, and doing so makes it more difficult to tackle the full range of individuals' substance use.

Taking drugs does not always cause problems, but this is rarely acknowledged by policy makers. In fact most users do not experience significant problems, and there is some evidence that drug use can have benefits in some circumstances. Drug policy also does not take into account the different reasons that people take drugs or can become addicted. In short, there is not a single drug problem and so we need a variety of solutions to a variety of problems.

The debate over drugs reflects the different sets of values and professional interests that those engaging in it have, and thus why there are different views on what should be done to tackle the issues. But polarising the debate, for example over the relative virtues of enforcement and of treatment, is not productive. Debates about drug policy need agreement on goals, which can be hard, but also more realism about what will achieve those goals effectively. One of the most important factors that has impeded the introduction of more cost effective drug policies, and understanding the consequences (often unintended) of current policies, is the fact there has been inadequate collection and analysis of evidence. To address this we need to improve both the collection of evidence and the ways in which it is analysed and used.

WHAT A FRESH APPROACH COULD LOOK LIKE

Drug policy is typically divided into three separate elements: prevention, treatment, and enforcement. This can result in duplication of work, missed opportunities for increased effectiveness through working together and feelings of institutional protectionism. When these different types of intervention operate without sufficient coordination they can function at cross-purposes - for example, enforcement activity near treatment centres can discourage people from turning up for treatment. These divisions, and a lack of open debate about the overall goals of drug policy, also lead to these interventions being seen not as tools but as goals in themselves, resulting in the focus being on activity rather than outcomes. That can reduce the effectiveness of programmes, lead to wasted resources, as well as inhibiting the development of more cost-effective ways of tackling drug problems.

A lack of open debate about the goals of drug policy results in the focus being on activity rather than outcomes.

We suggest making a clear distinction between the overall goals of drug policy and the tools to deliver it. Rather than starting with the traditional distinction between prevention, treatment and enforcement, it may be more effective to consider drug policy in terms of two higher level challenges.

First, we need to look at how **society and government can enable and support individuals to behave responsibly**. This means tackling underlying causes of drug use, providing the information and skills necessary for people to make sensible choices about drug use, and ensuring that where drug use does occur, it is undertaken in a way that minimises the harm to the user and others.

Second, we should focus on how **society and government can enable and promote recovery from entrenched drug problems**, whether for individuals or in communities. Then we can see how the practical tools of prevention, treatment and enforcement can help deliver this as well as how it links into wider social policy through the various supporting institutions, professional interests and social and economic programmes.

What we mean by 'responsible behaviour' is that an individual should seek to behave in ways that allow them to achieve their potential and contribute positively to their families and communities and also to avoid incurring harm to other people in general. Behaving responsibly and limiting harm and damage to oneself and others are two sides of the same coin.

At the heart of the goal of encouraging individuals to behave responsibly is the recognition that governmental policies and programmes can both facilitate and undermine this. Society and government need to adopt policies that seek to create an environment that is supportive of responsible behaviour.

For example, providing clean needles and syringes to injecting drug users to prevent the spread of HIV and other blood-borne viruses is a good illustration of how the state can help facilitate responsible behaviour, as it can also be a first step for drug users in a long journey of rebuilding their lives. Similarly, policies built on sound evidence designed to strengthen families and improve young people's life skills and attachment to school can facilitate responsible behaviour and delay and prevent harmful drug use, even though many will still go on to experiment and use drugs.

Governmental policies and programmes can both facilitate and undermine responsible behaviour.

But some policies can undermine responsible behaviour. It is now well recognised that very aggressive stop and search tactics aimed at addressing drugs - employed by police in some places, and amongst certain ethnic groups - has had unintended negative consequences.

Damage to communities' and individuals' trust in and their attitude to the police and other authorities can undermine other efforts to address the supply and use of drugs.

As part of efforts to encourage responsible behaviour, and our society's response to it, we cannot ignore the fact that a small but significant segment of the population will experiment with drugs, and that some of them will continue to use drugs, even if they know about the risks. So we do not believe that pursuing the goal of encouraging responsible behaviour requires the prevention of all drug use in every circumstance. This is not to say that we consider drug use to be desirable. Just like with gambling or eating junk food, there are some moderately selfish or risky behaviours that free societies accept will occur and seek to limit to the least damaging manifestations, rather than to prevent entirely.

Drug policy needs to focus on ensuring that any drug use occurs in ways that pose lower risks of harm to others and to users. The bar should be set particularly high for children and young people given their physiological vulnerability to harm from drugs and because they are less able to make rational decisions about their own wellbeing.

On this basis, our approach is as follows. First, we conclude that the debate about drug policy should centre upon finding out how society and government can enable and support responsible behaviour, alongside stimulating and promoting recovery from drug addiction. Second, we say that focused work, looking at the evidence, is needed in order to show what policies we should adopt to achieve these goals. The best policy will depend on which users and suppliers we are talking about, on what drugs they are using and supplying, and on other factors relevant to their particular case as well as the types of harm being caused, both to individuals and to society. There are unlikely to be any silver bullets.

There are unlikely to be any silver bullets.

Over the past six years we have tested this approach by carrying out a wide variety of projects on particular problems and we have sought to make a careful assessment of what the evidence indicates might help address some of those problems. What follows here picks out the main conclusions of our work, and shows how the approach can be made to work.

SUPPORTING INDIVIDUALS TO BEHAVE RESPONSIBLY

There are a number of ways that society and government can foster an environment that supports responsible behaviour. This includes policies designed to prevent a range of harmful behaviours including truancy, offending and substance use, such as some early intervention programmes. While programmes which try to prevent young people from using drugs through education and information have generally been shown to have little or no impact - or even to increase drug use - some wider programmes that address children's general behaviour and their attitudes to school and their beliefs about what is normal behaviour, may have an overall positive effect.

The evidence for traditional drug law enforcement efforts, which have focused on arrests and drug seizures with the aim of reducing supply, suggests that often they have limited or no sustained impact on supply. Often, they also have unintended consequences, resulting in an increase in

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the consequential damage that drug markets inflict on a community, for example where arresting one group of drug dealers leads to an increase in violence in the area as a result of a turf war between rival gangs seeking to fill the gap created.

But there is growing evidence that law enforcement can be effectively targeted to support responsible behaviour by focusing on particularly harmful groups or behaviours. For example, police operations that use intelligence to identify and prosecute drug dealers who are particularly violent or who exploit children, while providing to those at the lower level of drug dealing the option of support to change their lives, have proved successful in reducing the harms to communities in some areas.

Similarly, current drug laws can lead to unintended consequences, such as criminalising many otherwise law-abiding young adults, and is not always effective in encouraging people to behave responsibly. This growing disconnect between policy and practice, uneven application of the law, and consequent erosion of respect for the law, combined with evidence of benefits of alternative approaches, indicates that there is a need to consider modifications.

PROMOTING RECOVERY FROM ENTRENCHED DRUG PROBLEMS

Recovery is neither an easy nor a linear process and takes considerable time and effort to achieve and sustain.

Recovery from problematic substance use is a process that involves not only achieving control over drug use, but also involves improved health and wellbeing and building a new life, including family and social relationships, education, voluntary activities and employment.

While the individual is at the heart of recovery, their relationship with the wider world - family, peers, communities and society - is an intrinsic part of the recovery process. Recovery is neither an easy nor a linear process and takes considerable time and effort to achieve and sustain, both for individuals and hard-pressed communities.

The stigmatisation of people with drug problems and their families is a significant barrier to recovery. The wider community, including potential employers, could play a greater role in helping individuals to recover. Having contact with people who are in recovery from drug problems can help overcome fears and misconceptions based on stereotypes that can arise from the way in which drug problems are covered in the media and political debate. Families of people with drug problems are also often overlooked. Yet, not only can adult family members aid their relative's recovery, but they also often need help in their own right.

There is scope for law enforcement and the criminal justice system to be more focused on supporting recovery. Programmes that seek to divert drug-dependent

offenders into treatment rather than simply relying on prison or probation, for example the Drug Interventions Programme and local initiatives such as Operation Reduction in Brighton, have proved successful in reducing acquisitive offending. In those cases where a prison sentence is necessary, the Integrated Drug Treatment System recently introduced in prisons has the potential to ensure that evidence-based treatment is more widely available for prisoners and to provide better links into community services so that progress in recovery can be maintained on release.

It is good news that there has been an increased focus on recovery in UK drug strategies. However, there is a risk that narrowly focusing on achieving abstinence from drugs does not make sufficient use of the evidence of the cost-effectiveness of a wide range of interventions and the need for flexibility and personalisation in service provision to accommodate the different needs of individuals. In short, one size does not fit all. Services such as needle exchange and drug consumption rooms have been shown not only to reduce harm from drug use, but also in some cases to provide a first step towards recovery. Similarly, treatment services, ranging from substitute prescribing to residential rehabilitation, can all contribute to recovery at different stages. Other factors, such as the availability of mutual aid and peer support, are crucial for sustaining recovery alongside a wider environment that is accepting of people trying to rebuild their lives, for example employers being more open and willing to give jobs to such people.

Independent research on what works in drug policy receives comparatively little funding in the UK.

BARRIERS IN POLICYMAKING AND DELIVERY

Beyond specific policy proposals, there is also a need to address how drug policy is made and delivered in the UK. We identify several areas where the ways in which we make and deliver drug policy may be limiting our ability to develop and implement more cost effective policies.

In general, independent research on what works in drug policy receives comparatively little funding in the UK. Among other bodies, this affects the government's Advisory Council on the Misuse of Drugs (ACMD). Its very limited resources are now increasingly dedicated to investigating and making recommendations on new drugs, rather than a comprehensive programme of wider research and policy analysis.

A separate issue is the location of the political lead for drug policy. The UK is unusual among EU countries in that the Home Office is the lead department for drug policy; most countries situate their leadership in the Ministry of Health. It has been suggested that the Home Office leadership encourages a view of drugs as a crime issue rather than a matter of health.

It is crucial that the introduction of these policies is matched with significant efforts to monitor their impact.

As noted previously, the debate about drug policy is often polarised and combative. This also applies in the political sphere. Because there appears to be such limited space for developing informed consideration of options, and reaching consensus, there are restrictions on the

potential for investigating some policy alternatives.

Finally, localism and devolution are allowing greater experimentation across the UK, which may create the potential for the testing of innovative policies. However, localism may also limit the ability of the government to implement and track the effectiveness of a coherent national drug strategy.

RECOMMENDATIONS

Having identified challenges, examined evidence, and suggested alternative ways of approaching drug policy, we conclude by making specific policy recommendations to address these challenges, based on our assessment of what evidence there is. It is crucial that the introduction of these policies is matched with significant efforts to monitor their impact and to extend the evidence base for what works. This will be valuable not only for demonstrating any successes, but is consistent with our belief that policy initiatives must be both evidence based and themselves be evaluated further; policymakers should also be transparent about what does not work.

Simply tackling drug problems and drug-using behaviour on their own is insufficient.

Supporting responsible behaviour

It is now well established that wider social and environmental factors contribute to turning someone's vulnerability to drug use into actual drug use, and that use then

becoming problematic. Equally, it is clear that there is a relationship between drug use and a range of other risky behaviours. This suggests that simply tackling drug problems and drug-using behaviour on their own is insufficient. Such efforts have to be integrated and coordinated with other social and economic policies.

Key opportunities for policy to support these include:

- *Tackle structural problems that increase risk of drug problems*

Social problems, such as income inequality, lack of a sense of community, feelings of exclusion and disenfranchisement, are likely to have an impact on whether someone develops drug problems. It is important that this is recognised within social policy more widely. The potential impact on drug problems should therefore be considered in broader social policy impact assessments.

- *Develop and evaluate early interventions to help families and communities build resilience to drug problems alongside other problems*

These programmes have the potential to provide a wide range of benefits beyond reducing drug problems but the evidence for their effectiveness is mixed. Nevertheless, there is some evidence for the cost effectiveness of some of these programmes, and this needs to be expanded and developed further. While it is likely that the overall impact on drug problems will be modest, there will be benefits in other areas as well.

- *Provide evidence-based prevention programmes to support less risky choices*

There is little evidence that drug-specific education makes a difference to the prevalence of drug taking. But we can give young people accurate information about drugs and other substances and their risks, which can influence drug-taking behaviour. Overall the evidence for cost effectiveness of drug-specific education is weak, although there is some evidence to support broader programmes that address behaviour more generally and build self-efficacy, help with impulse control and teach life skills, and these should be part of the national curriculum. Schools need to be provided with the necessary information to make sure they are in a position to choose cost-effective programmes and deliver them effectively.

Numbers of arrests and amount of drugs seized do not necessarily reflect success in reducing the availability of drugs.

- *Promote interventions which reduce the harms of drug use*

There is good evidence supporting a number of ways in which people who use drugs can be enabled to do so in such a way that harm to themselves and nearby communities are minimised. These include traditional harm-reduction programmes, such as needle and syringe exchanges and drug consumption rooms, and promising innovative approaches relating to recreational use of drugs, such as pill-testing services.

- *Involve local communities in law enforcement and assess its impacts*

The evidence is weak for the efficacy of most traditional drug enforcement activity, especially that directed at major and middle-level drug dealers and criminal networks as well as border interdictions. But what there is supports interventions that take a problem-solving approach and that involve local communities. The traditional indicators, of numbers of arrests and amount of drugs seized, do not necessarily reflect success in reducing the availability of drugs and the damage to communities. All drug enforcement operations should be assessed to demonstrate

The involvement of adult family members of people with drug problems can promote recovery for their drug-using relative.

their proven impact on communities, to allow for continuous improvements and better value for money. At the community level, enforcement should involve the affected communities in identifying problems and setting priorities to help focus on the most harmful aspects of drug markets.

Stimulating and promoting recovery from drug dependence

The new focus on recovery from drug dependence provides an important opportunity to increase the effectiveness of drug policy. However, as is recognised in the drug strategies across the UK, improved rates of recovery from dependence require the involvement of more than just treatment systems and government services.

Policy opportunities to support recovery include:

- *Tackle stigma towards people with drug problems and their families*

Society as a whole needs to be engaged if we are to achieve the goal of reintegrating people with drug problems. For this to be successful, tackling the damaging stigma towards people with drug problems will be vital to provide a foundation and then an environment in which recovery is possible. This needs to be wide-ranging and government can set an example, including through its announcements. A wider stigma ‘campaign’ could improve public and professional knowledge and understanding of drug dependence and recovery.

- *Make the criminal justice system more focused on recovery*

Different policies need to work together rather than against each other to promote recovery. There needs to be more support for smart enforcement programmes, such as Operation Reduction, that divert drug-dependent offenders into the treatment system rather than the criminal justice system, and that work with communities to support them to reintegrate. Reducing the numbers of those sent

to prison and improving integration between services provided in prisons and as part of community sentences and community-based services can also contribute to a criminal justice system that is more recovery focused.

- *Provide greater support to families of people with drug problems*

People with drug problems are more likely to achieve recovery if they have a supported and supportive family. The involvement of adult family members of people with drug problems can promote recovery for their drug-using relative, but they also need support in their own right. This needs to be reflected in local area planning processes and service development alongside the need to support children of drug-misusing parents. For families where substance misuse is intergenerational, new models of family intervention should be further developed and evaluated.

- *Continue to develop treatment systems, mutual aid networks and communities that support those recovering from drug dependence*

To support recovery, a wide range of treatment, mutual aid and supportive local community approaches is required.

Opportunities for action include promoting recovery through balanced treatment systems, which take account of the varied and individual nature of recovery, recognise diverse needs, and are underpinned by a competent workforce. The role of local communities including employers, faith groups and generic services should be enhanced, particularly if stigma among these groups is reduced.

This requires investment in a skilled and competent workforce, as well as sustaining the level of spending on treatment and recovery services by the government and local councils. There is some evidence that mutual aid really helps recovery, and local groups should be supported.

The laws on drug production, supply and possession

Our conclusions about how the law might be changed are structured in a possible order in which they could be introduced. We are aware that some are shorter term and some longer term adjustments. Of most importance is careful monitoring and evaluation of the impacts of any reforms.

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- *Review the process for classifying controlled drugs*

The 40-year-old ABC classification system and the process of providing advice to ministers and Parliament have significant weaknesses. For many people it has lost credibility. There should be a wholesale review both of the Misuse of Drugs Act and the underpinning classification system. Such a review ought to examine the possibility of devolving decision-making responsibility to an expert body which could be accorded a statutory role to make classification decisions, with appropriate democratic safeguards.

- *Reduce sanctions for drug possession*

There are a number of reasons that support consideration of an overhaul of some aspects of the drug laws. These include the disconnect between policy and practice, negative effects of enforcement, erosion of respect for the law, and evidence about the impact of some law reforms in other countries.

With some 42,000 people in England & Wales sentenced annually for drug possession offences and about 160,000 given cannabis warnings, this amounts to a lot of time and money for police, prosecution and courts. On top of this comes the cost to the individual in terms of damage to employment prospects. Some people who do develop drug problems may also be put off from seeking help earlier because they are doing something illegal.

The evidence from other countries is that this would not necessarily lead to any significant increase in use.

To address these costs, there is evidence to suggest that the law on the possession of small amounts of controlled drugs, for personal use only, could be changed so that it is no longer a criminal offence. Criminal sanctions could be replaced with simple civil penalties, such as a fine,

perhaps a referral to a drug awareness session run by a public health body, or if there was a demonstrable need, to a drug treatment programme. The evidence from other countries that have done this is that it would not necessarily lead to any significant increase in use, while providing opportunities to address some of the harms associated with existing drug laws.

Given its relatively low level of harm, its wide usage, and international developments, the obvious drug to focus on as a first step is cannabis, which is already subject to lesser sanctions than previously with the use of cannabis warnings. If evaluations indicated that there were no substantial negative consequences, similar incremental measures could be considered, with caution and careful further evaluation, for other drugs.

These changes could potentially result in less demand on police and criminal justice time and resources. Given the experience of other countries, our assessment is that we do not believe this would materially alter the levels of use, while allowing resources to be spent on more cost-effective measures to reduce harm associated with drug use. We would expect the net effect to be positive.

- *Address production and supply*

We do not believe that there is sufficient evidence at the moment to support the case for removing criminal penalties for the major production or supply offences of most drugs.

However, for the most ubiquitous drug, cannabis, it is worth considering whether there are alternative approaches which might be more effective at reducing harm. For example, there is an argument that amending the law relating to the growing of it, at least for personal use, might go some way to undermining the commercialisation of production, with associated involvement of organised crime and the development of stronger strains of cannabis ('skunk'), that we have seen in the UK and other countries in recent years. Perhaps the most expedient course to take here would be to re-examine sentence levels and sentencing practice to ensure that those growing below a certain low volume of plants face no - or only minimal - sanctions. The impact of any such move would need to be carefully measured and evaluated so policymakers could make informed decisions about future actions.

- *Review penalties for all drug offences*

There is a case for Parliament to revisit the level of penalties applied to all drug offences and particularly those concerned with production and supply. Even though maximum sentences are rarely applied, in recent years there has been a clear drift upwards in the length of imprisonment for drug production and supply offences. This incurs costs in terms of burden on the taxpayer, yet there is little evidence to support the idea that this is a deterrent or, more importantly, has any long-term impact on drug supply.

The priority for such a review should be to collect and evaluate evidence to ensure that penalties are working effectively to deliver proportionate justice for victims of drug-related crime, and to act as a deterrent for those whose activities are causing the most harm.

- *Establish consistency in controls over all psychoactive drugs*

Parliament should consider an integrated framework controlling the supply of all psychoactive substances, including alcohol, tobacco and solvents, as well as

other drugs that are used for cognitive, appearance or performance enhancement, such as modafinil as a study aid or anabolic steroids for building muscle mass. This would provide an opportunity to remove anomalies that have grown up over the years.

Improving structures and processes for how we make and implement drug policy

- *Introduce independent decision-making on drug harms*

Both the Advisory Council on the Misuse of Drugs (ACMD) and the New Zealand Law Commission have proposed that an independent body could be empowered to take delegated decisions about controlling new drugs. The National Institute for Health and Clinical Excellence (NICE) and the Medicines and Healthcare products Regulatory Agency (MHRA) operate in this manner.

With appropriate parliamentary oversight and accountability, we see no reason in principle why decision making over the process of classification might not be delegated in its entirety to a new statutory body. We therefore recommend that the government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.

Fundamental questions about the direction of drug policy need to be considered in a cross-party environment.

- *Improve research and policy analysis*

We need a better mechanism for embedding evidence and knowledge development into the drug policy process, incorporating evaluation of the drug strategy and a coordinated programme of research and knowledge dissemination. A

new independent body should be set up and resourced to provide independent leadership, and coordination of research and policy analysis.

- *Move the political lead for drug policy*

The national debate about drugs needs to shift so we can foster an environment that values responsible behaviour, and which promotes recovery for those who develop drink or drug problems. This does not diminish the need to take strong action against those who break the law, such as those involved in serious or organised crime.

Transferring responsibility for coordinating and leading national drug policy from the Home Office to the Department of Health would facilitate the development of a more active public health approach to drugs, that can improve public and political

understanding about how the UK should best respond to the drugs challenges over the next few decades. We do not think that transferring leadership will bring substantial change, at least in the short or medium term. But as a symbolic measure it would signal a fresh attitude to drug policy.

- *Create a cross-party political forum to progress dialogue about future policy*

Fundamental questions about the direction of drug policy need to be considered in a cross-party environment. The most productive way of making substantial improvements to drug policies may be for the leaders of the main parties in Westminster and devolved governments to commit personally to setting up a cross-party political forum tasked with exploring the question of ‘what next for UK drug policy?’ and engaging with the public to both reflect and inform public opinion.

- *Evaluate local approaches*

Devolution and localism should be seen as unique opportunities for natural experiments in drug policy which can, and should, be properly evaluated. Unfortunately we can find little evidence that either national or local public service bodies are considering this opportunity, except where they are initiated by central government.

If we continue to pursue national policies of devolution and localism in policing, health care and education, we can no longer rely on osmosis or the market to ensure that the evidence about the impacts of different approaches is spread and acted upon. National drug strategies must pay attention to the crucial need to build our research and knowledge base and provide a mechanism to ensure this is transferred to the people that matter at local level, whether these are local councillors, Health and Wellbeing Boards, Police and Crime Commissioners or professionals in a range of disciplines.

CONCLUSION

We think that our work has not only contributed to the development of policies that will be more cost effective in addressing the UK’s drug problems, but has also demonstrated the value of independent analysis of evidence.

Our research has identified a number of specific policy proposals which we are confident could be beneficially incorporated into practice. But of more value than the adoption of these specific policies would be a change in UK drug policy’s relationship with evidence. A commitment to the use of evidence

Of most value would be a change in UK drug policy’s relationship with evidence.

to inform which policies are adopted, combined with rigorous trials of new and existing policies, and a willingness to act on the results of this research, would go a long way towards ensuring that the UK has an effective and good value response to the use of mind-altering drugs.

INTRODUCTION

KEY POINTS

- >There is a widespread view that current drug policy is not working well
- >New challenges are putting further pressure on the ability of existing drug policies to reduce the harm that drug use can cause
- >Evidence-based approaches can provide a more effective policy that offers better value for money
- >Over six years the UK Drug Policy Commission has taken an independent, objective view of the evidence in many areas of drug policy and promoted its findings in order to improve drug policy and practice
- >This report brings together the findings from all our work and highlights our conclusions as to how drug policy and policy-making can be improved.

THE DOUBTS ABOUT DRUG POLICY

In June 2011, a YouGov survey asked, “In your opinion, how effective, if at all, is the current government’s approach to illegal drugs?”. Only 11% thought that it was very or fairly effective, while 53% thought it was ineffective*. The fact that for every person who thought the current approach is working, five considered the opposite, should give those concerned with the impact of drugs on society pause for reflection.

There are many policy makers and opinion leaders who privately express similar doubts about the effectiveness of the UK’s approach to controlled drugs. Many are hesitant to voice these publicly or act on those concerns either because they worry about the media and political consequences and see little political benefit in engaging with the issue or, perhaps more importantly, because they are uncertain what to do about it.

Drug policy in the UK cannot be considered in isolation from the international context. We are signatories to a number of relevant international conventions, and most illicit drugs used in the UK originate elsewhere. However, serving political leaders in a number of countries, sections of the media and members of the public are now openly questioning the efficacy of current drug policies.

At the sixth Summit of the Americas in April 2012, it was not only a handful of South American leaders calling for change. Stephen Carter, the Conservative Canadian Prime Minister, said: “What I think everybody believes is that the current approach is not working. But it is not clear what we should do.”¹ President Obama also said: “it is entirely legitimate to have a conversation about whether the laws in place are doing more harm than good in certain places”, although he insisted legalising drugs is not the answer for the United States.²

In this country, as elsewhere, the debate about drug policy often appears to be polarised. On one side are the ‘drug warriors’ who argue that more enforcement and less tolerance are needed. On the other are the ‘drug legalisers’ who argue that the drug control system, with criminal penalties for possession, production and supply, is what is at fault and needs to be replaced.

**In addition 25% responded ‘Neither effective nor ineffective’ and 11% ‘Don’t know’.*
 YouGov Survey Results http://cdn.yougov.com/today_uk_import/ygarchives-pol-yougov-drugs-130611.pdf [accessed 24/07/2012].

The debate is often given an emotional and moral aspect that is not seen in most other policy areas. This is reflected in some of the language used to describe drug users, such as ‘evil’, ‘junkie’ and ‘scumbags’. The label ‘evil’ is also applied to drugs themselves, and not just to their use and distribution. Politicians and much of the public tend only to become aware of drug use when it has very severe consequences and makes disastrous impacts on the lives of individuals and communities. The impact of the policies themselves is less obvious. The consequence is that while some policymakers might see the current approach as imperfect, they are reluctant to make changes for fear of being blamed for future problems.

Yet, despite this apparent polarisation, most people take more nuanced positions, at least in private, recognising that simple solutions are unlikely to be cost effective. In this report we set out to address how drug policies might be improved, without resorting to divisive ‘all or nothing’ solutions. It is possible to hold the view that current drug policies are not working as well as they might, without fully endorsing either of the polarised viewpoints described. But rather than simply seeking a solution in a compromise between these opposing views, we have sought to stand back and take a fresh look at how problems that can be caused by drug use might be tackled more effectively.

The difficulty lies, not in the new ideas, but in escaping from the old ones.

The benefits of doing things differently can be economic as well as social and cultural. Keynes’ observation about economic theory is salient: “The difficulty lies, not in the new ideas,

but in escaping from the old ones, which ramify, for those brought up as most of us have been, into every corner of our minds”.³

DRUGS IN SOCIETY

Throughout history, human beings have used psychoactive drugs: from hallucinogens in pre-Columbian America to opium in nineteenth century China, khat in East Africa and alcohol throughout much of the world. The majority of people in the world deliberately consume substances that alter their state of mind to varying degrees, whether as apparently innocuous as coffee and tea, or as damaging as heroin. Undoubtedly some users of all of these drugs may experience some level of harm including, for some, dependence or severe addiction. However, the majority pay for and use drugs, whether legal or illegal, simply to change their mood or their perception in ways that they consider beneficial and they consider the risk of harm to be acceptably low.

A standard defence of the legality of alcohol cites the general benefit from the increased sociability that it induces, which is taken to outweigh the harm that excessive alcohol consumption causes to individuals,

We have to recognise that, for many users, drugs bring something to their lives that they value.

families and communities. It is difficult, even dangerous, to suggest that some illicit drugs might have similar ‘benefits’, which might be weighed against their harm. But we have to recognise that, for many users, drugs bring something to their lives that they value, be it pleasure, relief from pain, enhanced perceptions or performance. This perspective challenges the prevailing wisdom that all drugs are inherently ‘bad’ if used for non-medically authorised purposes.

The fact that a significant fraction of the population is willing to break the law in order to experience the effects of illicit drugs is an indication of how desirable they are to some, but by no means the majority of people. This use will not always cause harm but, because of the underground nature of the drug market, users face uncertain risks each time they consume drugs.

Most substances, whether food, alcohol, pharmaceutical or industrial products, are subject to different levels of legislative controls that govern their production, sale and use. Many psychoactive drugs are considered sufficiently dangerous as to require strict controls to suppress or, in some cases, prohibit their availability and use. While only around 1 in 20 people globally use an illicit drug each year, consumption of these drugs is regarded as a serious worldwide problem that requires concerted efforts to address. In the UK, the level of drug use is above the global average, with nearly 1 in 10 having taken a controlled drug in the last year.* In many countries, including the UK, policy relating to these drugs is a high-profile and sensitive issue which frequently absorbs much media, public and political attention.

These illicit drugs and how we can best respond to their availability and use, are the subjects of this report. Drawing on nearly six years of work by the UK Drug Policy Commission (UKDPC) and other evidence, our aim is to evaluate whether the UK’s approach to these drugs and the problems they can cause is justified, and in what ways that approach could be improved.

*International comparisons need to be made with care as methods and frequency of data collection vary considerably as do cultural factors that may impact on willingness to report use. It is possible that the comparatively high level of reported drug prevalence and use in the UK is partly a consequence of better information systems and recording.

NEW CHALLENGES FOR DRUG POLICY

There can be no doubt that the use of all kinds of mind-altering drugs presents significant challenges in the UK. The harm that can be caused by the use of alcohol and tobacco are increasingly well known and are a focus of government attention. Likewise, and whatever one's view of the morality of drug use or the impact of existing drug laws, it is clear that the use of drugs poses problems that require determined attention. While the drug policies pursued by successive UK governments over the past twenty years have limited the problems caused by drug supply and use, there is no guarantee that this will continue, or that the results could not be improved upon.

Indeed, in addition to the harms, most of which have been known for many years, there are increasingly important new factors that are making it more difficult for governments to manage the problems that drug supply and use can cause:

- The rapid creation of **new psychoactive drugs** is changing the drug market more quickly than traditional methods of drug control can respond. Between 2009 and 2011, 114 new psychoactive drugs were identified in the EU.⁴ In the UK the Forensic Early Warning System identified 17 new substances between January 2011 and March 2012.⁵ While the UK government now has powers to introduce temporary bans on some new drugs, it is clear that such new drugs are now being brought to market far more rapidly than the law or enforcement agencies can identify them and restrict the supply and use of those deemed harmful.
- The dynamics of the **internet** have meant new routes for the supply of many products, including controlled drugs and pharmaceuticals. Enforcement and regulatory bodies, including postal and delivery services are struggling to keep pace with this phenomenon. It also provides a readily accessible and uncontrolled source of information on drugs and drug use, which may have both positive and negative aspects.
- The **economic crisis** is likely to have a lasting impact on the nature of drug use and drug problems in the UK. The availability and nature of treatment services for people with drug problems are changing and may become more restricted. This could lead to reduced numbers succeeding in recovering from drug addiction. Cuts to police funding will mean some efforts to tackle the drug trade are reduced.

But in addition, wider social and economic problems may have a direct effect on the nature of drug use. In the recession of the 1980s, heroin use became widespread and entrenched in areas where there was high unemployment and social disadvantage. There are significant concerns that similar problems may recur if social and economic exclusion is not addressed.

- A central part of the UK government's programme is to increase **local control over services**. The reforms are far-reaching, incorporating public health, policing and drug treatment. Given the scale and speed of the reforms, the impact on drug use and drug problems is unpredictable. There may be increased variations between different parts of the country in terms of the level of problems and in the nature of the response of local services. In some respects this might be valuable if it enables new approaches to be explored within the limits of the law and if best practices are recognised and more widely promoted. However, there are concerns that the risks of more local control have yet to be fully explored so that undesirable outcomes might be avoided.

The choice of which policies we use to address the problems associated with all psychoactive substances is not a simple one. Not only are responses often expensive and time-consuming, but policies can easily

Drug-related deaths are more likely where people are obtaining drugs of uncertain purity from drug dealers.

be ineffective, have unintended consequences and even be counterproductive. Some of the problems associated with controlled drugs may themselves be produced by aspects of drug policy and its implementation. For example, drug-related deaths are more likely where people are obtaining drugs of uncertain purity from drug dealers, and the high levels of acquisitive crime by people with drug dependence to fund their drug use would not be necessary if heroin were available on prescription, as once was the practice in the UK. While there is a need for effective policies to address the consequences of drug use, it is inescapable that any response incurs costs. It is therefore essential to ensure that these efforts are both cost-effective and, as far as possible, avoid the many unintended costs that can be incurred by inappropriate, ineffective or counterproductive drug policies.

The UK has been seen as a world leader in the development of effective responses to the harm associated with the rapid spread of opiate use. However, in other areas, attempts to improve the UK's drug policies have often struggled to make any headway. While there has been progress in some important areas, for example the expansion of evidence-based treatment for people with drug addictions, and some aspects of the UK's drug problems seem to be gradually lessening, people in the UK still appear more likely to use illicit drugs than people in many other developed countries.

New ways of responding to the issues associated with illicit drug use are necessary.

There are aspects of the current policy that can be built on, but at a time of reduced budgets, increased individual poverty and changing drug markets, we are concerned that UK drug policy may be reaching the limits of what is achievable within current

approaches and with available funding. New ways of responding to the issues associated with illicit drug use are necessary.

THE WORK OF THE UK DRUG POLICY COMMISSION

The UK Drug Policy Commission was established in 2007 as an independent charity, funded principally by the Esmée Fairbairn Foundation, to provide objective analysis of the evidence concerning drug policies and practice.

The Commission has brought together senior figures from policing, public policy and the media, along with leading experts from the medical and drug treatment fields. The Commission's aim has been to encourage the formulation and adoption of evidence-based drug policies through a series of evidence reviews, in which we have sought to involve key stakeholders to enhance the relevance and utility of the findings.

From the outset we decided to focus our efforts on examining domestic policies and interventions within the UK, while recognising many of the global influences underpinning drug policy. We also did not seek to examine the many parallel challenges in the use of other substances such as alcohol, tobacco or prescribed medicines although there are, of course, many similarities.

Each of the countries of the UK has its own drug policy and different mechanisms for responding to the problems associated with drug use and for collecting the information necessary for identifying such problems as well as monitoring policy implementation. These information and management systems are not always consistent, and so it is sometimes not possible to present data for the whole of the UK. Nevertheless we have sought to reach conclusions that can be applied broadly and will be useful for policymakers and practitioners throughout the UK.

Over the course of its work, the Commission has published reviews of the evidence across a range of issues in drug policy, including those relating to recovery from addiction, the families of drug users, drug policy and delivery systems, and approaches to law enforcement and drug control. The reports from these projects are available at www.ukdpc.org.uk.

The guiding principle for the work of the Commission has been to avoid preconceptions and to follow the evidence for what is effective, and to reach conclusions about how policies and interventions might be improved. We have sought to continue to be guided by that principle in the development of this final report. Our aim is that this report will not only be useful for those interested in the issues relating to illicit drug use, but that it will also demonstrate the value of evidence-based approaches to public policy more generally

Throughout the report, we show how policy can make better use of research and evidence in order to produce better results and value for money.

Policy can make better use of research and evidence in order to produce better results and value for money.

We identify where the evidence suggests specific improvements to existing policies can be made, and where it indicates that we should take a different approach altogether.

THE STRUCTURE OF THIS REPORT

In recent years, there have been several highly-regarded and wide-ranging inquiries into UK drug policy that have provided important and detailed conclusions. Among others, these include: the 2000 Police Foundation Independent Inquiry into the Misuse of Drugs Act; the government's Foresight Drugs Futures 2025 project (2005); the 2007 RSA Commission on Illegal Drugs, Communities and Public Policy; the Academy of Medical Sciences' 2008 report "Brain science, addiction and drugs"; and reports from the Advisory Council on the Misuse of Drugs. Parliament has also produced significant reports over the last decade, including the Home Affairs Select Committee's 2002 report and the Science and Technology Committee's 2006 report.⁶

A consistent theme in these reports has been that some policy reform is necessary. While most reform of drug policy will be evolutionary in nature rather than revolutionary, it is worrying that many of these recommendations have gone unheeded. But in addition to the new factors identified above, there is now a wider global recognition that all is not well with drug policy. The UK cannot insulate itself from this debate.

We begin with a review of where we are now, in **Chapter One**. This introduces readers to the current levels and nature of drug use and drug problems in the UK, and to the existing policy responses.

There is now a wider global recognition that all is not well with drug policy. The UK cannot insulate itself from this debate.

Chapter Two provides a different perspective on drug policy. It identifies some of the current barriers that are restricting progress in drug policy, and suggests ways of overcoming these. It evaluates the current approach to making drug

policy, covering all illicit drug use, as well as the way evidence and evaluation are, and are not, used to inform policy making. It suggests a fresh way in which drug policy can be approached.

Building on this, **Chapter Three** looks in more detail at how the approach identified by the previous chapter could be applied in practice. It adds a structure designed to encourage fresh thinking about ways of tackling drug problems. It makes use of the evidence available to evaluate the effectiveness of existing policies and to identify where improvements are needed.

Chapter Four identifies issues in existing systems of policymaking and delivery that could be limiting the introduction of more cost-effective drug policies. It covers scientific advice, policymaking structures, and delivery mechanisms.

Finally, **Chapter Five** draws on the findings of the other chapters to make specific recommendations on how drug policy can evolve over the next decade. It covers the Commission's conclusions on promoting responsible behaviour, encouraging recovery, the laws on drug possession, and how drug policy could be made in the future.

CHAPTER 1

WHERE WE ARE NOW

KEY POINTS

- >The UK appears to have higher levels of drug use than many comparable countries, although overall levels of use have been declining over recent years
- >Drug problems develop for complex reasons, including an individual's genetic/biological make-up, personality traits, personal history and social circumstances
- >The level of harm caused by drug use is dependent on the context in which the drug is used
- >UK drug policy has traditionally been organised under the three pillars of prevention, treatment and enforcement. More recently there has been an increased focus on recovery from dependence
- >While there have been some successes in UK drug policy there are also costs, including unintended consequences.

There is a tendency for people to talk about 'the drug problem' as if it was a simple, coherent issue, yet the picture is far more complex. UKDPC focused its attention on illicit drugs, which are the main focus of UK drug policy, but drawing distinctions among the wide variety of psychoactive substances is difficult (*see Box 1*).

Box 1:

WHICH DRUGS ARE ILLEGAL?

In the UK, the 1971 Misuse of Drugs Act is the principal legislation for controlling certain substances. The Act categorises substances into classes A, B and C, according to their levels of harm; this in turn provides the level of punishment for breaches. The Act also provides a scale of varying levels of severity of control, known as Schedules, which reflect each substance's suitability for medical or research purposes.

It is not the case that possession of substances controlled under the Act is forbidden or prohibited in all circumstances. Even those subject to the strictest level of Scheduling may still be used under a Home Office licence for research. Others have Schedules that allow them to be used medically: for instance opiates, which are categorised as class A, are widely employed for pain relief.

Therefore, while the term 'illegal drugs' is commonly used, it can be misleading. It is the way the drugs are produced, supplied and possessed, rather than the drugs themselves, that may be illegal. A further problem is that the term 'illegal' does not cover the harmful use of prescribed or other pharmaceutical drugs, nor the use of new psychoactive drugs that are not (yet) subject to legal control (known as 'legal highs').

An alternative, which we will use to describe all of these psychoactive substances, except when used medically or for research, is 'illicit drug use'. The substances themselves can be described as 'illicit drugs' when they have been produced, trafficked, or possessed against UK or international laws.

EXTENT AND NATURE OF DRUG USE

Estimating the number of people who use illicit drugs is not straight-forward.⁷ Nevertheless, in the UK we have better sources of information on numbers of drug users than most other countries. These, despite limitations, provide some robust information on trends in use over recent years.

While any substance use may cause significant problems, in the UK problem drug use is most often defined as heroin and/or crack cocaine use.

In thinking about drug use and associated problems people often distinguish between ‘problem drug use’ and ‘recreational drug use’. While any substance use may cause significant problems, in the UK problem drug use is most often defined as heroin and/or crack cocaine use, which is often

associated with dependence or addiction to these drugs and harmful consequences for health and crime problems.*

So-called ‘recreational’ drug use, on the other hand, generally involves less frequent use often in nightlife settings and has some similarities to alcohol use. In these circumstances it often involves ‘club drugs’ such as powder cocaine, ecstasy, amphetamines, ketamine and the newer drugs, sometimes called ‘legal highs’. Cannabis is also most often used recreationally and in a wider range of settings, and is sometimes also used for therapeutic purposes.

In addition, there is the group of drugs that are termed ‘enhancers’⁸, which are used to enhance cognitive or physical performance. Of course caffeine has been in widespread use for many years to help people keep going longer, but in the US there is increasing concern about the use of drugs such as methylphenidate (Ritalin) as a study aid, and in the field of sport the use of steroids and other methods of enhancing performance is a constant issue worldwide. These distinctions are not absolute. There is overlap between the groups, and all of these substances can cause problems of varying levels of severity in different individuals and circumstances.

*The definition tends to vary from country to country as it is a term of convenience used to define the most common and most harmful drugs in that country to provide a focus for policy. In Scotland it is defined as problem opiate or benzodiazepine use, in Northern Ireland where rates of drug use are lower it includes opiates and any cocaine use, while in Wales it is long duration or regular use of opioids, cocaine powder and/or crack cocaine.

Levels of problem drug use

Until recently, the main focus of UK drug policy has been on the most severe end of the spectrum of drug problems: problematic heroin and/or crack users and injecting drug users. Estimating the numbers of people who have this level of problem is particularly difficult since the chaotic nature of the lifestyle of many of them means they are not included in most general population surveys. Other indirect methods of estimation, which make use of the fact that many people in this group have contact with treatment or the criminal justice system at some time, have to be used. In the UK, such methods have been developed and used regularly over recent years to give estimates of different types of problematic drug use.

Within the UK the patterns of problem drug use vary between the constituent countries, as illustrated in *Table 1* which shows the most recent and most comparable estimates of problematic use by country. Northern Ireland has much lower rates of problem drug use, particularly of opiate use, and their concerns are more with powder cocaine use. Scotland has higher rates of problematic use and also has had a greater problem with misuse of benzodiazepines, which is included in their estimates rather than crack use.

Table 1:
**ESTIMATED PREVALENCE OF PROBLEM AND INJECTING DRUG USE
 ACROSS THE UK
 ADULTS AGED 15 TO 64 YEARS**

Source: UK Focal Point on Drugs *United Kingdom Drug Situation 2011 edition*

Country	Problem Drug Use		Injecting Drug Use	
	Estimate	Rate/1000	Estimate	Rate/1000
England	306,150	8.93	103,185	3.01
Northern Ireland	1,395	1.28	470	0.41
Scotland	55,328	16.16	23,933	6.99
Wales	16,389	8.46	5,524	2.85
United Kingdom	379,262	9.31	133,112	3.27

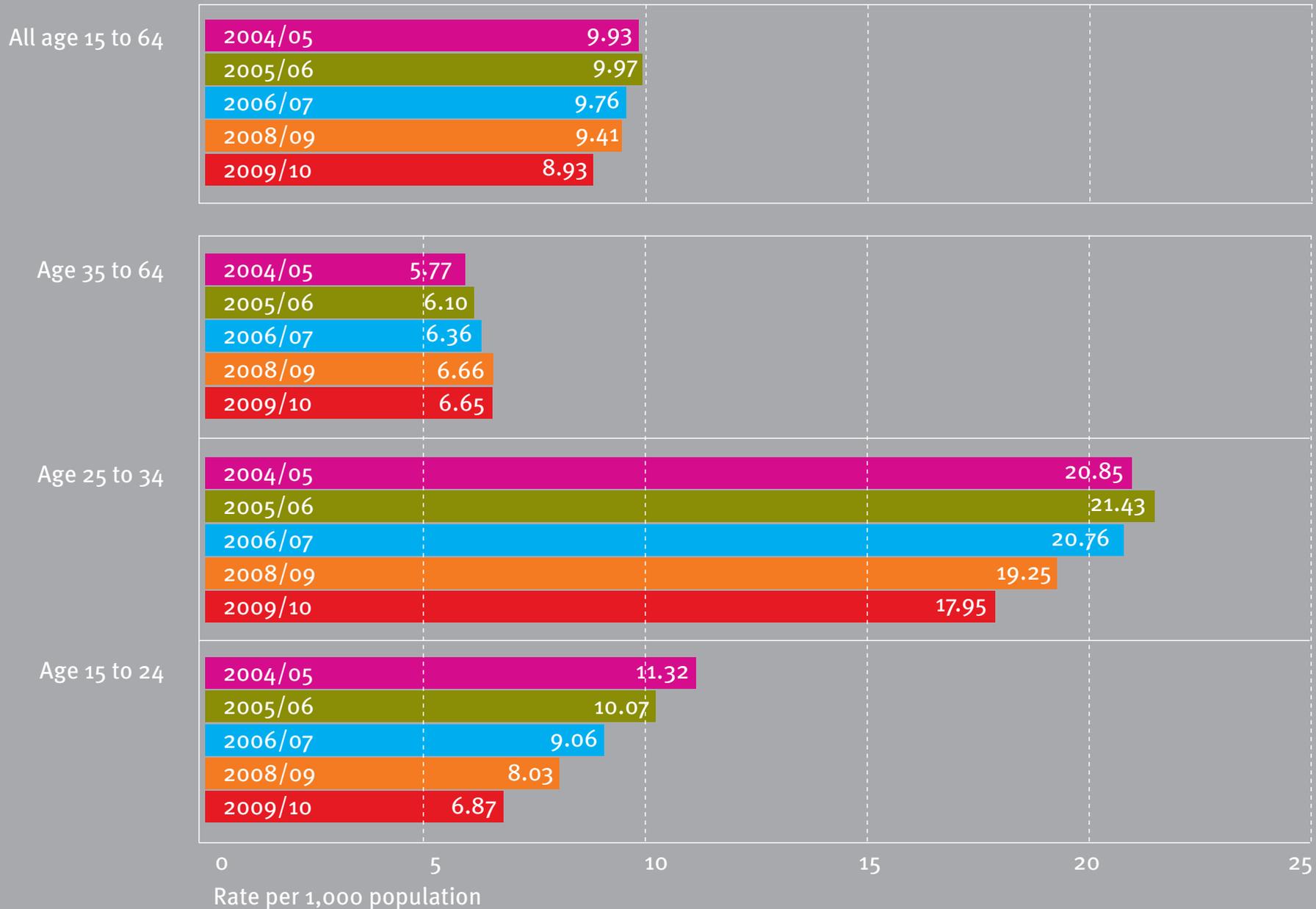
Although comparisons are difficult, the available data suggest that the UK has relatively high rates of problem drug use. For example, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports that recent national estimates of problem opiate use tend to vary across Europe between one and eight cases per 1,000 population aged 15-64.⁹ The most recent estimate for England in 2009/10 was 7.7 per thousand. However, the EMCDDA report also provides some comparative rates for other countries, with Russia and Ukraine having markedly higher rates than England (16 per thousand and 10-13 per thousand respectively) with rates for Australia (6.3), Canada (5.0) and the USA (5.8) all being slightly lower.

In England, the prevalence of injecting drug use and of problem drug use have recently started to decline due to a reduction in problem opiate use. Since the decline in problem drug use is driven by a decrease in both the prevalence rate and number of drug users in the younger age groups, it appears the number of new users is also decreasing (see Figure 1). The other side of this coin is that there is a growing cohort of older dependent users with changing needs associated with aging and the consequences of long-term opiate use.

The UK has relatively high rates of problem drug use. Estimates of problem opiate use for England in 2009/10 was 7.7 per thousand.

In Scotland, problem drug use is taken to include problematic use of benzodiazepines. Some trend data is available and the decrease in problem drug use seen in England is not replicated: the number of users appears to be approximately stable. Wales and Northern Ireland have only so far had one estimate of problem use so there is no robust information on trends available.

Figure 1:
TRENDS IN PROBLEM DRUG USE IN ENGLAND BY AGE GROUP¹⁰
 Adults aged 15 to 64 years. Rates per 1,000 population



Cannabis: the most commonly used drug

Cannabis is much the most commonly used illicit drug in the UK, as in most of the world. In England & Wales in 2011/12, 31% of adults¹¹ said they had used cannabis at some time in their lives, 7% had used it in the last year and 4% in the last month. In Scotland figures are similar but slightly higher with 8% reporting use of cannabis in the past year.¹² Northern Ireland has slightly lower rates with 5% of adults reporting last year use of cannabis.¹³ In both these cases the figures relate to 2010/11. Across Europe prevalence of last year use of cannabis varies widely, ranging from less than 1% to about 14%.¹⁴

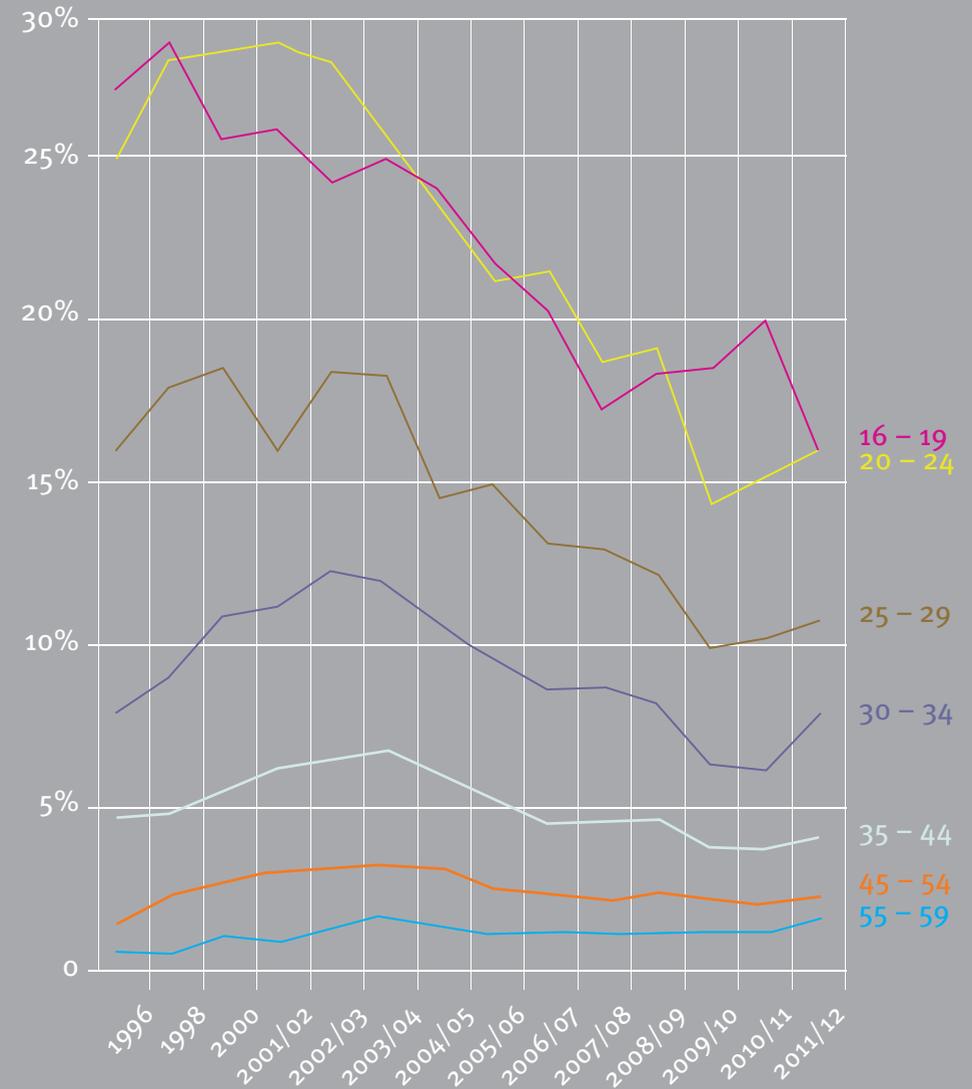
Cannabis is much the most commonly used illicit drug in the UK. In 2011/12, 31% of adults said they had used cannabis at some time in their lives.

Cannabis use in the UK has been declining for several years, and the decline has been greatest in younger age groups, although recently there has been a levelling off (see Figure 2).¹⁵ The decline in cannabis use is seen in surveys of both schoolchildren and adults and also appears to be occurring, although less markedly, in Scotland, as well as in England and Wales. In other European countries trends vary. Data from ESPAD (the

European School Project on Alcohol and other Drugs: a survey of schoolchildren conducted across much of Europe) also shows the marked decline in prevalence of cannabis use among 15 to 16 year old schoolchildren in the UK between 2003 and 2011, which is also seen in Ireland and Italy. However, in the Netherlands, Portugal and Sweden, prevalence is more or less stable over the same period.¹⁶

Figure 2:
TRENDS IN CANNABIS USE IN THE LAST YEAR IN ENGLAND & WALES
BY AGE GROUP

Source: Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales

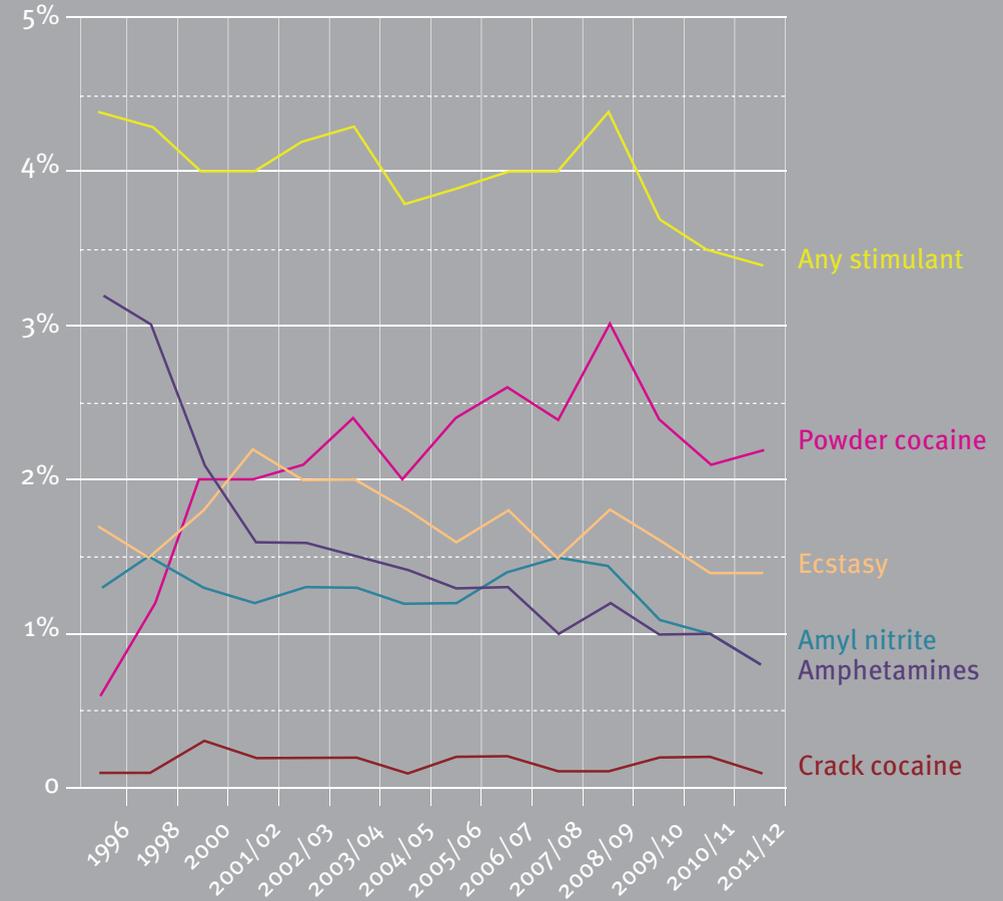


The wide range of other drugs used

The UK also has relatively high rates of use of other ‘recreational’ drugs, with new drugs creating a particular challenge for policymakers.¹⁷ Most of these drugs are stimulants and are used alongside alcohol in nightlife settings, such as clubs, bars and parties. Assessing the extent of, and trends in, use of such ‘party drugs’ is complicated by people using more than one type of drug (so-called ‘poly-use’), and also switching drugs depending on quality and availability.¹⁸ For example, *Figure 3* shows trends in use of the most common stimulant drugs in recent years among adults in England and Wales. While cocaine use rose between 1996 and 2008/09, at the same time amphetamine use declined and ecstasy use remained more or less stable. As a result, overall stimulant use has remained essentially steady.¹⁹

Figure 3:
TRENDS IN LAST YEAR STIMULANT USE IN ENGLAND & WALES
ADULTS AGED 16 TO 59 YEARS

Source: Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales



In recent years, the quality (ie purity) of the stimulant drugs on the market has been declining, and in an illicit market it is impossible for the user to know what they are buying.

In recent years, the quality (ie purity) of the stimulant drugs on the market has been declining, and in an illicit market it is impossible for the user to know what they are buying. Partly in response to this, novel drugs have been appearing in this market, including a range of new synthetic substances. These drugs initially have the appeal of being available legally, via the internet or 'head shops', and, reportedly, with consistent quality, at least until legal controls are applied to restrict their sale. The

most well-known of these was mephedrone ('meow meow') which very rapidly increased in prevalence so that in 2010/11 1.4% of adults said they had used it in the past year. Mephedrone, along with a number of drugs with a similar structure, was controlled in 2010. In 2011/12 the proportion of adults who reported using mephedrone had declined slightly, to 1.1% of the population, but a wide range of other substances have come on the market. Studies of groups of drug users have also indicated that since mephedrone became a controlled drug, its use may have decreased but in many cases users have simply switched to other substances, such as ecstasy.²⁰

The majority of people who use these drugs do so only occasionally and report few problems. Nevertheless, there are some users attending clinics for help. Problems that can arise include the development of symptoms of dependence and for some there are associated mental and physical health harms. For example, on rare occasions their use, particularly mixed with other substances, may cause death; ketamine is linked to bladder problems; and the uncertainty about what is being taken can lead to overdose and other problems. The often uncontrolled mixing of drugs and alcohol is a particularly important potential cause of harm.

As well as new manufactured synthetic substances which are coming onto the market at an increasing rate (17 between January 2011 and March 2012 in the UK),²¹ there are many other legal and controlled substances that some people use and which can sometimes cause problems. These include steroids and other enhancers, khat, prescription and over-the-counter medicines. The inhaling of various volatile substances, such as glues, gas and solvents, is the second most common type of drug use reported by 11 to 15 year olds (in 2011, 3.5% reported it in the last year) and for those aged 11 to 13 it is the most common.²² All of these substances pose different challenges for drug policy.

Drugs and diversity

Another aspect of the diversity of drug use is the variation in the extent of drug use among different groups of people. In general men are more likely to use illicit drugs than women and young adults are more likely to do so than older ones.²³

The extent and nature of drug use also varies by ethnicity. There is considerable diversity within Black and Minority Ethnic (BME) communities although most surveys do not have large enough samples or collect the relevant information to be able to provide robust evidence about drug use in many of these groups.

However, a UKDPC evidence review²⁴ found that, in general, overall drug use is lower among minority ethnic groups than among the White population, although reported drug use prevalence was highest among those from Mixed Ethnic backgrounds in a number of studies, largely as a result of high levels of cannabis use. However, when the younger average age of this group was taken into account, their drug use levels were similar to those in the White population. Lowest overall levels of drug use are reported by people from Asian backgrounds (Indian, Pakistani or Bangladeshi).

Cannabis is the most commonly used drug across all ethnic groups and age groups. Rates of class A drug use are higher among people from White and Mixed Ethnic backgrounds than among other ethnic groups. Poly drug use is most common among White groups, compared with other ethnic groups. In some ethnic communities, khat use is particularly prevalent. Although khat use is legal, concerns have been raised regarding its potential negative health impacts.

The types of drugs that cause individuals to seek help also vary between different communities. Among the Asian community the most common reason for seeking treatment is problematic use of heroin. Asian drug users also appear to be more likely to use smoking or chasing as their method of administration while those in White communities are more likely to inject drugs. Drug users from Black groups are most likely to seek treatment for crack cocaine and cannabis use.

Some lesbian, gay, bisexual and transgender (LGBT) people have a lifestyle that incorporates high rates of illicit drug use. A UKDPC review of the evidence²⁵ indicated that drug use among LGBT groups is higher than among their heterosexual counterparts.* 'Recreational' drug use is comparatively high among LGBT groups, and thus they may use new drugs before they are widespread in

*This holds true even after the generally younger age distribution of the LGBT population compared with the general population is taken into account, and for both men and women.

the general population. LGBT people, particularly gay men, may also be at risk of misusing other drugs, such as steroids and Viagra. Some types of drug use may also be associated with risky sexual behaviour, including exposure to HIV infection. Strong links have been reported between Viagra use and sexual risk, with Viagra used to counteract negative physical effects of other stimulant drugs.

It is important to recognise that LGBT people are not a homogeneous group, but the published evidence often fails to distinguish between sub-groups or has a very narrow focus on one particular group. In particular, it should be noted that most of the evidence available relates to gay men only. Gay men report higher overall rates of use of drugs than lesbian women, largely due to higher rates of stimulant use, particularly amyl nitrite ('poppers'). Cannabis is the most commonly used drug among lesbian women, with prevalence rates similar to those reported for gay men.

There are other groups within the population who may have particular types of drug problem, but because evidence is not collected in such a way as to allow their identification their problems remain hidden. For example, some disabled people may be at increased risk of drug problems since inequality, disadvantage and feelings of isolation may exacerbate drug use and drug problems. In addition some people with particular health problems find cannabis use therapeutic. However, at the moment routine data sources do not allow the extent of drug use among such groups to be identified.

FACTORS ASSOCIATED WITH DRUG USE AND DRUG PROBLEMS

For most people illicit drug use is something that happens in teenage years or young adulthood and which they 'grow out of'. More than one in three adults say they have used an illicit drug at some time in their life but less than one in 10 report (8.9%) having done so in the past year and only one in 20 (4.8%) in the past month.²⁷ Although a few people may continue to use drugs throughout their lives, for most people illicit drug use is something that naturally ceases and was most likely an enjoyable phase that was largely unproblematic. Therefore, it is important to consider not only the reasons people choose to use drugs in the first place but also why, for some people, this use becomes problematic. Both involve a complex interplay of factors including social, environmental, genetic and biological factors.

Factors underpinning drug use and the development of drug problems

There is much debate about whether drug addiction is a disease, a moral failing or a social construct. In the end there is probably no one single answer, just as there is not a single type of drug problem. Both non-problematic and problematic drug use arise from a complex interaction of a variety of factors, some of which may increase risk while others are protective, with the mix varying from individual to individual.

For example, a recent evidence review found that the likelihood of initiating substance use is related to: personality traits such as propensity for sensation-seeking, self-control and extroversion; mental health factors such as self-esteem and depression; social factors, such as peer influence and social activities; parenting styles and levels of parental monitoring; family breakdown and negative life events; and environmental factors, such as access to drugs.

There is much debate about whether drug addiction is a disease, a moral failing or a social construct. In the end there is probably no one single answer.

Continued use and the progression to problematic use and addiction depend on many of the same things. But it also depends on the quality of the experience of use, which is influenced by biological factors relating to the reward receptors in the brain, as well as the circumstances in which use takes place.²⁸ The extent of social and material support available will also have an impact, with lack of support increasing risk and positive experiences sometimes able to mitigate some of the worst effects. Hence the strong relationship between disadvantage and social dislocation and drug problems.²⁹

Researchers are increasingly paying attention to this interplay between the individual and environmental factors that can influence the development of drug problems for both the individuals and society, and to how these vary over time. For example, a recent review of the evidence concerning both risk and protective factors concluded that an individual's vulnerability to drug use and drug problems results from a mix of genetic, neurobiological and behavioural factors. But these predisposing factors are also dependent on external factors, such as social and environmental experiences, for such behaviour to occur.³⁰ The experience of drug use itself may also have a role in determining whether the user continues to take drugs.

Since the adolescent brain is still developing it may also be more susceptible to long-term damage from substance use, such as reduced IQ.

There is growing evidence to suggest that the immaturity of the brain in adolescence leads young people to be impulsive, with tendencies to ignore the possibility of negative consequences, and prone to experimentation and novelty-seeking. At the same time it appears that they may get a greater, more pleasurable social effect from alcohol and other substances than older people. These differences may make them

more likely to try, and then continue to use substances. Since the adolescent brain is still developing it may also be more susceptible to long-term damage from substance use, such as reduced IQ.³¹

This evidence of risk and protective factors applies to substance use generally, and not just illicit drug use. It also supports the notion of a common liability to addiction, rather than the ‘gateway hypothesis’ that sees the development of addiction problems as a sequential process of stages where use of a ‘soft’ drug, usually cannabis, leads an individual on a trajectory to addiction to ‘hard’ drugs. A recent review of the evidence makes it clear that the gateway theory is not supported by empirical evidence, as the sequencing of substance use is variable and can most readily be explained by common underlying factors, rather than by any deterministic process of progression. The gateway hypothesis also includes no mechanism for explaining why some people progress from use to addiction.

In contrast, the theory of a common liability to addiction is well supported by the evidence, including emerging findings relating to the genetic and neurobiological underpinnings of addiction. It therefore provides a much better basis for developing prevention and intervention programmes.³²

Understanding why people use drugs is also important for developing effective prevention programmes. People use drugs for a wide range of reasons. For example, a study of young poly drug and alcohol users found the most commonly selected reasons were: relaxation (given by 97% of participants); intoxication (96%); to keep awake while socializing (96%); to enhance an activity (88%); and to alleviate depressed mood (87%).³³ Similarly a study of long-term cannabis users in Australia³⁴ found the most common reasons given for use were for relaxation or relief of tension (61%) and enjoyment or to feel good (27%). Studies in people with different medical conditions³⁵ have reported they use drugs for coping with a range of symptoms and conditions, including multiple sclerosis, neuropathy, chronic pain, loss of appetite, nausea, anxiety and depression.

This variety of factors is discussed further in Chapter Two, with reference to its implications for policy.

The range and nature of drug-related harms

Another question is whether different substances are more or less likely to cause harms. As will be discussed further in Chapter Two, there have been a number of attempts to compare the harms from different psychoactive substances, and although the exact rankings vary, studies consistently find that the legal substances, alcohol and tobacco are associated with more harm than many illicit substances. This is partly due to the greater number of people using these substances, but that does not account for all of the differences.

A recent World Health Organisation study sought to estimate the amount of disease in different parts of the world that was caused by a range of major risk factors, in 2000. This estimated that the proportion of the total burden of disease in the Western European region, which includes the UK, that was attributable to tobacco was 12.1%, to alcohol was 6.6% and to illicit drugs was just 2.1%.³⁶ This suggests that our policy responses to licit and illicit substances may be disproportionate and inconsistent.

It is also clear that the extent of any harm (or indeed benefit) from using a substance is very dependent on context. For example, heroin, as pharmaceutical diamorphine, provides huge benefits and cost-effective pain relief for many ill people when prescribed by doctors. But the same drug sourced from criminal gangs and used by a vulnerable individual may be associated with a wide range of harms to both the individual user and to wider society.

This complexity is also reflected in the wide range of harms that can be related to drug problems. The UKDPC report Refocusing Drug-related Law Enforcement to Address Harms includes a harm matrix (*Table 2*) which illustrates the breadth of these harms by considering:

- Harm at different levels: individuals; families; neighbourhoods, national and international level
- Harms from use, supply, production, and the unintended consequences of interventions; as well as
- Different types of harms: health; social/structural; economic; environmental.

Table 2:
SUMMARY MATRIX OF EXAMPLES OF DRUG RELATED HARMS AT DIFFERENT LEVELS

Source: UKDPC, 2009: *Moving towards Real Impact Drug Enforcement*

Individual (user or dealer)	Family and peers	Local community	National	International
HEALTH HARMS		HEALTH HARMS		
Physical/diseases Mental Overdose/death Risks from cutting agents Risk of accidents	Poor child welfare Mental/emotional stress More likely to use drugs	Disease transmission Normalisation of drug use and easy access to drugs	Disease transmission Normalisation of drug use and easy access to drugs	Harms caused by crop spraying Risk of death for drug mules Production health risks
SOCIAL/STRUCTURAL HARMS		SOCIAL/STRUCTURAL HARMS		
Spiralling criminality Impact of CJS (e.g. time in prison) Victim of crime/ intimidation Exclusion and vulnerability Loss of support networks Poor life skills Poor/no accommodation Distrust of authority	Victim of crimes (e.g. theft) Fear of safety Domestic violence More likely to commit crime Exclusion Family breakdown Poor life chances Negative role model Poor parenting Loss of confidence in authorities	Victim of crimes (e.g. theft) Fear of safety Domestic violence More likely to commit crime Exclusion Family breakdown Poor life chances Negative role model Poor parenting Loss of confidence in authorities Fear of crime/anti-social behaviour (ASB) Victim of crime/ASB Attraction or recruitment to criminal life Related crime (prostitution, gangs, corruption etc.) Strain on local services 'No go' areas Local reputation Lack of social cohesion Loss of amenities Corruption	Fear of crime Increased crime statistics Growth in organised crime Underclass of vulnerable people Lack of social cohesion Corruption Loss of respect for law Loss of confidence in authorities Strain on NHS Overcrowded prisons	Conflict/violence Growth in organised crime Exploitation of vulnerable people Corruption Destabilised communities/governments Loss of respect for law/ confidence in authorities
ECONOMIC HARMS		ECONOMIC HARMS		
Unemployment Poverty/debt Poor prospects	Poverty/debt Loss of breadwinner Cost of being victim of crime Cost of help/support for user	Cost of help/support services Cost of crime Cost of enforcement and the criminal justice system Property devalued Barrier to regeneration Loss of business Increased unemployment	Cost of help/support services and welfare Cost of crime Cost of enforcement/CJS Loss of tax revenue	Cost of help/support services Cost of crime Cost of enforcement/CJS Loss of tax revenue Dependency on drug revenues stifling economic development/investment
ENVIRONMENTAL HARMS		ENVIRONMENTAL HARMS		
	Degradation of neighbourhoods, e.g. discarded paraphernalia Hazards from illicit production, e.g. labs/farms			Deforestation Chemical waste

A UKDPC study estimated that at least 1.5m adults in the UK are affected by a relative's drug use and the costs amounts to about £1.8 billion a year.

Quantifying and putting a cost on such diverse types of harm is methodologically challenging. Nevertheless, the annual cost to society of class A drug use in England and Wales has been estimated at over £15bn, mostly through drug-related crime.³⁸ The equivalent estimate for Scotland is £3.5 billion.³⁹ Furthermore a UKDPC study estimated that at least 1.5m adults in the UK are affected by a

relative's drug use and the costs of the harm they experience as a result amounts to about £1.8 billion a year.⁴⁰

Such a broad range of harms clearly requires a multi-faceted response from a wide range of agencies. There are no simple solutions and drug policy and the debate around it need to reflect this complexity.

Two key areas which have been the focus of much drug policy because of their major contribution to the above costs are drug-related crime and health harms.

The link with crime

Drug use is linked to crime in two main ways. Firstly, there are the drug offences, or crimes against the drug laws: drug possession, supply, production and trafficking. This is where organised crime is involved as drugs represent an important source of income and a commodity for criminal gangs both in the UK and internationally, providing them with the strength to undermine communities as well as public and private institutions. Internationally the trade in drugs has led to appalling levels of violence in some places on drug-supply routes, for example in Mexico, where organised crime is estimated to have killed 12,903 people in the first nine months of 2011.⁴¹

Then there is also the crime committed by drug users, either to obtain money or drugs to feed their addiction, mainly acquisitive crime such as burglary or shoplifting, but also crime committed while under the influence of drugs, such as disorder and vandalism.

Identifying the extent of both these types of drug-related crimes is difficult, since they depend on the crimes being notified to the police and, in the case of crime by drug users, being able to attribute the offence to drug use.

The number of drug offences recorded is very much a reflection of how much time and effort the police devote to dealing with drugs. The most recent published figures for drug offences in England & Wales cover the financial year 2011/12. They show a total of 229,103 drug offences: 6% of all crimes recorded in the period.⁴² As can be seen from *Figure 4*, the majority of these offences, 86% in 2011/12, relate to drug possession, mainly possession of cannabis (70% of all drug offences). In 2011/12 there were 77,914 cannabis warnings and 15,930 penalty notices for disorder relating to cannabis issued.⁴³

The overall number of drug offences increased markedly up to 2008/09 but has since stabilised. However, the increase has been greatest in respect to cannabis possession, the numbers of which have almost doubled since 2004/05. This

illustrates the fact that drug offences are a measure of the level of activity by police rather than reflecting the extent of the problem, since over this period the prevalence of cannabis use has been declining.

The number of drug offences recorded is very much a reflection of how much time and effort the police devote to dealing with drugs.

The vast majority (93%) of those convicted for importing or exporting drugs were sentenced to immediate custody.

These figures are dominated by the large number of warnings and penalty notices for disorder associated with cannabis that do not come to court. For those offences that do come to court, the sentencing statistics provide information on the penalties that are applied for those

convicted of different types of drug offences and for offences relating to drugs in different classes.⁴⁵

Table 3 shows that in England and Wales a fine is the most common punishment, used for about two-fifths of those convicted for drug offences. About a fifth (21%) are given community sentences, and 16% an immediate custodial sentence. This divide reflects the fact that possession offences make up over two-thirds (70%) of the total in 2011. The vast majority (93%) of those convicted for importing or exporting drugs were sentenced to immediate custody as were almost half of those sentenced for trafficking offences, such as supply or possession with intent to supply, but this was true for only 3% of those convicted of possession offences. They were most likely to receive a fine (52%) or a community sentence (19%) or another punishment (24%), usually a conditional discharge (this excludes summary offences, of which there were about 2,000 in 2011).

Table 3:

DRUG OFFENDERS CONVICTED AND SENTENCED AT ALL COURTS, ENGLAND AND WALES 2011

Source: Criminal Justice Statistics Quarterly Update to December 2011. Supplementary tables Vol 5.

Type of disposal	Import/export		Trafficking		Possession		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Immediate custody	618	93%	7740	46%	1247	3%	76	13%	9681	16%
Suspended sentence	29	4%	3376	20%	655	2%	125	21%	4185	7%
Community sentence	6	1%	4156	25%	8136	19%	194	32%	12492	21%
Fine	7	1%	974	6%	21862	52%	108	18%	22951	38%
Other disposal	5	1%	489	3%	10167	24%	105	17%	10766	18%
Total sentenced	665	100%	16735	100%	42067	100%	608	100%	60075	100%

Sentences vary due to the class of drug involved, which is to be expected, but this is most marked when it comes to importation and trafficking. In 2011 98% of those convicted of unlawful importation or export offences relating to a class A drug received an immediate custodial sentence. This compares with 86% for class B drugs and 61% for class C. The equivalent figures for trafficking offences were 76% for class A drugs, 31% for class B and 16% for class C. However, there was less difference over possession: 45% of those convicted of possessing a class A drug received a fine compared with 54% of those possessing class B drugs and 49% of those caught with class C drugs, while 27% of class A possession cases were given a community sentence compared with 17% for class B and 13% for class C.

In 2009/10 Black people were seven times more likely to be stopped and searched (per 1,000) population than White people; the negative impact on community relations is well documented.

Stop and searches for drugs by the police are responsible for about half of all stop and search activity. In 2010/11 there were 587,790 stop and searches for drugs in England and Wales out of just over 1.2 million in total.⁴⁶ Of these, only 7% resulted in an arrest. But in 2009/10 Black people were seven times more likely to be stopped and searched (per 1,000 population) than White people,⁴⁷ and the negative impact that this can have on community relations is well documented.⁴⁸

As at 30th June 2012, there were 12,314 people in prison for drug offences, 15% of the total prison population.⁴⁹ Most of these (87%) were sentenced prisoners, ie people who had been convicted and given a prison sentence rather than people held on remand while awaiting trial.

It is much more difficult to estimate how many offences are carried out by people with drug addictions in order to obtain drugs or while under the influence of them, and such estimates can often be overstated.⁵⁰ Many offenders are drug users, but just because someone has used drugs does not mean that their offending is caused by drug use; and it is also likely that someone who is predisposed to offend is also predisposed to use illicit drugs.

Nevertheless, many people with opiate and crack addiction do resort to crime to enable them to buy drugs, but they are not the only people committing acquisitive crimes, and there are many other common offences that they very rarely commit. The Arrestee Survey, which was undertaken in a random sample of custody suites throughout England and Wales between 2003 and 2006, showed that while the

most common reason for arrest in 2005/06 was assault (29% of all arrestees) only 4% of this group were considered problem heroin or crack users (ie using heroin and crack at least once a week). And while 9% of arrests were for criminal damage, only 1% of these used heroin or crack at least weekly. By way of contrast, shoplifting accounted for 10% of arrests, and burglary for 8%, while the proportion of arrestees for these offences who used heroin and crack at least once a week was 45% for shoplifting, and 23% for burglary.⁵¹

We need to keep the debate about the link between drugs and crime in perspective.

So while drug problems may be considered an important driver of some types of crime, particularly lower-level acquisitive crimes, these make up quite a small proportion of offences dealt with by the criminal justice system. We need therefore to keep the debate about the link between drugs and crime in perspective.

Health harms

A recent report attempted to summarise the range of health harms associated with different licit and illicit drugs.⁵² Some of the most severe are considered here.

Each year there are in the region of 2,000 drug-related deaths in the UK, although the exact number depends on how drug-related deaths are defined. Using the EMCDDA definition*, there were 1,930 drug-related deaths in the UK in 2010 (a decrease of 7.7% from 2,092 in 2009)⁵³. Decreases were also evident in data sources using other definitions. As can be seen in *Table 4*, opiates are the main drugs mentioned on death certificates and this has been the case for the last 10 years. Between 2009 and 2010 there was a sharp fall in ecstasy-related deaths (72%) and deaths in which cocaine was mentioned fell by nearly one quarter. It has been suggested that this may be related to the sudden increase in mephedrone use during this time, as well as reduced availability and hence lower purity of ecstasy and cocaine.

**Identifying and deciding what constitutes a drug-related death is difficult and different definitions are used in different places. To some extent the numbers identified depends on whether coroners and doctors certifying the deaths consider and investigate for the presence of drugs. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illegal drug. The Office for National Statistics uses two definitions for reporting drug-related deaths in England and Wales. One includes all deaths relating to drug poisonings whether accidental or intentional, which includes legal drugs. They also report deaths from drug misuse, which are those where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the Misuse of Drugs Act 1971 are involved.*

The average age of death has risen in recent years from 32 in 1996 to 39 in 2010, which is consistent with the increasing age of opiate users. Deaths associated with volatile substance abuse (VSA), that is abuse of gas and solvents, also occur, although these have been declining in recent years, particularly among people aged under 15. In 2008 there were 36 VSA deaths in the UK down from a peak of 152 in 1990.⁵⁴

Table 4:
DRUG MENTIONS ON DEATH CERTIFICATES IN THE UNITED KINGDOM,
2002 TO 2010

Source: UK Focal Point report, 2011

Drug	Year									
	2002	2003	2004	2005	2006	2007	2008	2009	2010	
Heroin/ Morphine	1,118	883	977	1,043	985	1,130	1,243	1,210	1,061	
Methadone	300	292	300	292	339	441	565	582	503	
Cocaine	161	161	192	221	224	246	325	238	180	
Amphetamine	55	41	47	57	55	62	68	46	50	
Ecstasy	79	66	61	73	62	64	55	32	9	
Diazepam**	356	282	217	205	186	223	489	300	315	
Temazepam	89	114	87	55	55	56	55	48	38	

**A revised data collection form was introduced in Scotland in 2008 which has resulted since then in more specific drugs being identified than in previous years.

One of the key times when drug users are at risk of overdosing on opiates is when they are released from prison, probably as a result of loss of tolerance. A study of prisoners released in 1999 found that in the week following release they were about 40 times more likely to die than people in the general population, and 90% of the deaths in this period were from drug-related causes.⁵⁵ There is similarly an elevated risk of death immediately after leaving treatment.⁵⁶

Those who inject drugs face an array of potential harms. Infections are common: about one-third of injecting drug users report having symptoms of a bacterial infection (such as a sore or abscess) from injecting themselves in the past year. These include infections with a range of common bacteria, such as *Staphylococcus aureus*, that can cause severe illnesses and since 2000 there have been 163 cases of wound botulism, 93 of *Clostridium novyi* infection, 52 confirmed cases of anthrax and 35 of tetanus associated with injecting drug use in the UK.⁵⁷

Injecting drugs also carries a high risk of transmission of a number of blood-borne viruses, most commonly Hepatitis B and C and also HIV. The prevalence of HIV among those who have injected drugs remains comparatively low in the UK: in 2010 the HIV prevalence among injecting drug users (IDUs) in the UK was 1.1%. There is some evidence that on-going HIV transmission amongst IDUs within the UK may be somewhat higher than a decade ago, and in particular this may be increasingly amongst those who started injecting recently.⁵⁸

Around one-half of those in the UK who inject drugs have been infected with hepatitis C and one-sixth with hepatitis B. However, sharing needles and syringes (the main way these infections are transmitted) is lower than a decade ago, although one-fifth of people who inject drugs continue to share.

People who use drugs and alcohol have an increased likelihood of mental health problems, and vice versa. In a survey of adults living in private households in Great Britain in 2000 people with symptoms of common mental disorders, such as anxiety and depression, were more than twice as likely to have used drugs in the last month as those without (12% compared to 5%), and to have signs of drug dependence. There was also a significant association between drug dependence and probable psychosis, although the numbers with that diagnosis were very small.⁵⁹

People who use drugs and alcohol have an increased likelihood of mental health problems, and vice versa.

Similarly a study of people attending community mental health and substance misuse services found that 31% of those attending reported using drugs in the past year and 75% of those attending a drug service had a psychiatric disorder in the past year.⁶⁰ However, it is not clear whether there is any causal relationship between the two and if so how much and in what direction.

Despite a marked increase in the prevalence of cannabis use in the latter part of the last century, there was no similar increase in psychotic disorders.

There has been particular concern about the relationship between cannabis use and psychotic disorders, such as schizophrenia. While there is strong evidence that cannabis use may be associated with transient psychotic symptoms, such as hallucinations and paranoid delusions, the strength of the relationship between cannabis use and the development of serious mental illness is still the subject

of debate. Despite a marked increase in the prevalence of cannabis use in the latter part of the last century, there was no similar increase in psychotic disorders. Nevertheless, recent reviews of the evidence⁶¹ indicate that cannabis use most probably does increase the risk of psychosis, although this is an increase in what is overall a very low risk, with a strong genetic component. However, the reviews found the evidence was weak for a link to affective disorders, such as depression. It also appears that the risk is related to the use of larger amounts of cannabis and early initiation. Since adolescence is a period of rapid brain development this may make young people particularly vulnerable.⁶²

However, the picture is also complicated by the fact that cannabis contains a mix of psychoactive substances and while some, particularly THC (tetrahydrocannabinol), appears to increase the risk of psychotic symptoms, another one, CBD or cannabidiol, may be protective and be of benefit in treating psychotic symptoms.⁶³ In general the newer varieties of herbal cannabis have two to three times more THC than those available 30 years ago but the balance between THC and CBD also varies within different strains of cannabis and this may further complicate the picture.

There are also a wide range of problems that may be associated with 'recreational' use of substances. Some of these relate to the individual susceptibility and some to the specific action of the drugs, for example the potential for serious bladder problems resulting from ketamine use. Other problems arise from the context in which the drugs are taken and how they are taken, for example the potential

harms that may be associated with the smoking of cannabis, which are the same as or greater than for as smoking tobacco.⁶⁴ Another important factor is whether the drugs are mixed with other drugs or alcohol; when cocaine is taken with alcohol, it leads to the formation of cocaethylene which is more harmful than the substances on their own. In addition some of the cutting agents used to bulk out some drugs are themselves harmful, eg phenacetin has been used to cut cocaine and is suspected to be carcinogenic.⁶⁵

CURRENT POLICY RESPONSES

We will now briefly describe the structure of policy that responds to these challenges. However before looking in detail at the ways in which we approach drug policy, the term itself should be clarified: *see Box 2.*

Box 2:

WHAT IS DRUG POLICY?

In the traditional sense, **drug policy** is about dealing with problems directly associated with the non-medically authorised use of drugs that might cause serious harm to users and to society. For historical reasons, this excludes some, such as alcohol and tobacco, which logically fall into this category. This interpretation implies that the overall **goal** is to reduce problems but this is an issue that is often not clarified or discussed.

Policies are enacted through a range of different types of **interventions**, which include legal controls and their enforcement, but also encompass treatment and recovery for people with drug addictions; information and education programmes aimed at dissuading people from using drugs; and policies designed to reduce the harms caused by each drug user, producer or supplier. Some parts of drug policy are about how the drug laws, such as the Misuse of Drugs Act, are framed and implemented. Other aspects, such as policing and healthcare, are underpinned by the legal system but are largely shaped by organisational structures, administrative and professional interpretation, and funding arrangements.*

*The drug legislation is a 'reserved' Westminster power but with the implementation delegated to the devolved UK countries..

The overall structures and goals of drug policy across the UK are guided by **drug strategies**, which are intended to coordinate the work of different government departments. The first comprehensive Strategy was published in 1995 and between then and 2002, leadership and coordination was handled through the Cabinet Office. Since 2002, national drug strategies have been coordinated and led by the Home Office, with many local health and preventive responsibilities transferred to the devolved administrations. In Scotland coordination and leadership is effected through the Minister for Community Safety and Legal Affairs; in Wales through the Minister for Local Government and Communities, and in Northern Ireland through the Minister for Health, Social Services & Public Health.

Drug policies are shaped also by the UK's European and global commitments. There are a number of international treaties that the UK has signed up to, which have been influential in framing the drug laws in the UK over the past century. More recently, collaboration through the EU has created a range of drug policies, especially in the justice sphere. While there is convergence between countries on a number of issues, for example drug-related money-laundering, other policies are decided at a national or local level, for example prevention and health care policies.⁶⁶

So drug policy is not solely the responsibility of Westminster politicians and civil servants. Some aspects are governed from the centre: in London, these are led by the Home Office. But other aspects are decentralised across the UK and to the devolved governments. Decisions about which drug markets to intervene in, which offenders to pursue, which modes of treatment to fund, which educational programmes to apply, or what sentence to apply to someone convicted of a drugs offence, are all part of drug policy, and should be subject to efforts to build the most cost-effective responses, regardless of whether policies are decided locally or nationally.

Within the recent reform of the NHS as part of the Health and Social Care Act, much more responsibility for setting priorities and implementing drug policy in England is being devolved to local areas. Responsibility for commissioning drug treatment is shifting to Directors of Public Health within local government, with priority setting being done by local Health and Well-Being Boards. Police and Crime Commissioners will have responsibilities and resources to support services to promote community

safety and, through their budget making duties, have an indirect influence on how the drug laws are enforced locally. In Scotland, Wales and Northern Ireland, local public service partnerships are the key vehicle through which drug policy is implemented and delivery bodies held to account.

HOW DRUG POLICY IS ORGANISED

For more than two decades, drug policy in the UK has been based around a series of drug strategies and organised under the three main 'pillars' of prevention, treatment and enforcement.⁶⁷ Prevention includes school education, mass media campaigns and preventive

Drug policy in the UK is based around a series of drug strategies and organised under the 'pillars' of prevention, treatment and enforcement.

interventions targeting specific risk factors for drug problems, such as parenting. Treatment includes a range of medical and psychosocial therapeutic interventions, and also can include so-called public health 'harm reduction' responses such as providing injecting addicts with clean syringes and needles. Enforcement includes local, national and international interventions, including direct and indirect action to seize drugs, along with suppliers and traffickers such as through border security. It also encompasses local and wider intelligence operations both in the UK and in other countries to prohibit supplies, activities to control precursor chemicals, as well as working through international aid programmes, such as crop diversification efforts in producer countries. These three pillars are sometimes grouped under the broader headings of supply reduction (largely enforcement) and demand reduction (including both treatment and prevention).

More recently, drug policy has embraced an increased focus on recovery and social re-integration for those with drug dependency.⁶⁸ There has also been a move to address the use of a wider range of drugs rather than focusing mainly on opiates and crack, and in some instances to have joint drug and alcohol strategies.⁶⁹

Although the main focus of the work of UKDPC and of this report is on drug policy within the UK, drugs are a global challenge and UK drug policy does not exist in isolation. The UK is signatory to a number of international conventions of relevance to drug policy which are described in **Box 3**.

Box 3:**INTERNATIONAL COLLABORATION**

Collaboration between the UK, national governments and internationally is effected at many different levels and through a number of treaties and bodies. These include:

1. Three United Nations Drug Conventions:

The 1961 **Single Convention on Narcotic Drugs** was set up as a universal system (replacing the various treaties signed until then) to control the cultivation, production, manufacture, export, import, distribution of, trade in, use and possession of narcotic substances, paying special attention to those that are plant-based: opium/heroin, coca/cocaine and cannabis. More than a hundred substances are listed in the four schedules of the convention, placing them under varying degrees of control.

The 1971 **Convention on Psychotropic Substances**, in response to the diversification of drugs of abuse, introduced controls over the licit use of more than a hundred-largely synthetic psychotropic drugs, like amphetamines, LSD, ecstasy, valium, etc, again divided over four schedules. An important purpose of the first two treaties is to codify internationally applicable control measures in order to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, while preventing their diversion into illicit channels.

The 1988 **Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** was agreed in response to the increasing problem of drug abuse and trafficking during the 1970s and 1980s and provides for comprehensive measures against drug trafficking. These include provisions against money laundering and the diversion of precursor chemicals, and agreements on mutual legal assistance.

The UN Drug Conventions are not self-executing. The implementation of the provisions in the Conventions is left to the signatory parties themselves.

This leaves room for interpretation, allowing countries to develop a differentiated national drug policy. However, this latitude or 'room for manoeuvre'⁷⁰ is not unlimited. In general, the Conventions anticipate application and enforcement by the parties.

2. European Union decisions:

The 2004 **Framework Decision on penalties for trafficking** lays down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking and has led to more harmonisation on penalties across the EU.

The 2005 **Council Decision on new psychoactive substances**, which is being reviewed in 2012, provides for the information exchange, risk-assessment and control of new psychoactive substances and has led to the setting up of an EU wide 'early warning system'.

3. International and EU bodies:

The **International Narcotics Control Board** (INCB) is the quasi-judicial control organ for the implementation and oversight of all three United Nations drug conventions.

The **World Health Organisation** (WHO) is responsible for the medical and scientific assessment of all psychoactive substances and advises the Commission on Narcotic Drugs (CND) about their classification into one of the schedules of the 1961 or 1971 treaties.

The **European Monitoring Centre for Drugs and Drug Addiction** (EMCDDA) exists to provide the EU and its Member States with a factual overview of European drug problems and a solid evidence base to support the drugs debate.

While ‘traditional’ drug problems appear to be stable or reducing in the UK, new drugs and patterns of use are appearing that pose new challenges.

The evidence presented within this chapter illustrates the many types of drug use and drug problems within the UK. Drug problems arise from a complex mix of factors so there is no simple solution to address them. There has been considerable investment in drug policy and drug-related interventions over recent years but there continues to be a lack of evidence concerning effectiveness and

value for money in many areas of drug policy. Although there have been benefits from some areas of policy there are also considerable costs, many of which are generally not measured.

While ‘traditional’ drug problems appear to be stable or reducing in the UK, new drugs and patterns of use are appearing that pose new challenges. What this means for drug policy is considered further in the next chapter.

CHAPTER 2 THE NEED FOR A FRESH APPROACH

KEY POINTS

- >The way that drug policy is made and implemented may be limiting the effectiveness of attempts to address the consequences of drug use
- >Drug problems can only be fully understood in their social and economic context
- >The distinction between use of drugs and use of alcohol and tobacco is not always helpful
- >Drug use is not always problematic, yet this is rarely acknowledged by policymakers
- >Drug policy takes insufficient account of the different reasons underlying drug use and drug problems, and of the differing consequences of use
- >Debates about drug policy, and policy itself, can be more productive when based on shared goals and taking account of all the consequences of policies
- >It is not clear why drug policy appears to prioritise some goals over other legitimate aims
- >Inadequate collection and analysis of evidence has been an important factor restricting the introduction of more cost-effective drug policies.

Drug policy in the UK has produced some significant and under-recognised successes over the past quarter century. For example, the public health harm reduction approach has delivered rates of HIV among injecting drug users in the UK that are among the lowest in the world⁷¹ and saved thousands of lives. Greater investment in different types of drug treatment services and in programmes within the criminal justice system to divert drug-using offenders into treatment have also increased the numbers of people accessing these services and remaining in treatment long enough to help many people overcome drug dependence.

Yet, as highlighted in Chapter One, there remain considerable problems. Compared with other EU countries, use of some drugs,

Total drug-related deaths are higher in the UK than in any other EU country.

including cocaine, is particularly high in the UK. Total drug-related deaths are higher in the UK than in any other EU country.⁷² We continue to have nearly 400,000 people with major dependency problems. Profits from organised crime work their way through our financial institutions. Large sums of money are spent on enforcement which leads to considerable costs to the criminal justice system in processing possession offences (mainly cannabis), while in some areas having a negative impact on community relations.

While there has been some progress over the last two decades, this progress has been slow, and took place largely in a benign environment. Unemployment was relatively low, and funding was available for a rapid and significant expansion of harm reduction and drug treatment services, as well as money for enforcement, largely predicated on the need to reduce crime. Now we are in a long-term period of austerity, there can be real concerns that existing policies may not be able to achieve further progress, while significant sections of the public, politicians, media and drug sector professionals are not convinced that our current approach to drug policy is the best we can do. Alongside this are the challenges associated with new drugs and new routes of supply.

It may be that incremental changes to some policies will produce some benefit. The Westminster and devolved governments' focus on improving the prospects of recovery for people with addictions is a good example of this. However, there is also a need to address the question of whether the way that drug policy in general is made and implemented is itself limiting the cost effectiveness of attempts to address the consequences of drug problems, or even making them more severe.

Fundamental socio-economic issues such as income inequality are significantly associated with levels of drug use.

We are concerned that some aspects of the way we have traditionally responded to the problems associated with illicit drug use may be ultimately unhelpful and the UK's current approach does not fully recognise the complexity of the challenges.

This chapter takes a high-level view of how we approach drug policy, and points to ways this could be reformed. It does not seek to make specific policy recommendations - these are developed later in this report - but it aims to show that there could be benefits in taking a fresh perspective.

THE LIMITS OF ADDRESSING DRUGS IN ISOLATION

Despite the apparent wide-ranging scope of drug policy, there are reasons to be concerned that the approach it takes is simplistic. Conceiving of and addressing drugs in isolation from other social, economic and cultural issues, and from other substances, restricts the ability of policymakers and practitioners to produce cost effective and long-lasting change.⁷³

Drug use should not be seen simply as a cause of problems

As discussed in the previous chapter, evidence has accumulated about the range of genetic, neurobiological, behavioural and environmental factors that are associated with risk of drug problems. Fundamental socio-economic issues such as income inequality are significantly associated with levels of drug use, as indicated by the international correlation between income inequality and levels of illicit drug use shown in *Figure 5*.⁷⁴

Figure 5:
INTERNATIONAL LEVELS OF DRUG USE AND INCOME INEQUALITY
Source: The Equality Trust



A comparison of inequality with levels of drug addiction and deaths from drug overdose in the 50 states of the US has shown a similar pattern: the most unequal states had higher death rates.⁷⁵

In the UK this was reflected by the way some forms of drug use grew in the 1960s, a cultural trend that was followed in the 1980s by the growth of entrenched drug problems, particularly among heroin users. The development of higher rates of addiction in the 1980s appears to fit the pattern of entrenched drug problems developing in association with increasing inequality.

Cultural factors influence the desirability of drugs, their availability fluctuates over time, and treatment systems affect how well people are able to overcome drug problems.

This is not to say that all drug problems were caused by inequality or that they can be explained by income inequality alone. Cultural factors influence the desirability of drugs, their availability fluctuates over time, and treatment systems affect how well people are able to overcome drug problems. Yet, the strength of the international and historical correlations between inequality and drug problems, and the analysis that has pointed to

inequality having a causal link with a range of other social ills, such as trust, social cohesion and mental illness, indicates that this is a relationship that should not be ignored.

Studies indicate that problems that are related to social status get worse when social status differences are increased. Greater inequality increases social evaluation anxieties: concerns about how one is seen and judged, which affects self-confidence, self-esteem and social anxiety.⁷⁶

This connection has been acknowledged to some extent in policy. The 2010 Drug Strategy includes a chapter on early intervention for young people and families to help those who may be at risk of involvement in crime and anti-social behaviour. But it may be missing the point to attempt to address these drivers of drug use with interventions that relate only to criminal and anti-social behaviour. If it is correct that levels of harmful drug use are closely linked to levels of inequality, and perhaps to other factors such as unemployment, lack of housing, poor educational achievement and family breakdown, as well as social dislocation, disempowerment and hopelessness, such efforts in isolation may be unlikely to produce significant and lasting change. Without tackling some of the underlying problems, it may not be possible to significantly reduce the most harmful drug use.

Indeed, some of these wider problems may themselves have other consequences that are at least as damaging as drug use, especially when taking into account the relatively small proportion of the population that suffers or causes harm because of illicit drug problems. Consequences include poorer health and reduced life expectancy. In this respect, it is neither possible nor wise to isolate drug policy entirely from other parts of public policy.

Without tackling some of the underlying problems, it may not be possible to significantly reduce the most harmful drug use.

A recent analysis of why Scottish people die younger than those in other parts of the UK concluded that the patterns of poor health and social problems that emerged from the 1980s were influenced and shaped by the consequences of the UK's political and economic policies from the late 1970s. The researchers argued that "[a]ny analysis which only refers to tobacco use or alcohol, or even to 'early years', massively significant as these factors undoubtedly are, will inevitably fail to identify the overall causality of this profoundly troubling phenomenon, and will be liable to generate, at best, partial policy interventions, which are, in turn, most liable to prove disappointing in their outcomes."⁷⁷

The greatest risk in efforts to address drug problems is that a focus on drug use directs attention away from the causes of problems, and onto the symptoms of those problems. By separating drug policy from other areas of social policy, unrealistic expectations are created that lasting progress can be made through drug-related interventions such as treatment and recovery programmes or enforcement actions to disrupt drug markets.

While there should be continued efforts to improve drug policies where this is possible, some of the problems associated with illicit drugs are best recognised as a facet of socio-economic and other factors. This is one of the key principles of this report. This is not to say drug policies are not needed or that they do not have many positive impacts. The challenge we are raising is whether an approach that focuses just on the drugs or even drug problems, rather than the factors underlying those problems, is likely to achieve a significant, lasting and cost-effective reduction in harms that can be caused by drug use.

A more consistent approach to all substance use is needed

We are also concerned by the focus on illicit drugs at the exclusion of other potentially harmful psychoactive substances, notably tobacco and alcohol. Many argue there are economic benefits from the alcohol trade, for example in the drink-producing and hospitality industries, as well as taxes for the Exchequer. But, as is becoming more evident, the use of those substances may cause even greater harms than much illicit drug use, measured in deaths, ill-health, and social breakdown.

Each year, smoking causes around 115,000 deaths, while alcohol causes 35,000. In comparison, illicit drugs cause about 2000 deaths a year.

This is certainly true when taking into account the much greater numbers using tobacco and alcohol: in England, 26% of men report drinking more than 21 units in an average week, while 18% of women report drinking more than 14 units in an average week. Meanwhile there are around 10 million adults in the UK who smoke cigarettes.⁷⁸ Each year, smoking causes around 115,000 deaths, while alcohol causes 35,000.

In comparison, illicit drugs cause about 2,000 deaths a year in the UK.⁷⁹ Of course, illicit drugs have other associated costs, such as acquisitive crime and instability in other countries. Legal controls over illicit drugs are a factor in these costs, although they may also be a factor in reducing the numbers who use them. But even taking into account other costs involved in the production and use of illicit drugs, the harms caused by use of alcohol and tobacco remain of at least comparable significance.

There is also a strong case that alcohol and tobacco can be more harmful to each individual user than some illicit drugs, although this has been contested (*see Box 4*). Yet, however one measures and compares total harms, there can be no serious challenge to the fact that we have inconsistent control and regulatory frameworks governing the availability of different psychoactive substances. The separation between these drugs and the illicit ones is entirely artificial and historical. In a world where policy could be made without reference to current behaviour and past decisions, that separation would probably not exist.

Box 4:

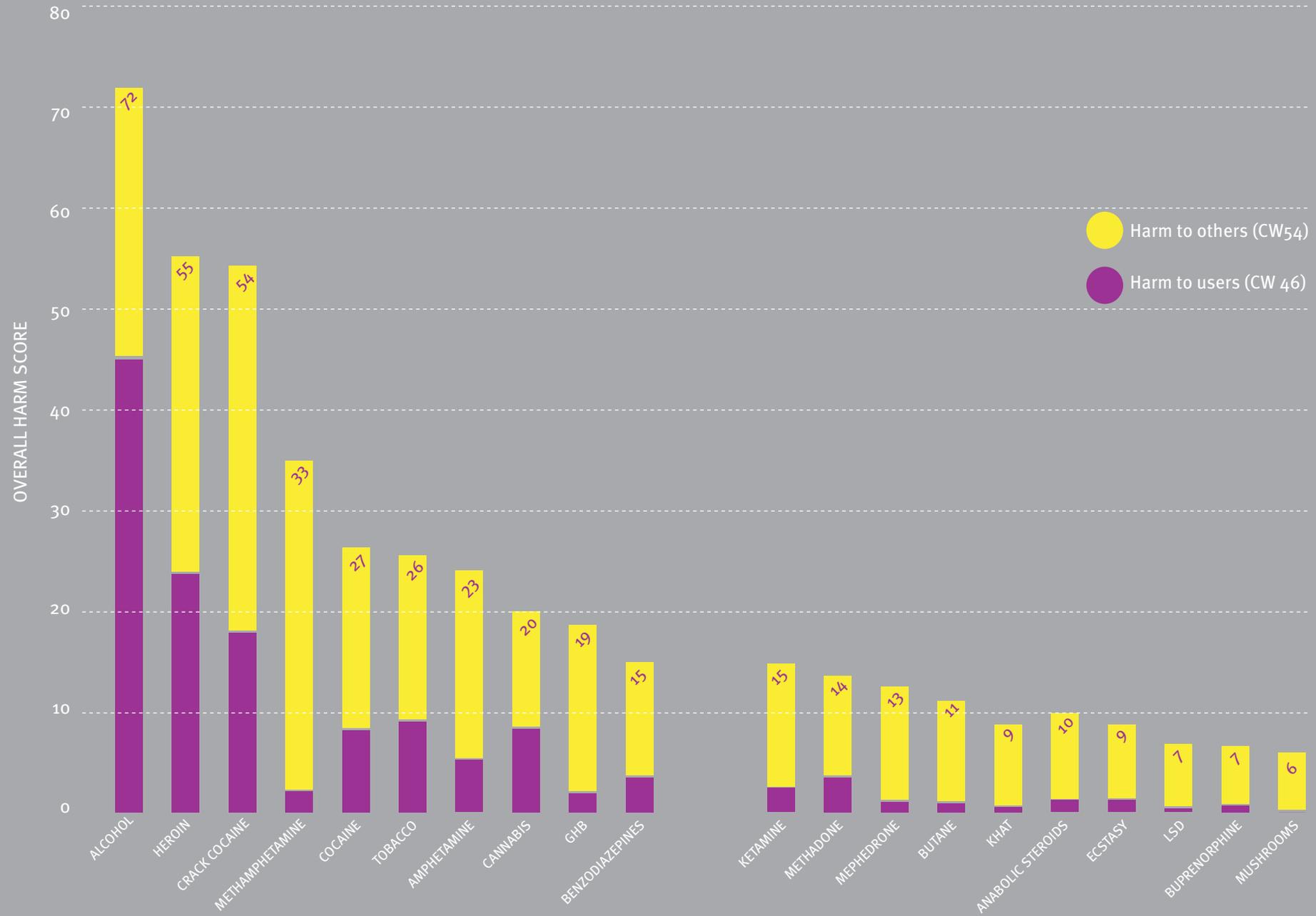
COMPARING HARMS CAUSED BY DIFFERENT SUBSTANCES

Many experts are sceptical of the value of comparative rankings of harms caused by different substances, because of the impact of individual and contextual factors on the harms associated with any drug use, and also the impact of legal status on the prevalence of use. Nevertheless, drug control is justified on the basis of harm to individuals and society, and the Misuse of Drugs Act 1971 established a classification system for drugs in order to prescribe the maximum penalties associated with offences relating to drugs in that class. Implicit in this is that the hierarchical classification reflects the level of harm or dangerousness associated with the drugs in each class.

A number of attempts have been made to compare the harms associated with different psychoactive substances. These include comparisons of the harms associated with use at a single point of time, such as the WHO global burden of disease estimates, attempts to compare the severity of health effects for heavy users of different substances and measures of lethality as a poison. What all these have in common, with the exception of the lethality measure, is that legal substances, tobacco and alcohol, were found to be among the most harmful substances.⁸⁰

Recent attempts at ranking have sought to develop systematic and, as far as possible, evidence-based approaches. The most recent attempt in the UK was led by Professor David Nutt, a former chair of the Advisory Council on the Misuse of Drugs, and involved other experts in a multi-criteria decision-making process to review harms caused by different drugs, including alcohol and tobacco as well as those controlled by the Misuse of Drugs Act.

The process assessed physical, psychological and social harms to users, and harm to others. The results, shown in *Figure 6*, reinforce the view that the current classification system is inconsistent, since several class A drugs are among those with the lowest levels of harm. It also suggests that alcohol is the most harmful of all the psychoactive substances considered, while tobacco ranks sixth, making it more harmful than cannabis, mephedrone ('meow meow'), and ecstasy. Although the method has been criticised on several grounds,⁸¹ it is hard to dispute the conclusion that alcohol and tobacco are at least as harmful as some illegal substances.

Figure 6:⁸²**HARMS CAUSED BY DRUG USE**Source: Nutt, D et al, 2010. *Drug harms in the UK: a multicriteria decision analysis.*

Yet the fact that this separation between licit and illicit drugs is currently made is inescapable, and ignoring this would produce an analysis that would have little application in the real world. It is also important that we learn from different approaches of controlling each substance. For example, alcohol prohibition in the USA in the 1930s famously had costs, such as the explosion of organised crime and widespread flouting of the law, but it also had benefits, such as improvement in certain health conditions. More recently - without prohibition, but with taxes - we have seen the growth in the UK of illicit alcohol production and the increasing avoidance of customs and revenue controls.⁸³ Counterfeit and smuggled tobacco also present control and health challenges.

Without prohibition, but with taxes, we have seen the growth in the UK of illicit alcohol production.

It is important also to recognise that the use of illicit and licit drugs is often influenced by similar and overlapping challenges. These include the reasons people use substances, the extent to which they might substitute one substance for another, and why and how substance use turns to

dependency for some people. These factors suggest that the various substances should be tackled with the recognition that their use is often closely connected.

This relationship has been acknowledged to some extent in drug policy and practice. The 2010 Drug Strategy recognises the harm caused by severe alcohol dependence; local structures increasingly cover both alcohol and drugs (eg Drug and Alcohol Action Teams or Community Safety Partnerships in England and Wales, and Alcohol and Drug Partnerships in Scotland); treatment services often provide treatment for both drug and alcohol addiction; and people with serious drug problems are often also addicted to alcohol and tobacco at the same time. But these usually relate only to those whose use is the most harmful. There continues to be a distinction between less extreme levels of alcohol consumption, and moderate drug use, which may not be justified by evidence of the harms associated with use of each substance.

THE RISKS OF MAKING GENERALISATIONS ABOUT DRUG USE

Since the early 1990s, the UK's approach to drug policy aims to ensure public departments and bodies support one another to achieve common goals. However, while coordination is necessary, we are concerned that there are risks in seeking to base drug policies

There are risks in seeking to base drug policies on generalisations about drug use and associated problems.

on generalisations about drug use and associated problems. The current approach may be counter-productive, in two different ways.

Drug use is not always problematic and may bring perceived benefit

First, many people enjoy taking drugs. As discussed in Chapter One, some people choose to take drugs for pleasure, in much the same way as many people use other mind-altering substances such as alcohol. In other cases people may self-medicate, consciously or unconsciously using illicit drugs to deal with mental or physical problems. For many in both of these groups, drug use may not be a cause of significant other problems for themselves or others around them, for much of the time (*see Box 5*).

Box 5:**DO PEOPLE EXPERIENCE BENEFITS IN DRUG USE?**

The question of whether people experience any benefit from drug use is controversial. There is no doubt that many people feel that they receive some benefit through using drugs, such as relaxation, relief of mental or physical pain or other symptoms, increased sociability, or feelings of energy. However, some people dispute whether these perceptions should be considered meaningful, as they argue that the negative consequences of drug use will always outweigh any of these benefits.

It may be impossible to calculate such costs and benefits in a way that would be widely accepted. However, two points can be made with confidence. Firstly, many people participate in other activities that have short-term benefits and long-term costs, such as drinking alcohol or eating fatty foods. In these cases there is widespread acceptance that such short-term benefits can be acceptable.

Secondly, survey data of personal experiences of drug use suggest that positive experiences are widespread. For example, a recent survey of schoolchildren in England⁸⁴ found that of those pupils who reported that they had ever taken drugs, 45% said they felt good the first time they took them, a similar proportion (44%) said they felt no different and only 11% reported that they felt bad. Boys were more likely than girls to report that they felt good after taking drugs the first time (50%, compared with 40% of girls).*

In addition, the value of cannabinoids for relieving symptoms in some medical conditions is well-established and ‘Sativex’, a mouth spray that contains cannabis extracts, is licensed for prescription in the UK.⁸⁵ However, it has not yet been assessed by NICE and not all health authorities will fund its prescription, and there is anecdotal evidence that some doctors are advising patients to obtain illicit supplies of cannabis.

* Conversely, girls were more likely than boys to say they felt no different (48%, compared with 40% of boys). Similar proportions of boys and girls said they felt bad the first time they took drugs (10% of boys, 12% of girls).

It is striking how rarely this point is acknowledged by policymakers. Where it has been mentioned, such as in the national Anti-Drug Coordinator’s introduction to the 1998 Drug Strategy,⁸⁶ this has generally been in passing, with little attention to its wider implications. Yet, these implications are profound.

Millions of people in the UK use drugs each year, simply because they expect, often based on experience, to get pleasure from them. Communications about the negative consequences of drug use have little credibility if they do not acknowledge many people’s positive experiences of drugs.

Another implication of the high levels of use is that the argument for tightly restricting availability of certain drugs cannot rest on an assertion that drug use necessarily causes significant problems. This is not to say that drug controls should necessarily be relaxed, but there is a need to provide alternative reasons for these continued controls and, if they are to have widespread acceptance, these will need to recognise that there are positive experiences of drug use which need to be weighed against the risks.

The diversity of drug use

A further concern is that the nature of drug use and drug problems may be a too diverse phenomenon to be subjected to a single overarching set of goals. This diversity operates in several dimensions, each of which increases the difficulty of making generalisations about drug use.

The nature of drug use and drug problems may be a too diverse phenomenon to be subjected to a single overarching set of goals.

Reasons for starting drug use vary widely. For some, drugs such as heroin offer an opportunity to suppress mental or physical pain. Others choose to consume drugs such as mephedrone or ecstasy as part of a social group or at nightclubs, and often these young clubbers grow up, hold responsible jobs and have families, and choose to stop taking drugs. Cocaine use may provide a stimulant for well-heeled users in business and the cultural industries. Crack on the other hand typically manifests itself in disadvantaged communities. Cannabis use can be a response to physical pain, or simply a means of relaxing with friends at home. For a limited and relatively small number of people, occasional use of any drug can descend into dependency and addiction. Broad approaches to drug policy can find such variations awkward to deal with.

Consequences of drug use and supply are similarly diverse. While the use of some drugs have a higher likelihood of leading to serious problems, others are much less likely to be harmful, particularly if used in moderation. As discussed above, occasional drug use appears more likely to lead to serious entrenched problems for those who already are experiencing social and economic exclusion. There is also considerable variation in consequences according to how they are used, for example whether clean needles and syringes are available for injecting drug users.

In more affluent communities, drug problems may have relatively little obvious impact beyond the user and their family and friends; more deprived communities appear to be the most vulnerable.

The impact on communities of drug supply and use reflects similar variations. In some more affluent communities, drug problems may have relatively little obvious impact beyond the user and their close family and friends. But more deprived communities appear to be the most vulnerable. Drugs provide both a commodity and a source of income for criminal gangs. The potential for young people to gain status, desirable goods and money through joining these gangs as junior dealers is particularly attractive

where there are few other prospects. Reducing the availability of the drugs may provide some respite but will not solve the social problems in those localities.

Ease and reasons for stopping use also vary significantly. Clearly some substances are more addictive and harder to give up than others. But some people and groups of people are able to stop using even the most addictive drugs much more easily than others can. The experience of many heroin-using US soldiers in Vietnam, whose drug use stopped on their return to America,⁸⁷ indicates the importance of the context of drug use in influencing users' decision and ability to stop taking drugs.

The stigma experienced by many people with drug problems can also make it more difficult for some to overcome addiction. This stigma does not affect different groups equally, with heroin and crack users more stigmatised, as well as female users.

The impact on policy of a generalised approach

This wide variety in drug use underlies the difficulties involved in applying generalised goals to drug policy. Since the nature and impacts of drug use are so diverse, a goal that may be relevant for one aspect of drug policy may be counter-productive in another aspect.

It is possible to identify several possible circumstances where basing policies on broad generalisations that do not take account of the diversity described above may lead to less cost-effective policies. For example:

- A goal of reducing drug use overall, rather than a more nuanced focus on the quantity used or the relative harms of different substances may be less effective at reducing drug problems. Efforts to stop someone who occasionally uses drugs, such as ecstasy, in a low-risk way may deflect resources away from working with someone with an established crack or heroin addiction. But the associated harms are very different. A general goal of reducing overall drug use provides an incentive to treat all drug use equally or focus on those easier to affect, regardless of the relative levels of harm involved.
- A fall in the number of people using particular illicit drugs would not necessarily lead to better health and reduced crime if it masked a switch from less harmful drugs to more dangerous alternatives. One example of where this could happen is in the stimulants market, where a tightening of controls over some substances that might be relatively less harmful, such as mephedrone, could create an incentive for users to switch to other potentially more harmful drugs such as powder cocaine and untested new drugs.
- A goal of encouraging people to stop taking drugs altogether may also have unintended consequences. For example, the current focus on abstinence as a treatment goal creates strong incentives to encourage heroin users to stop taking the drug or a prescribed opiate alternative. If this occurs before they are ready to stay drug-free, there is a risk that this will increase the chances of relapse, overdose and death. Equally, creating strong pressures for those who are convicted of a crime and test positive for drugs, to enter treatment regardless of whether their crime was drug-related or of the nature of their drug use, may damage the treatment system for other patients by overloading it as well as potentially wasting resources.

The stigma experienced by many people with drug problems can also make it more difficult for some to overcome addiction.

We conclude that some aspects of the way we make drug policy may now be creating more problems than they solve. The disparate factors that influence and govern different aspects of drug use and the competing goals that underlie drug policies make it unrealistic to expect that it can be approached in isolation from other issues, with goals that do not take into account the diversity in drug use.

Some aspects of the way we make drug policy may now be creating more problems than they solve.

Over the remainder of this report, we examine the policy implications of these conclusions. However, there remain two key issues outstanding in this review of how we approach drug policy: the need for open debate, and the value of evidence.

THE NEED FOR OPEN DEBATE

As there is not a single drug problem it would be wrong to expect a single solution. It is also important to recognise the limitations of drug policy, given the complex range of factors that underpin drug problems. It is important that there is discussion of what can be achieved through any drug policy so that expectations are realistic. For example, it is clear from the evidence that drug education will never stop all drug use, neither will enforcement activity completely prevent all drug supply nor treatment prevent all acquisitive crime.

Drug problems are complex but there can be shared goals

The debate about drugs is highly polarised reflecting different sets of values and professional interests. Hence drug policy is best viewed as a ‘wicked issue’: a social problem characterised by resistance to resolution over long periods of time, being fractured by different deeply held values and by being connected to other similarly complex and unresolved issues.⁸⁸

The 2010 Drug Strategy is built around three goals: reducing demand, restricting supply, and building recovery in communities. While it was announced as a “fundamentally different approach to tackling drugs”, there was in fact a great deal of continuity and overlap with the previous strategies. As with previous strategies, the goals and interventions were built around the pillars of prevention, treatment and enforcement.

The first UK-wide Drug Strategy, for 1995-1998, was also built around three goals. These were similar to those in the 2010 Strategy: helping young people to resist drugs; increasing community safety from drug-related crime; and reducing the health risks of drug misuse, which included a focus on drug-free recovery from addiction. These goals are, in reality, designed around the paradigm of a single drug market dynamic (demand and supply) and the activities and interests of the main departments of state: Home Office (enforcement); Health (treatment and recovery); and Education (prevention), similarly reflected in Wales, Northern Ireland and Scotland.

While the goals of the Drug Strategies have been largely consistent since 1995, there is relatively little explicit evaluation of, firstly, why these goals should be chosen and, secondly, whether such generalised and discrete goals are helpful for drug policy.

Addressing the first of these issues, it is not self-evident what the overall purpose of drug policy should be. There are competing goals that could be prioritised, and while each of these is legitimate, they would lead to different approaches that may not always be compatible, for example:

- Increasing the safety, wellbeing and prosperity of the general public, including families and neighbours of those involved in drug production, supply and use
- Improving the safety of those using or considering using drugs
- Minimisation of restrictions on the liberty of individuals to seek potential benefits from drug use
- Facilitation of individuals’ ability to address physical and psychological distress.

The tensions between these potential goals present challenges for drug policy; this is particularly relevant for the debate about whether, and to what extent, restrictions on controlled drugs might be changed. However, recent drug policy has tended to prioritise the first and second goals, protection of safety and prosperity, at the exclusion of the other goals.

It is not self-evident what the overall purpose of drug policy should be.

This is not surprising, since there is almost always more pressure on governments and parliament to prevent or minimise drug-related disease, deaths and crimes. The safety of those using drugs or considering doing so is an important goal also. Young people and other vulnerable groups, who are over-represented among drug users, are particularly in need of protection.

But the other goals, of minimising restrictions on liberty, and facilitating individuals’ ability to seek pleasure or address distress, cannot legitimately be dismissed without further consideration. These goals can apply to drugs just as they do to alcohol, and it seems anomalous that the harms caused by drugs are taken into consideration in policymaking, but their benefits are not.

The potential for competing goals of drug policy presents challenges for policymakers, and the balance between them needs to be agreed before effective policy can be developed.

Young people and other vulnerable groups, who are over-represented among drug users, are particularly in need of protection.

Research by UKDPC with Demos, which addressed this question, used a ‘soft systems approach’ to consider the challenge posed by new psychoactive substances.⁸⁹ It showed how people with very different perspectives on the drug problem could nevertheless reach agreement on actions that could make progress against intermediate objectives. (see Box 6).

Box 6:

CASE STUDY: IDENTIFYING SHARED GOALS TO OVERCOME POLICY CONFLICTS

In seeking approaches to the control of new psychoactive substances, UKDPC and Demos held two workshops with participants who were selected for their diverse experience, and to span the range of opinions on drug policy. Through a structured approach that allowed each participant to explain their perspective on the issues and then, rather than challenging these or endeavouring to reconcile them, the workshops focused on identifying opportunities for action that everyone could agree on, regardless of their underlying values or beliefs about the nature of the issue.

For example, one of the themes that emerged concerned the need for better information to be made available about the new drugs. This information was seen as necessary whether to prevent use, reduce the likelihood of harms associated with use, help with treatment of problems or to assist in enforcement of drug control measures. To achieve this, it was agreed that the most important step was the collection and collation of accurate information on new drugs.

These workshops demonstrated that alternative approaches to problems with apparently intractable differences can produce solutions that are not available to traditional methods. Minimising the impact from substance misuse on well-being⁹⁰ or health inequalities⁹¹ could provide an overarching goal that might offer a starting point for identifying action to address the problems associated with use of both licit and illicit substances.

The potential consequences of policies need to be acknowledged

One aspect of open dialogue is the need to recognise the potential harms and other unintended consequences from the policies or interventions themselves. Whether a policy is deemed a success or failure may also depend on what the perceived policy goal is. If the overall aim of recent drug policy has been to prevent all drug use and drug production, then it has clearly failed. But if lower level and more pragmatic goals are considered, it is clear there have been successes in a number of policy areas, as outlined above.

The wide range of unintended consequences that can arise from drug control and enforcement has been highlighted by the former Director of UNODC, Antonio Maria Costa among others.⁹² Some examples are highlighted in Box 7.

Box 7:

TYPES OF UNINTENDED CONSEQUENCES OF DRUG CONTROL AND ENFORCEMENT

- A large criminal black market, with associated violence and other crime
- Policy displacement: due to the opportunity costs of the high expenditure on enforcement
- Geographical displacement: markets shift to new areas or use different supply routes
- Crime-type displacement: users and user-dealers turn to other types of crime or to more crime if dealing becomes too risky or if they need to raise more money
- Tactical displacement: dealers develop new ways of dealing or distributing drugs, such as the use of the internet or mobile phones, or new techniques of concealment
- Target displacement: dealers seek to open new markets in different sub-groups of the population if existing markets are hit
- Substance displacement: new drugs are developed all the time
- The stigmatisation of people suffering from addiction, which may impede access to treatment and rehabilitation.

Adapted from: UNODC, 2008; and National Police Improvement Agency analysis guidance

There is evidence that some public education campaigns can increase the likelihood of drug use.

However, the potential for unintended consequences applies to the whole range of interventions. For example, it has been found that some drug education interventions are not only ineffective in preventing or stopping

drug use, but sometimes even have a negative impact. There is evidence that some public education campaigns, or public service announcements (PSAs), can, in fact, increase the likelihood of drug use. For example, in 2006 the US Government Accountability Office recommended removal of funding from the \$1.2 billion National Youth Anti-Drug Media Campaign because an independent evaluation showed it had no impact on either cannabis initiation rates or curtailing use among people who were already using, despite the fact that young people could remember the advertisements and commented favourably on them. Indeed the only significant finding in relation to cannabis initiation was of small increases in likelihood of initiation among some sub-groups in some data collection periods. It was suggested that this might be because the campaign led to young people believing that drug use was more widespread than was the case.⁹³ This finding is not unique. A systematic review of anti-drug campaigns aimed at young people found that “multiple studies have noted the potential of anti-drug PSAs to weaken anti-drug norms among youth, which may in turn lead to increases in the prevalence of drug use among this population”.⁹⁴ This will appear counter-intuitive to people yet remains a powerful finding.

In a similar counter-intuitive vein, from around 2000, the UK government sought to reduce waiting times for drug treatment, to increase the numbers entering treatment through the criminal justice system (CJS), and to get greater numbers remaining in treatment for a minimum period in order to reduce drug-related crime. The rapid expansion of treatment services, which focused on prescribing substitute medication did succeed in engaging a large proportion of people with opiate problems, stabilising their lives and reducing the offences they committed. However, the focus on crime reduction encouraged services to emphasise bringing people into and keeping them in treatment, rather than on promoting their recovery.

It is also important to recognise that some of the tough talking about drugs can itself have negative consequences. The stigma associated with drug problems may delay people from seeking help, or cement drug-using identities. Research by UKDPC demonstrated how constant repetition of messages representing people

with drug problems as ‘junkie scum’ and ‘once a junkie, always a junkie’ can make people reluctant to acknowledge their problems and seek treatment. It can also make employers reluctant to give them jobs, make landlords reluctant to give them tenancies, and result in communities being

opposed to the establishment of treatment centres. As a result, drug problems remain entrenched rather than overcome.⁹⁵ It is noteworthy that in the United States, both the President and his drug ‘czar’ now openly talk about the ‘illness’ of addiction. As the ex-head of the United Nations Office of Drugs & Crime now argues, those with drug dependency problems should be helped by the health care system rather than through criminal justice.⁹⁶ Yet the prevailing public and political narrative is one of responding to drug dependency and addiction in order to achieve crime reduction rather than helping people get better. Of course both are important reasons but this can skew consideration of, and public support for, examining different approaches.

When Portugal adopted a more treatment-focused approach towards drug users, there was an open and constructive dialogue which facilitated major developments in drug policy. The change in the drug law was preceded by a public debate about the issues, led by the president who used his position to promote public awareness, influence politicians and to build support for a new pragmatic approach.⁹⁷ Similar developments have taken place in the Czech Republic and are happening also in a growing number of South American countries. Our research has identified leadership, which is open to the evidence, seeks consensus on proposals, and fosters open dialogue as the key characteristics of the ‘good governance’ of drug policy.⁹⁸

Recognising the complexity of the problem and the potential for unintended consequences could provide the beginning of a policy process that is more open to learning from evaluated innovation and can acknowledge where a policy has not worked as intended. In a period of austerity it is particularly important that money is not wasted on cost-ineffective interventions.

The stigma associated with drug problems may delay people from seeking help, or cement drug-using identities.

THE USE OF EVIDENCE

So far in this chapter, we have focused on the structure of the UK's response to illicit drug use. We have concluded that drug policy should take more account of other social and economic factors, should recognise the limitations of overarching strategies with broad goals, and needs to be steered by more open debates.

However, while we believe that addressing the structure of policy making is important, the approach does not tell us anything about what particular mix of drug policies we should adopt: how illicit drugs should be regulated; what should be done to address drug dependence; how the harms associated with drug use can be reduced; and other questions that make up drug policy. To do this requires much closer attention to the building of a solid evidence base and promoting awareness of the findings amongst professionals and policymakers, something often referred to as 'knowledge management'.

The collection and promotion of evidence

Throughout the work of UKDPC, our studies have evaluated the evidence about different drug policies, and some of the barriers in responding to drug problems. We have noted where independently verifiable evidence for a policy or intervention is strong, where it is mixed, and where it is poor. However, too often we have had to conclude that there is not enough evidence, or examination of the evidence, to make a judgement of the effectiveness, let alone cost-effectiveness, of existing or potential drug policies. We simply have no way of knowing what the overall impact of such policies and programmes are, other than the superficial headlines. And that is simply not good enough in the 21st Century and in tough economic times.

We spend at least £1.2bn on drug policy each year - about £400 for each taxpayer.

We spend at least £1.2bn on drug policy each year - about £400 for each taxpayer⁹⁹ - there is a powerful case for systematically testing whether this money is being spent well and whether policies could be improved or alternatives trialled.

As the House of Commons Science and Technology Committee noted in 2006, "UK investment in addiction research is woefully inadequate. The Government's failure to ensure that sufficient resources are devoted to building the evidence base to underpin drugs policy is at odds with its commitment to adopt an evidence

based approach."¹⁰⁰ This was not a new observation. A Home Office Research Study in 1988 stated "The fundamental problem facing the Government in its deliberation on drug control measures is the paucity of information on the subject".¹⁰¹

In order to ensure that money and time are better spent throughout drug policy, it is essential that we develop a pre-requisite for knowledge. Our research has highlighted a number of areas where there are considerable gaps in the evidence base for interventions that are underway (see Box 8).

In order to ensure that money and time are better spent throughout drug policy, it is essential that we develop a pre-requisite for knowledge.

Box 8:

EXAMPLES OF AREAS OF DRUG POLICY WHERE EVIDENCE IS LACKING

In a 2008 review, we looked at interventions for drug-dependent offenders within the criminal justice system (CJS)¹⁰² and concluded that while the principle of using CJS-based interventions to encourage engagement with treatment is supported by the evidence, there were no evaluations of effectiveness of many of the specific interventions, such as CARAT (Counselling, Assessment, Referral, Advice and Throughcare), the range of programmes based on cognitive behavioural therapy, conditional cautions, diversion from prosecution schemes and Intervention Orders. Where programmes had been evaluated, the evidence was often weak. Since then there have been some significant changes in policy, particularly in treatment and support within prisons with the roll-out of the Integrated Drug Treatment System (IDTS), which is the subject of an on-going evaluation, and pilots of drug-recovery wings. It is important that evaluations are properly resourced and the results acted upon when available.

Another area where evidence for effectiveness and value for money is lacking, is drug law enforcement. Part of the reason for this is that the traditional measures of enforcement activity - arrests and seizures -

provide no information on the impact on drug problems. Work by UKDPC in collaboration with the Association of Chief Police Officers (ACPO) and the Serious Organised Crime Agency (SOCA) suggested that focusing on the most important drug-related harms in an area, involving communities in identifying these harms, developing enforcement interventions that targeted these harms and identifying a wider range of measures of outcomes, is most likely to have an impact.¹⁰⁴

In our response to the 2007 drug strategy consultation, which we developed through a process that included engagement with key academics, we called for the establishment of a 'knowledge pillar' within the new strategy in order to address the underdeveloped knowledge base for much of the strategy.¹⁰⁵ Although a cross-departmental research programme has been put together, this essentially works to co-ordinate, and is limited to government-funded research. The need identified in 2007 still remains and any strategy should include a framework for regular and independent evaluation of the drug strategy,* as well as commissioning new research and programme evaluations, and should be funded appropriately. We also felt that consideration should be given to the establishment of an independent body charged with leading this work. This conclusion is discussed further in Chapter Five.

Although building processes that aid learning and development into a strategy is always good practice, it is now particularly important to ensure that policy is able to adapt to changes in the future, given the rapid development of new drugs and new supply routes. A 2012 Cabinet Office paper on randomised controlled trials argued for their routine introduction throughout public policy in the UK.¹⁰⁶ We share the view that such trials can both improve policy and save money. The Medical Research Council's Guidelines for Good Clinical Practice in Clinical Trials provides further details on how such research should most effectively be conducted.¹⁰⁷

*The 2010 Drug Strategy promised the development of an evaluation framework but one year on this has yet to be completed.

It is our view that the way we collect, analyse and use evidence in UK drug policy has often been inadequate, and that this has held back cost-effective policies that could have improved the lives of millions of people who are directly and indirectly affected by drug problems. While a randomised control trial is not needed to prove the efficacy of every piece of policy, too often we have slipped to the other extreme and relied simply on anecdote. It is essential to recognise that, as Campbell points out, reforms, such as the current development of Payment by Results for a wide range of services, are essentially experiments and those supporting and delivering these programmes must be open to unbiased appraisal of success or failure, and be prepared to take a different approach should the evaluation prove negative.¹⁰⁸ It is also important to replicate these studies to build clear evidence of cost-effectiveness and identify the conditions under which a particular approach works.

International collaboration is invaluable for building the evidence base. The work of the Campbell Collaboration,¹⁰⁹ a research network that produces systematic reviews of the effects of social interventions, is a good example of how evidence can be brought together to answer questions in social policy. However, it has been less influential than the comparable Cochrane Collaboration in the field of medicine, due to the paucity of international support and funding. It is important that drug policy research is adequately funded and is able to take advantage of funding streams such as the Public Health Research Programme of the National Institute of Health Research.¹¹⁰

We also need to change how we make use of evidence. In the process of making drug policy, evidence is often treated as a stakeholder whose interests should be taken into account, rather than as a tool that is useful for all participants. To make progress on tackling the problems associated with illicit drug use, we need a new and more mature relationship with evidence.

The way we collect, analyse and use evidence in UK drug policy has often been inadequate, and this has held back cost-effective policies that could have improved the lives of millions of people.

To make progress on tackling the problems associated with illicit drug use, we need a new and more mature relationship with evidence and providing an environment that is supportive of recovery.

Analysis and use of evidence is currently limited

It is not just a question of more and better evidence. We also need to ensure the evidence is analysed and used appropriately. We have identified five areas as examples where such improvements are necessary.

1. Willingness to be guided by evidence

Even where good evidence is available, the willingness to act on it may be limited

if the implications are politically difficult. Equally, there is a danger that evidence collection can be used as a tool to verify pre-existing beliefs, with challenging evidence being discarded. Such ‘cherry-picking’ has to be resisted if policy is to learn from uncomfortable findings. This is one of the greatest difficulties and requires not only political courage but also a greater willingness in other groups, including the media and third sector, to be persuaded by evidence that challenges their expectations.

2. Recognition of different forms of evidence

There also needs to be greater recognition and understanding of the different forms and levels of evidence. The reality of complex issues is that evidence is often incomplete, imperfect or suggestive of only relatively small effects. It is crucial that policymakers are able to distinguish between better and worse quality evidence. Anecdote may be important for suggesting issues that need further exploration, but it is not a substitute for thoroughly evaluated and evidenced assessments.

3. Clarity on the objectives of policy

When analysing evidence, we need to be able to identify whether a particular intervention is achieving specific objectives - and whether it is producing unintended consequences. Careful setting of specific objectives is crucial if evidence is to be valuable to policymakers. For example, evidence might indicate that long prison sentences for heroin possession would reduce acquisitive crime in the short term. But if the aim of policy is not just to reduce crime in the short term, but also to help people with heroin problems to overcome addiction and build productive and fulfilling lives, the policy conclusions might be different.

4. Overcoming desire for trials to produce positive results

A related challenge is the political sensitivity of trials. There is a risk that they are seen not as honest attempts to understand what does or does not work, but as the first wave of new government policies. The consequence is that policymakers are less willing to test policies that they are not confident about, and when a trial is started, negative results are seen as a government failure. Instead, there should be recognition of the value of negative results: knowing what does not work can sometimes be as useful as knowing what does work. A further challenge is to recognise that the results of trials may not always accurately reflect the impact of a policy when it is implemented on a wider scale.

5. Awareness of alternative policies

Equally, there is often too little attention paid to alternative approaches and opportunity costs. It may be the case that evidence suggests a particular intervention is effective, but its costs may be greater than the costs of other approaches. Greater overall benefits might be achieved with these other policies.

Inadequate collection and thorough analysis of evidence has been one of the greatest limiting factors for drug policy in the UK. As the report of the Science and Technology Committee went on to say, “[t]he Government has been remiss in failing to conduct a proper evaluation of the impact of its policy decisions in this area and has, as a result, missed out on opportunities to gather valuable data to improve policy making in the future.”¹¹¹

Inadequate collection and thorough analysis of evidence has been one of the greatest limiting factors for drug policy in the UK.

As long as there continues to be inadequate collection and analysis of evidence, public money spent on drug policy will not be used as efficiently as it could be. This inefficiency would be unethical at any time, but it is particularly so when reduced resources mean that more sacrifices in public spending are necessary. Tackling this would provide an important tool to overcome the barriers that currently restrict more cost effective policy.

In order to begin to achieve this, our first step is to identify what we know so we can act on it, and what we do not know so we can plan evidence collection and analysis. The third chapter will now evaluate the evidence in order to identify opportunities for improvements to drug policy in the UK.

CHAPTER 3 WHAT A FRESH APPROACH COULD LOOK LIKE

KEY POINTS

- >The division of drug policy into prevention, treatment and enforcement unnecessarily separates policy areas that cannot effectively work independently
 - >An approach to drug policy that would facilitate an integrated approach, both across departments and with other social policy areas, focuses on the twin overarching goals of supporting individuals to behave responsibly, and promoting recovery from entrenched drug problems.
- Supporting individuals to behave responsibly**
- >Evidence supports some early interventions that reduce a range of problems
 - >Drug-use prevention programmes are generally not supported by evidence, although some wider programmes may have a positive effect
 - >For those people who nevertheless decide to use drugs there is evidence that a range of interventions can encourage them to do so in less damaging ways
 - >Law enforcement can be better targeted to support individuals to behave responsibly

>Current drug laws lead to unintended consequences and may not be cost effective in encouraging individuals to behave responsibly.

Promoting recovery from entrenched drug problems

>Recovery from problematic substance use is a process that involves not only achieving control over drug use, but also improving health and well-being and building a new life, which includes family and social relationships, education and employment

>Communities have an important role in supporting individuals' recovery

>Law enforcement and the criminal justice system can be more focused on supporting recovery

>Families of people with drug problems can not only aid recovery, but often also need help in their own right

>There is evidence showing ways in which the broader treatment system can be changed to improve rates of recovery by providing a range of different types of treatment options and linking in wider support services, including mutual aid.

The purpose of Chapter Two was to evaluate the principles governing the UK's approach to drug policy and to suggest how these could be improved. This chapter applies those conclusions to the evidence of what we know works in drug policy, in order to identify where policy can be improved.

With few exceptions, drug strategies and policy are divided into a three-part structure of prevention, treatment and enforcement. While we are cautious of breaking a convention that is so dominant, and reflected in political, professional and practical institutional structures, nevertheless we are concerned that this approach has significant limitations. Creating clear divisions between the different areas of drug policy may create the misleading impression that each area can operate independently of the others. Yet in practice, this is not the case. Furthermore, it may inhibit the development of more efficient and effective approaches to tackling drug problems. At times such areas can function at cross-purposes, for example where enforcement activity near treatment centres discourages people from engaging with treatment.

These divisions and a lack of open debate about the overall goals of drug policy, also leads policymakers to treat the interventions not as tools but as goals in themselves. This results in a focus on activity rather than outcomes. So this may reduce the effectiveness of programmes, waste resources, and inhibit development of more cost effective ways of tackling drug problems.

We have therefore taken a different tack, and in this chapter, we consider the evidence for policy interventions to address two broad high-level goals. The tools of prevention, enforcement and treatment can be used to achieve these, as can broader social policy.

First, we look at how society and government can enable and support individuals to behave responsibly. This includes not only policies designed to discourage people from taking harmful substances, but also law enforcement approaches that focus on the behaviour and markets that cause the most harm, as well as other policies intended to limit the risks and harm associated with both occasional and more problematic use.

Which policy is best will depend on which users and suppliers we are talking about, on what drugs they are using and supplying, and on other factors relevant to their particular case.

Second, we consider policy that can enable and promote recovery from entrenched drug problems, both for individuals and communities. This looks at evidence around drug treatment systems, as well as wider support including housing and employment policies. It also includes aspects of policy around law enforcement and how we deal with people who are convicted of crimes associated with drug use.

Our intention is that this approach will help foster a greater focus on the overall goals of drug policies and how the different components of policy interact with each other, which often appears to be insufficient in current drug policy structures. Which policy is best will depend on which users and suppliers we are talking about, on what drugs they are using and supplying, and on other factors relevant to their particular case, as well as the types of harms being caused, both at individual and societal levels. There are unlikely to be any silver bullets.

AN ENVIRONMENT THAT SUPPORTS RESPONSIBLE BEHAVIOUR

The term ‘responsible behaviour’ risks meaning different things to different people as it is, to some extent, a moral judgement. Terms such as ‘personal responsibility’ also come with a certain amount of baggage attached. *Box 9* shows what we mean by the phrase.

Our analysis of the evidence has identified a number of opportunities for action to encourage responsible behaviour and in this way reduce the harms from drug use and other social problems.

Box 9:

WHAT DO WE MEAN BY RESPONSIBLE BEHAVIOUR?

What we mean by ‘responsible behaviour’ is that an individual should seek to behave in ways that allow them to achieve their potential, and contribute positively to their families and communities as well as to avoid, in general, incurring harms to others. Behaving responsibly, and limiting harm and damage to self and others are two sides of the same coin.

At the heart of the goal of encouraging individuals to behave responsibly is the recognition that governmental policies and programmes can either facilitate or undermine this. Society and government need to adopt policies that seek to foster an environment that is supportive of responsible behaviour.

With respect to drug use therefore, policy should be primarily directed towards enhancing pro-social behaviours and reducing the harm that drug use and supply can cause to users and the people around them.

This includes seeking to:

- Reduce deprivation, disadvantage and inequalities
- Ensure that people have accurate information about the risks associated with drug use on which to base decisions
- Prevent people from developing serious drug problems
- Act so that drug markets cause less harm to communities and individuals
- Enable those who take drugs to do so in ways that cause themselves less harm
- Protect children and young people from drug use and roles in drug supply
- Prevent drug-related crime, particularly violent and acquisitive crime.

Providing clean needles and syringes to injecting drug users to prevent the spread of HIV and other blood-borne viruses is a good illustration of how the state can facilitate responsible behaviour in part, as it can also be a first step in a long journey of rebuilding their lives. Similarly, policies built on sound evidence that strengthen families and improve young people’s life skills and attachment to school can facilitate responsible behaviour, and delay and prevent harmful drug use, even though many will still go on to experiment and use drugs.

But some policies can undermine responsible behaviour. For example, it is now well recognised that very aggressive stop and search tactics employed by police in some places and amongst certain ethnic groups aimed at addressing drugs has had unintended negative consequences. Damage to communities' and individuals' trust and respect for police and the authorities more generally can undermine other efforts to address the supply and use of drugs.

A small but significant segment of the population will use drugs. We do not believe that pursuing the goal of encouraging responsible behaviour means seeking to prevent all drug use in every circumstance. This is not to say that we consider drug use to be desirable. Just like with gambling or eating junk food, there are some moderately selfish or risky behaviours that free societies accept will occur and seek to limit to the least damaging manifestations, rather than to prevent entirely.

Drug policy should focus on ensuring that any drug use occurs in ways that pose lower risks of harm to others and to users themselves. The bar should be set particularly high for children and young people, given their physiological vulnerability to harm from drugs and the fact they are less able to make rational decisions about their own wellbeing.

Once someone is addicted, they may have less ability to make rational choices. Therefore, while we should ensure that anyone who continues to use drugs does so in a way that minimises harm, support should go beyond this to help them recover in the longer term by working with them to build the hope, aspiration and skills required to be a full member of society. This is why we separate the goal of supporting responsible behaviour from that of promoting recovery. For those with serious drug problems, recovery may be the necessary first step to responsible behaviour: it may be counter-productive to demand significant behaviour change from them before the recovery process has begun.

Tackle risk factors that predispose people to drug problems

No-one seriously doubts that use of psychoactive substance carries some risk. But it is also clear that the degree of risk varies between individuals. In adolescence, an increase in risk taking is a normal part of development and for many young people drug use is just one of a range of risky behaviours that they undertake. Usually such experimentation is short-lived. However, it is also a time when the brain is developing rapidly, which can increase the potential for harm.¹¹³ Whether experimental or occasional drug use develops into more harmful use or dependence is associated with a range of personal, social and environmental factors, some of which are fixed and some of which can benefit from intervention.

The wide range of factors that make people vulnerable to drug problems and influence whether or not these develop was discussed in Chapters One and Two, as were the specific risk factors which vary over an individual's life.¹¹⁴ The challenge is to identify effective interventions that can address the relevant factors at each stage.

Drug use is just one factor impacting on people's health and well-being, and contributing to health inequalities. The approach highlighted in the Marmot Review, which indicates the need for tackling socio-economic factors in order to provide more inclusive and cohesive communities, may also be valuable for preventing drug use and providing an environment that is supportive of recovery for those who do develop problems.¹¹⁵

Tackling socio-economic factors may also be valuable for preventing drug use and providing an environment that is supportive of recovery.

Drug use is one of a number of behaviours posing a risk to adolescent health, which tend to cluster together and have been shown to be associated with the same risk and protective factors that may be amenable to intervention, such as those relating to poor parenting.

Intervening early may help to avoid problems in families who have multiple disadvantages by helping them to become more resilient, and develop social capital. Examples in the UK include the Family Intervention Projects (FIPs) and more general support programmes such as Sure Start. FIPs "aimed to reduce anti-social behaviour (ASB) perpetrated by the most anti-social and challenging families, prevent cycles of homelessness due to ASB and achieve the five Every

Child Matters outcomes for children and young people. FIPs use an ‘assertive’ and ‘persistent’ style of working to challenge and support families to address the root causes of their ASB.” There is some evidence that these might be effective and cost-effective¹¹⁶ although there are concerns about the design of these studies and the robustness of the findings.¹¹⁷ Their impact on future substance misuse is unclear given the long-term nature of that outcome. If similar approaches are to be adopted under the Coalition’s Troubled Families programme, it will be necessary to establish good evidence of the effectiveness and sustainability of these programmes.

Other programmes providing support to vulnerable young people and their families at a later age, such as Targeted Youth Support, may also be valuable,¹¹⁸ although they depend on identifying young people experiencing problems as early as possible, and having an evidence-based model underpinning the intervention and integration of provision. Therefore how these programmes are delivered is likely to have a big impact.¹¹⁹ There is also some evidence that the Strengthening Families Programme, which has been adapted for use in a range of countries including the UK, can have a positive impact on substance use and a range of behaviours.¹²⁰ But assessing the likely impact and cost effectiveness of these programmes is made more difficult by the number of interventions that might have an effect on outcomes, as well as the range of outcomes and the long time-frame over which impacts are looked for.

Drug use affects people from all social groups, but those with more resources at their disposal may be better placed to manage problems and overcome them.

It is important to recognise that drug use affects people from all social groups, but those with more resources at their disposal may be better placed to manage the problems and overcome them. However, high-profile cases such as that of Amy Winehouse and Eva Rausing show that, unfortunately, the difficulty of overcoming such problems means that this is not always possible. It is also the

case that, while those from the most disadvantaged backgrounds have a higher than average risk of developing problems, they make up only a comparatively small proportion of the population. For example, the Troubled Families initiative is expecting to engage with 120,000 families yet there are over seven million families with dependent children in the UK, so reducing drug problems among this group may in fact have a comparatively small impact on overall drug problems.

Support sensible choices

There is extensive literature on behaviour change¹²¹ that illustrates the array of factors, both at individual and society level, that underpin decisions about what people do. Whether the decision is to buy or not to buy a new dress, have another helping of dessert, or have an alcoholic drink or use drugs, the choice depends on a complex trade-off between the perceived benefits and any potential problems. People vary in many ways that affect how this trade-off is perceived. Simply knowing something is bad for you in the long term is often not enough to prevent you from doing something that brings you some sort of immediate reward. Factors that may impact on behaviour include: values, beliefs and attitudes; norms and identity; sense of agency, self-efficacy and control; habit and routine; and how an individual feels at a particular moment.

However, external factors that encourage or inhibit an action may also be important. Cultural factors that encourage hedonism and the use of substances such as alcohol, or that present drug use as an acceptable part of a celebrity lifestyle also have an impact. The recent interest in achieving changes through choice architecture - so-called ‘Nudge’ theory - reflects the significance of external factors.

In the field of preventing drug use, the evidence for the effectiveness of most programmes is very limited. However, it has been argued that inexpensive universal programmes that have a very small positive effect may nevertheless be cost effective¹²² and those that are not specifically drug-related but seek to build general self-efficacy and social skills have the potential to make an impact on many kinds of risky behaviours, thus multiplying the benefits.

The evidence that drug-related mass media campaigns work is limited and some have been shown to actually increase the likelihood of drug use. What evidence there is supports school-based drug education programmes that are aligned with models of behaviour change and that aim to build self-efficacy and social or life skills generally.¹²³ However, the impact on drug use is not likely to be large.

The evidence that drug-related mass media campaigns work is limited and some have been shown to actually increase the likelihood of drug use.

There are a number of drug education programmes that are quite widely used, but which have been shown to be ineffective.

Importantly, there are a number of drug education programmes that are quite widely used, including the Drug Abuse Resistance Education (DARE), but which have been shown to be ineffective.¹²⁴ At a UKDPC seminar looking at the potential impact of current reforms in a period of austerity, concerns were raised that as schools become increasingly free from Local Authority controls and responsible for their own budgets, there is likely to be an

increased use of ineffective programmes that are widely marketed and distributed freely.¹²⁵ Equally, a review of prevention interventions in non-school settings found very little evidence of their effectiveness.¹²⁶ The assessments included motivational interviewing and some family interventions.

In contrast, other more general programmes such as the Good Behaviour Game, aimed at primary school age children, appear to be effective at increasing attachment to school and improving a range of behaviours, which included reducing substance use. Such programmes that seek to influence behaviour more generally, rather than focusing solely on substance misuse, may be more cost-effective and beneficial because of their wider impact.

Although some people would prefer that no-one uses drugs, the experience of more than 50 years of global efforts to prevent drug use indicates that this is not an achievable objective, at least with the tools currently available. Given this, there is good evidence to support a range of interventions that will encourage those who do use drugs to do so more safely or responsibly.

As Room points out, “drinking, smoking and drug use can symbolize freedom and autonomy, providing youth with a seemingly adult status.” Telling young people not to undertake these activities, which in the case of alcohol and smoking are acceptable adult behaviours, seems hypocritical and is therefore often ignored.¹²⁷ Recreational drugs are generally seen as little different to the licit drugs, and their use by celebrities and other groups such as the media and city workers is perceived to be widespread. So for young people who use drugs, recreationally, there is a good justification for the provision of credible non-judgemental information on ways of using drugs that are particularly risky, such as mixing drugs and drugs and alcohol, using alone, and re-dosing. In the Netherlands, a confidential pill testing service is available which overcomes a key problem with these drugs: uncertainty about what they actually contain. If this service is shown to have benefits, it

should be considered for the UK. The need for these types of approaches is now even more salient with the increasing number of new psychoactive substances becoming available, with little certainty about their content.

The value of needle exchange programmes in reducing the spread of infectious diseases is well established, and there is also sufficient evidence to support the provision of foil.¹²⁸ There is also considerable evidence showing the value drug consumption rooms (DCRs) have in both reducing drug-related deaths, and harm to health for injecting drug users,

as well as reducing nuisance from users injecting in public in local communities. In 2006 an Independent Working Group convened by the Joseph Rowntree Foundation concluded that DCRs offer a unique and promising way to work with the most problematic users to reduce the risk of overdose, improve their health and lessen the costs to society. It recommended that pilot DCRs should be set up and evaluated in the UK. This has not happened but the evidence in support of them from other countries has continued to build. So although injecting drug use appears to be declining in the UK, the potential benefits of DCRs should again be considered. It is disappointing that the UK government recently stated its view that the provision of DCRs would be a criminal offence.¹²⁹

The widespread provision of take-home Naloxone, a safe drug that can reverse the effect of heroin overdose, is also well supported by the evidence.¹³⁰ Both Scotland and Wales have programmes to extend the provision of Naloxone packs and there are pilot projects underway in England. Concerns have been expressed that this will encourage heroin use by providing a ‘safety net’, but there is no evidence that this occurs and by contrast it may well encourage individuals to take responsibility for helping others.

While these harm reduction programmes can help promote safer or more responsible drug use, they can also provide a first step in the process of recovery.

Focus enforcement and control on supporting responsible behaviour

The legal controls on psychoactive substances have an impact on the behaviour of those who use drugs, but the evidence concerning that impact is mixed. Making the use or possession of particular substances illegal clearly does not stop people using them completely, but does almost certainly deter some people

Harm reduction programmes can help promote safer or more responsible drug use and provide a first step in the process of recovery.

from using. But as criminologists have long observed, the deterrent impact of any law lies in the risk and probability of detection rather than the simple fact something is illegal.

Traditional drug enforcement efforts, which have focused on arrests and drug seizures with the aim of reducing supply, often have limited or no sustained impact on supply, because most drug markets are large, resilient and quick to adapt. The risk of detection is, in reality, quite limited and the costs associated with improving detection rates are disproportionately high and expensive. Enforcement can also have unintended consequences, resulting in an increase in the damage that drug markets inflict on a community, for instance, by triggering a ‘turf war’.¹³¹ When drugs are illegal, it also reduces the options for enacting controls that can make their use less harmful, for example quality-control measures and labelling requirements, as well as restrictions on who may sell or purchase them. Balancing the delivery of justice with effectiveness and value for money is not an easy consideration for policy makers in this area.

Identifying problems and setting priorities at community level should be done in collaboration with the community affected.

These issues are exemplified in the new psychoactive substances, the so-called ‘legal highs’, which appear with increasing frequency. The current approach appears neither to be targeting clear, desirable outcomes, nor to be based on evidence of effectiveness.¹³² Criminalising supply of all new psychoactive substances is likely to

have negative unintended consequences, for example leading to the development of other more harmful substances, increasing uncertainty over what is supplied, and increasing enforcement costs. An approach that targeted the outcome of reducing harm to young people might draw on other legal responses such as using enhanced consumer protection powers, eg trading standards, to regulate the availability and nature of certain new substances. It appears from other countries and the experience of better regulation of solvents under the Intoxicating Substances (Supply) Act 1985 that there is potential for using the wider legal control system to improve health and wellbeing, and public safety.¹³³

Within the current legal framework there is only limited international or UK evidence of the effectiveness of any enforcement activities. But what there is tends to support partnership approaches that involve the community. The evidence suggests that identifying problems and setting priorities at community level should be done in collaboration with the community affected.¹³⁴ Neighbourhood

policing community meetings could provide an opportunity for this, while engaging the community through structured, deliberative processes could help to develop a stronger understanding of the problems caused by drug markets and the options available to alleviate them.

There is also evidence that enforcement approaches that target particularly harmful behaviours may be effective at reducing the harm to communities and the environment. Our review that looked at the potential for improving the impact of enforcement¹³⁵ identified three broad and potentially overlapping approaches that could be used to deliver an overall reduction in harms:

Enforcement approaches that target particularly harmful behaviours may be effective at reducing the harm to communities and the environment.

1. Targeting specific individuals or groups identified as being particularly harmful, eg using schemes such as Integrated Offender Management, or one-off targeted operations
2. Targeting areas where drug problems are particularly damaging, eg seeking to displace a market to another area, where it will have less impact, or ‘closing’ open markets
3. Targeting particularly harmful behaviours, eg addressing the use of violence and intimidation, or the use of young people as lookouts and couriers.

Examples of the first group are assertive outreach schemes such as Operation Reduction in Brighton & Hove, and Operation Iceberg in Kent. In these schemes, street-level dealers, who have been identified as user-dealers, are approached and offered the opportunity to enter a programme of treatment and rehabilitation as an alternative to arrest and prosecution. An independent evaluation of Operation Reduction suggested that it was successful in rehabilitating individuals and reducing their offending, and also reduced the costs associated with arrest, prosecution and incarceration.¹³⁶

The Drug Market Intervention (DMI) initiative in the US is quite similar to this and seeks to tackle open-air drug markets that are causing particular problems within a neighbourhood. The most violent offenders are targeted, and prosecuted as examples. The strategy then targets low-level offenders and stages an intervention with families and community leaders with the aim of encouraging them away from crime.¹³⁷ This appears to have been effective in some areas¹³⁸ but not in others and research is underway seeking to identify the characteristics of neighbourhoods and drug markets that are associated with good outcomes.¹³⁹

Other projects have targeted gangs, such as the Boston Gun Project, and a similar approach which is being tested in Glasgow. Recently there has also been an increase in operations that seek to ‘follow the money’ and use asset recovery to try and hit the organised crime leaders who benefit most from the drug trade and thus reduce their ability to fund the trade. While some high-profile groups have been brought to justice in this way, these are long-term operations requiring specialist skills.

The Proceeds of Crime Act (POCA) has been increasingly used in drug crime cases. Some research suggests that it may be a deterrent, but the evidence is mixed. The potential for providing additional revenue for police forces or communities makes it appealing, but there is anecdotal evidence of unintended consequences from indiscriminate use of the act, such as when the family of a person who has been convicted of growing a few cannabis plants may lose their house.¹⁴⁰

Stop and search for drugs is responsible for about half of all stop and search activity and fewer than 1 in 10 result in drug arrests.

Communicating with the public about enforcement activities can help to address people’s concerns and demonstrate that such strategies deliver results. However, the typical media images of a police ‘crackdown’ - smashing in doors and making arrests - may have a downside in that they may create a demand for a style of enforcement that is not always the most cost effective. It is also the case that what may be reassuring to one part of the

public might heighten the concerns of others. There needs to be more innovative ways to engage the public and reassure people that action is being taken; the cases presented above illustrate examples of such approaches.

Some enforcement practices can alienate communities and hence potentially increase the likelihood of drug use within the community. Stop and search for drugs is responsible for about half of all stop and search activity and fewer than 1 in 10 result in drug arrests. The differential impact of stop and search on ethnic minorities is well documented and can have a negative impact on community relations.¹⁴¹

Ensure that drug laws support responsible behaviour

Whether drug laws are effective in supporting responsible behaviour is difficult to assess. On the one hand, the low overall levels of use of controlled drugs compared with alcohol could be evidence of the power of the law as a deterrent. In surveys the fact that drugs are ‘illegal’ is often cited as a reason why people do not use them. However, the fact that an estimated 11 million people across the UK have at some time in their life used drugs might also be seen as evidence of its ineffectiveness. Equally, the fact that an estimated three million have used at least one illicit drug in the past year suggests the law has, at best, a limited deterrent effect.

With about 42,000 people in England & Wales sentenced every year for possessing drugs and about 160,000 given cannabis warnings, this amounts to a lot of time and money for the police, prosecution service and the courts. On top of this comes the cost to the individual in terms of damage to employment prospects. Some people who do develop drug problems may also be put off from seeking help earlier because they are doing something illegal.

There are a number of reasons for amending the law in relation to the possession of drugs for personal use:

The Misuse of Drugs Act is over 40 years old

Since the 1971 Misuse of Drugs Act was passed, the nature of drug use in the UK has changed radically. The Act was not designed to deal with such high levels of use nor the rapid development of new drugs.

The ABC classification system (*see Box 1, page 37*) and the associated schedules of drugs which are at the heart of the legislation were created both to designate the status of the substances, and to provide a guide to the courts when sentencing. In recent years, the emergence of new psychoactive drugs, now at a rate of one a week, has created a rate of change in the drugs market that is beyond anything anticipated by the designers of the Act. This is something the New Zealand government recognised when they commissioned the New Zealand Law Commission to review their Misuse of Drugs Act.

With about 42,000 people in England & Wales sentenced every year for possessing drugs, this amounts to a lot of time and money for the police, prosecution service and the courts.

In addition, the ABC classification system has become increasingly discredited because a drug has never been reclassified downwards (with the exception of cannabis, which was then reclassified upwards). When experts and scientists have suggested reclassifying drugs such as ecstasy and cannabis downwards in the past, this has been rejected by ministers. Some experts have suggested that the system has outlived its usefulness, that politicians and the public do not fully understand its purpose, and that with the advent of the Sentencing Council, there is an argument for de-coupling the assessment of harm from the legal and sentencing framework.

Many thousands of people each year are cautioned or given criminal records for possessing drugs; we need to ask whether this is a proportionate response.

Disconnect between policy and practice

The current laws also bear little relationship to what actually happens in practice. Over the years the police and courts have used their judgement to the extent that relatively few people receive a prison sentence simply

for possessing a controlled drug. Many people addicted to drugs who commit acquisitive crimes are dealt with through other provisions in law. In effect, simple drug possession offences have increasingly become depenalised, except for repeat offences, and in a few relatively isolated instances. It is not clear why the law should be so disconnected from custom and practice, yet it is clear that the police and prosecution authorities do not consider such offences to be a high priority. There are also legitimate concerns that the law is applied unevenly, with some groups of users appearing to be subject to more strict action and penalties than others, most notably those from ethnic minorities.

Growing *de jure* decriminalisation of some drugs

In recent years, new legislation has introduced powers for the police to issue warnings and penalty notices for the possession of small amounts of cannabis. Yet the possession of class C anabolic steroids for personal use does not attract a criminal sanction. More recently, the new Temporary Drug Class Orders do not result in criminal sanctions for those found with small amounts of the temporarily controlled drug. In effect we are seeing a gradual *de jure* decriminalisation for the possession of small amounts of some drugs. Yet there is no clear explanation about why this should apply to users of these drugs, but not to users of other drugs.

Negative effects of enforcement

Many thousands of people each year are cautioned or given criminal records for possessing drugs. We need to ask whether this is a proportionate response, particularly since enforcement tends to be focused on certain groups, particularly the young and some ethnic groups in particular localities. There are also legitimate concerns that drug control laws lead to greater risks for each drug user, as substances are sold with less predictable dosages, and more uncertainty about content or possible contaminants. The ex-head of the UNODC is not alone in calling for the decriminalisation of the consumption (possession in the UK) of drugs.¹⁴²

Over recent years there has been a clear drift upwards of length of imprisonment for drug production and supply offences, even though maximum sentences are rarely applied.¹⁴³ These appear disproportionate in comparison with some other countries,¹⁴⁴ and it is not clear that these tougher sentences provide any greater deterrent for those who might break the drug laws.

Erosion of respect for the law

The risk of being caught possessing drugs is very low compared to the prevalence of drug use overall. As criminologists know, the perceived risk of detection is an essential component

Changes in drug laws do not necessarily lead to changes in individuals' decisions about drug use.

of deterrence,¹⁴⁵ and the point has been reached where drug laws are largely seen as an irrelevance by those who break them. Opponents of depenalisation and decriminalisation raise concerns about the message that a change in the law would send to the public, particularly young people. We recognise that the law expresses the sort of society we wish to live in. But the law relating to the possession of drugs has become discredited to such an extent that any usefulness in setting a moral position has in many situations become largely ineffectual. One example of the disconnect between law and behaviour is the reclassification of cannabis. After reaching a peak in 2001, the prevalence of cannabis use in the UK has been broadly declining. This has been in spite of the classification and punishments for possession being eased in 2004 and then increased again in 2007. As noted by the Chair of the Advisory Council on the Misuse of Drugs in relation to the changes in classification of cannabis, "It is as if cannabis users either do not know or do not care".¹⁴⁶

Acceptability of other approaches

Many people are concerned that if the law were to be changed so that possessing controlled drugs was no longer a criminal offence, then use, especially by young people, would increase. This is understandable. But what evidence there is indicates that changes in drug laws do not necessarily lead to changes in individuals' decisions about drug use. In the UK, the reclassification of cannabis, both downwards and subsequently upwards, coupled with an increasing use of other penalties by the police, took place at the same time as a steady decline in reported use of cannabis, with no apparent impact on levels of use caused by the changes in legal status.

Some other countries have gradually moved towards a more decriminalised approach to personal possession of small amounts of all drugs. This has been seen for example in Portugal, Czech Republic, and Switzerland, and for cannabis in parts of Australia, the US, and some South American countries. We acknowledge that the evidence of the impact of such changes is disputed by some observers. But while we cannot say with certainty what the total impact has been, one simple lesson we can draw with confidence from such initiatives is that 'the roof has not fallen in' and that prevalence and consumption have not increased in these countries to any significant extent. Some experts indeed argue that these reforms have led to decreasing problems.

The reclassification of cannabis, both downwards and subsequently upwards, had no apparent impact on levels of use.

It is important to note that recent research in Australia concluded "that decriminalizing cannabis shifts the age distribution of uptake towards younger age groups while leaving the proportion of those who will start using cannabis unchanged. This suggests that decriminalization affects when individuals start using cannabis, rather than whether or not they start".¹⁴⁷ Given the particular harm that drug use can cause to young people, this

finding indicates the importance of combining any change in drug laws with effective drug education and treatment programmes, with close evaluation, in order to identify and mitigate risks of increased drug use among young people.

Inconsistency with other substance controls

We do not have consistent and integrated laws to regulate the production, distribution and use of mind-altering and harmful substances, such as alcohol, tobacco and other potentially harmful drugs, including those for cognitive and

performance enhancement. Our attitudes to the public health consequences of tobacco and alcohol seem to be hardening. Smoking controls, alcohol pricing and sanctions for intoxication illustrate a move towards more controls and regulation. There appears to be a move in the opposite direction for some controlled drugs, particularly cannabis.¹⁴⁸ With performance-enhancing drugs, doubts have been raised about whether the current regulatory systems for medicines and medical devices can respond successfully to the problem. We believe all these changes represent a search for a new, more consistent and fairer equilibrium, and such moves should be welcomed and encouraged.

We do not have consistent and integrated laws to regulate the production, distribution and use of mind-altering and harmful substances.

It is often argued that by reforming the law on drugs we may in fact make matters worse. Policy makers are understandably cautious. The concern is that, as we do not start from a blank sheet, relaxing the drug laws will send a message, and that this is likely to lead to an increase in consumption of drugs, especially amongst vulnerable young people. Supporters of the existing drug laws argue that they are drawing on the precautionary principle, which urges policymakers to be watchful and circumspect.

In one analysis of the relationship between the precautionary principle and evidence, reference is made to an international exposition of the issue in relation to the environment: "Where an activity raises threats of harm to the environment or human health, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically. In this context the proponent of an activity, rather than the public bears the burden of proof."¹⁴⁹ Clearly for many people who are cautious of changes to drug policy, the case for change has not so far been adequately made to meet the burden of proof.

Yet for proponents of drug policy reform, the arguments largely rest on the basis that sufficient evidence has accrued to show the negative consequences of current policies. Thus, it might be argued that the burden of proof should be reversed and that the precautionary principle would indicate that it is those who seek to use laws to restrict drug use who need to demonstrate that such interventions are necessary.

While there may be a strong case for reforming the drug control laws, there is still a need for caution in any changes.

However, while there may be a strong case for reforming the drug control laws, there is still a need for caution in any changes. We return to this debate in Chapter Five, where we present our recommendations for how drug policy, including the drug laws, can be used

most cost effectively to support responsible behaviour.

Designing enforcement in order to meet the goal of supporting responsible behaviour opens up the potential to achieve additional benefits beyond that of merely enforcing the law and hence can bring wider benefits to communities. It can encourage innovation with the potential for developing more cost-effective interventions.

IMPROVED RECOVERY – FOR INDIVIDUALS, FAMILIES, NEIGHBOURHOODS AND SOCIETY

In 2008, in response to what was becoming an increasingly polarised debate over what constitutes recovery from drug problems, UKDPC facilitated a consensus process which brought together a disparate group of people to develop a shared vision of recovery.¹⁵⁰ The group included several people in recovery, and family members of people with drugs problems, as well as local commissioners and practitioners coming from services that provided a full range of types of care and support. Participants also came from different parts of the UK and different ages and cultural backgrounds. This group developed the following consensus view on recovery:

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

The term “control over substance use” is deliberately inclusive of both abstinence and maintenance approaches to recovery: both can provide the necessary control over substance use. However, it was agreed that neither ‘white-knuckle abstinence’,

Recovery is neither an easy, nor a linear process. It takes considerable time and effort to achieve and sustain.

with a constant fear of relapse, nor being ‘parked’ on prescribed drugs, with little consideration of people’s individual needs and aspirations (which may change over time), constituted recovery.

Recovery is neither an easy, nor a linear process. It takes considerable time and effort to achieve and sustain, both for individuals and hard-pressed communities. Yet, there is good evidence that treating people who have drug problems can have a big impact. Treatment for drug dependency and addictions has a robust international scientific evidence base to justify the provision of public expenditure, and has proven efficacy.^{151 152} The use of methadone and other prescribed medications as part of a treatment package has substantial research evidence in support, including use in prisons. It is important that these treatment options are retained while evidence is built up for other interventions to facilitate recovery.

But as reflected in the second half of the vision statement, it was also considered very important to recognise that recovery is about more than reducing or removing harm caused by substance misuse, as it must also encompass building a fulfilling life. This involves improving health and well-being, rebuilding relationships, and participating fully in society, for example through education, voluntary activities or employment. Above all, the group recognised that while the individual must be placed at the heart of recovery, their relationship with the wider world - family, peers, communities and society - is an intrinsic part of the process.

The statement also reflects the evidence about how the community, the wider environment and facts such as deprivation and disempowerment can influence recovery: something that is not often addressed.

Recovery and communities

Our research into the stigma experienced by people with drug problems and their families, and the impact this has on their potential recovery highlighted the importance of this issue, if the vision for improved recovery in the current drug strategy is to become reality.

Part of the research was a UK-wide household survey of public attitudes towards people with a history of drug dependence. This showed a general support for the idea of recovery - 81% of respondents agreed that it is important for people recovering from drug dependency to be part of the normal community, and 73% agreed that people recovering from drug dependency should have the same rights to a job as anyone else. However, 43% of adults said they would not want to live

81% of respondents agreed that it is important for people recovering from drug dependency to be part of the normal community.

next door to someone who had had a drugs problem, which compared with only 9% who in a similar survey said this about someone with mental illness. Only two-fifths of people (41%) would be willing to work with someone with a history of drug dependence and 39% think someone with a history of drug dependency should be excluded from public office.

This stigmatisation is also evident in many government pronouncements about the welfare system, in which those with drug problems, although only a small proportion of those on benefits, are singled out as being targets for specific action. This may, paradoxically, make it harder for people in recovery to obtain work.¹⁵³

The basis for this stigmatisation of those with drug problems appears to be a lack of understanding about addiction, and seeing it as a matter simply of personal choice. Our research also indicated that a large proportion of the general public believe that people with drug dependence are to blame for their problems, and could give up if they really wanted to. However, the situation is far more complex than that and there is a need for better information and a wider debate to address this. Our research also showed that press reporting of drug use is dominated by themes of crime and celebrity and often uses pejorative language that frames the public understanding of drug dependence. Recovery and integration are rarely spoken about.

The research also showed that in general, respondents who currently or previously had lived, worked or were close friends with someone with a history of drug dependence, had more positive attitudes to such people than those who had not had any personal experience. This suggests that stigma within communities might be reduced through:

- Improving the knowledge and understanding among the general public about drug dependency and recovery
- Engineering new ways to support and promote community participation and increased contact with recovering drug users. The Brink recovery bar in Liverpool established by Action on Addiction, and the Tea Room Social Enterprise set up by Burton Addiction Centre are examples of this sort of approach. These promising innovations need to be evaluated and the lessons disseminated.

A key aspect of participation in society involves employment. Further research commissioned by UKDPC to examine employers' attitudes identified two main concerns for employers about hiring recovering drug users: the requirement for individuals to be 'fit for the job'; and the potential risk to their business or other employees. Nevertheless, in many cases where recovering users had

been employed they were seen as good employees. Our research found that experiences of employing this group are often very positive.

But two-thirds of employers in a survey said they would not consider hiring someone with a history of heroin or crack use even if they were otherwise suitable.¹⁵⁴ Specific concerns described by employers included dealing with relapse, recognising the recurrent nature of the condition, risks to other employees, and concerns about methadone.

The research also identified a number of legislative and administrative barriers which can diminish the likelihood of people recovering from drug problems to get a job. For example, the Equalities Act contains a specific exclusion for people with drug or alcohol addiction from the Disability Discrimination protections; many employers even within the drug sector impose arbitrary requirements for someone to have been two years drug free before they can be considered for employment; and a criminal record is becoming an ever greater barrier to work as more and more employers apply CRB checks for new applicants.

Parliament approved changes to the Rehabilitation of Offenders Act (ROA) in May 2012¹⁵⁵ which aim to reduce the impact that having a criminal record has on getting a job. Given that employment can be hugely important to aid recovery from drug problems, this change is welcomed, even though some commentators have argued that it does not go far enough. As Jonathan Aitken has said, "Looking at the reforms there are some gains but a few disappointments".¹⁵⁶ We are of the view there is still scope for further amendments to the ROA so that there are shorter rehabilitation periods required where an offender has to declare their record.

Welfare reform is another government policy area which can have a major impact. About 80% of people entering treatment for drug problems are unemployed and the nature of drug addiction means that achieving recovery is a long-term process, many are in receipt of benefits for considerable periods of time. Evidence indicates that for many getting a job can only be a long-term goal, and is a lengthy process. Quite long periods of work

Parliament approved changes to the Rehabilitation of Offenders Act in May 2012 which aim to reduce the impact that having a criminal record has on getting a job.

Pushing people into formal employment too quickly can create a vicious cycle of failure and relapse.

experience, such as volunteering, to help build skills, confidence and stability can be very valuable. Yet, pushing people into formal employment too quickly can create a vicious cycle of failure and relapse. It is clear that an approach based on using penalties within the benefit system to ‘encourage’ people with entrenched drug problems into work is not supported by the evidence,¹⁵⁷ and it assumes that finding work is a simple matter of choice on the part of the drug user. So there is a risk that changes to the system will have a differential impact on this already disadvantaged and vulnerable group, and there is some evidence to suggest that this may be already happening with the current reforms, such as the implementation of the Work Capability Assessment.¹⁵⁸

Removing legislative and administrative restrictions which reinforce stigmatisation of people with drug dependence and addictions is therefore another important area to take action to develop recovery-oriented communities.

Maximising the use and cost effectiveness of community sentences is likely to be more beneficial than imprisoning problem drug-using offenders.

Recovery and the Criminal Justice System

There is evidence that certain types of enforcement activity may be able to reduce the harm to the community from certain types of crime and also provide a starting point for recovery. Operation Reduction in Brighton & Hove, described earlier, incorporates assertive outreach to encourage people dependent on drugs, who are dealing to support their drug

use, to engage with treatment, and to achieve recovery with sustained support.¹⁵⁹ The national Drug Intervention Programme, and Integrated Offender Management also aim to encourage engagement with treatment.

It is important that the criminal justice system is also focused on recovery and supports the work done in the community. The ‘revolving door’ of short-term prison sentences that interrupt treatment and are too short to begin to deal with the complex issue of drug addiction was documented in our 2008 research review *Reducing Drug Use Reducing Reoffending*. Some progress has been made since, but the findings are still of relevance. We identified two broad areas where the evidence indicates a significant impact might be made:

1. The use of diversion and community punishments rather than imprisonment for most drug-dependent offenders.

Imprisonment can have unintended negative consequences for offenders

generally^{160 161} and with those who are drug-dependent, there are many practical issues which frustrate the delivery of successful drug treatment programmes in prisons, particularly for prisoners with short sentences. An environment which is struggling to cope with record numbers of prisoners is unlikely to be conducive to recovery, and custodial sentences may frequently do more harm than good. By creating or exacerbating problems such as housing, employment and family relationships and increasing health risks such as infection from blood-borne viruses, the chances of successful long-term outcomes are further reduced. Meanwhile enforced detoxification without adequate follow-up support also increases the risk of relapse, overdose and death, particularly on release.

Maximising the use and cost effectiveness of community sentences is likely to be more beneficial than imprisoning problem drug-using offenders for less serious acquisitive crimes and drug possession offences. This appears to be increasingly recognised by the low levels of prison sentences for possession alone.

Imprisonment is more likely to entrench some problems for the offender and their family, rather than solve them.

Community sentences have the potential to offer better value for money and deliver similar reductions in reoffending. However, we need to pay attention to how to make these sentences more cost effective by thinking about how they work with models of behaviour change and what is known about recovery processes. Evidence from Project Hope in the US and related projects suggest that clear, swift and short penalties for breaches are important for success, but the evidence is from a cohort of mainly stimulant-using offenders. Recent research on drug courts also highlighted community sentences’ potential to provide wider benefits although outcomes are quite variable.¹⁶² More research into ways in which community sentences in this country can be developed to enhance their cost effectiveness and recovery focus is needed.

For less problematic drug users, schemes that divert drug-using offenders in the early stage of offending, and before their criminality and drug problems have become entrenched from prosecution on condition that they address their substance use and other problems, may merit being expanded. Imprisonment is more likely to entrench some problems for the offender and their family, rather than solve them. Using restorative justice may be appropriate in some cases.

Adult family members affected by a relative's substance misuse have been largely neglected.

2. Prison drug services could be improved further and linked into community recovery systems.

With so many drug-dependent offenders within the prison system, largely because of non-violent acquisitive crime offences, the extent and effectiveness of drug treatment

and other interventions must be improved so that prison care is equivalent to that found in the community. The rollout of the Integrated Drug Treatment System is a positive step but continued improvement is necessary. The evaluations of this and of the new Drug Recovery Wings need to be used as the foundation for continuous improvement.

Release is a time of particular risk as there are high rates of drug-related death and relapse into drug use.¹⁶³ Developing support and aftercare needs to be a priority. The pilot at Peterborough prison using a payment by results approach may provide a useful model and there are initiatives elsewhere. It is important that these are all evaluated and good practice spread more widely. Key areas which could lead to significant improvements in levels of recovery include:

- The process for identifying problem drug users on reception
- Ensuring all prison healthcare adheres to NICE and other clinical guidelines
- Enhancing performance management and clinical governance of prison healthcare
- Continuity of care within the prison system and with community services before prison and after release.

Recovery and families

Children of drug-using parents are at particular risk; their needs were highlighted in the ACMD report Hidden Harm¹⁶⁴ and since then more attention has been paid to them, and a number of programmes developed to try to address these needs. Some of these programmes are the subject of evaluation and are showing promising results, for example the Moving Parents and Children Together programme¹⁶⁵ and the Family Drug and Alcohol Court, which seeks to work with families at risk of having their children taken into local authority care.¹⁶⁶ It is difficult to evaluate their cost-effectiveness though because of the potential long-term nature of the impacts.

Adult family members and close friends of people with drug problems can also experience significant stress and health problems. The impact can also spread more widely, for example affecting family members' employment, their social lives and relationships, and the family finances.

However, adult family members affected by a relative's substance misuse have been largely neglected, partly due to concerns about stigma, but also because the focus and that of drug treatment services has been first and foremost towards helping the person with the drug problem. To put this in perspective, research for UKDPC¹⁶⁷ estimated that in 2008 in the UK, at the very least:

- 1.4 million adults were significantly affected by a relative's drug use (including about 140,000 adult relatives of people in drug treatment)
- the cost of the harms they experienced was about £1.8 billion per year, and
- the value of support they provide would cost about £747 million per year (at 2008 prices) if it was to be delivered by health and social care providers.

Clearly, families and the support they give are a crucial asset to those needing their help and for the wider community. Adult family members' support for their drug-using relative has been shown to be important in three distinct but related ways:

- Preventing and/or influencing the course of the substance misuse problem
- Improving substance-related outcomes for their drug-using relative, i.e. reduced substance misuse, as well as promoting better engagement with treatment
- Helping to reduce the negative effects of substance misuse problems on other family members.

Thus adult family members may need help to meet their own pressing needs, but also to assist them to give effective help to their drug-using relative and to other family members. However UKDPC research¹⁶⁸ has indicated that the provision of support to this group, although acknowledged often in drug policy documents, remains a comparatively neglected area which deserves more attention.

How recovery is achieved, and the time taken, differs from person to person.

There is a need to consider what recovery means for families, what White & Kurtz¹⁶⁹ describe as "family recovery", as well as for the individuals with drug problems themselves and support provided to family members to help them and the family unit adjust.

Recovery is a process that takes time, and lapses and relapse must be expected in many cases, so people need continuing support.

Recovery for individuals

There has been a welcome increased focus on recovery in drug strategies in the UK,¹⁷⁰ accompanied, and no doubt stimulated by, a burgeoning recovery movement. However, focusing on recovery is not simply about providing particular types of services, but rather about people directly controlling their own care, shifting the balance of power

towards individuals. It also seeks to build hope and aspirations across a range of areas leading to the achievement of a fulfilling life, rather than focusing on clinical symptoms and the chronic nature of the condition. This requires a significant change in culture within many services, as well as the development of new services and new partnerships, for example developing links between treatment services and mutual aid groups. The challenge of this for the workforce should not be underestimated.

As is widely recognised,¹⁷¹ recovery differs between individuals. What causes the problems associated with substance use, and the extent of them, varies between individuals, as do the resources (whether personal or external) available to them and also their personal priorities. So how recovery is achieved, and the time taken, differs from person to person. Similarly, recovery may be associated with a number of different types of support and interventions, including medical treatments, or none at all.

This complexity was highlighted by the findings of a recent expert group looking at the role of medication-assisted treatment in recovery.¹⁷² The group highlighted a number of ways in which the improved outcomes resulting from the expansion of the treatment system over recent years can be increased further by making the system more recovery-orientated. These include ensuring that systems and services have a strong and clear vision and framework for recovery, that the treatment provided is optimised through proper care planning, review and adaptation to respond to failure and take advantage of windows of opportunity for improving progress. It identifies a need for ‘dynamic’ packages of care that deliver a range of interventions at different intensity at different times according to individual needs and choice.

While the treatment itself needs to be individually tailored and follow best practice, the report also highlights the importance of a range of different types of support to facilitate recovery – whether via the person’s peers, employment

and housing, family support, and health and lifestyle interventions – support which will need to continue after treatment is completed.

The report reflects that for most people recovery is an on-going process and they may always consider themselves ‘in recovery’ rather than recovered, although others may eventually feel that they are no longer at risk of relapse. It notes that recovery may be achieved in a variety of ways including through medically-maintained abstinence as well as for some people without professional assistance.¹⁷³ Besides this tailored support, what is absolutely essential is a wider environment that is accepting of people trying to rebuild their lives, for example employers being more open and willing to give jobs to such people.

The development of recovery-oriented care systems is a major opportunity for change but this will take time. There are encouraging signs that this change is already beginning as increasing numbers of people leave treatment free from dependence, according to the most recent treatment statistics.¹⁷⁴ There is an important opportunity for drug policy in fostering and developing such a system, but the evidence for how this can be done is still limited although there is useful evidence from the US and the mental health field that can provide some guidance.¹⁷⁵

Recovery is a process that takes time, and lapses and relapse must be expected in many cases, so people need continuing support. There are risks associated with relapse, which include an increased risk of overdose deaths. There is also good evidence that early re-entry to treatment once someone relapses is associated with much better long-term outcomes,¹⁷⁶ so it is important that a focus on recovery outcomes does not lead to negative unintended consequences. The use of outcome measures that include abstinence-based discharge and no readmission within a particular time period may have the potential to lead to these negative consequences, as does an emphasis on full recovery that may make people feel they have failed if they relapse.

Payment by Results systems, whereby the providers of services are paid for the results achieved, are being piloted and evaluated as a way of incentivising change to a focus on recovery in treatment services, but the evidence casts doubts on the likely impact and value for money of this approach.^{177 178}

The development of recovery-oriented care systems is a major opportunity for change.

There are many ways in which the treatment system can be changed and incentivised to improve the chances of recovery and it is important that all of these are explored and evaluated. There are examples of innovative practice being developed at the grassroots, ranging from working with current providers to provide more integrated, recovery-focused provision, through the development of new services and organisations, such as recovery cafes and social enterprises to provide training and employment opportunities, to schemes that allow service users to earn credits from voluntary activities that can be put towards activities of their choice that may assist their recovery. The sharing of best practice is very important.¹⁷⁹

Within these new developments it is very important not to ignore the evidence we do have for the cost effectiveness of current treatments, such as substitute prescribing, as well as for new treatments such as heroin prescription for those for which traditional treatments have not worked. The importance of these, and indeed of the harm reduction services such as needle exchanges and drug consumption rooms for helping people begin the recovery process, should not be underestimated.

CHAPTER 4 BARRIERS IN POLICYMAKING AND DELIVERY

KEY POINTS

- >Independent research on what works in drug policy receives comparatively little funding in the UK, compared with some other countries
- >The government's Advisory Council on the Misuse of Drugs (ACMD) is under-resourced and in the context of the rapid appearance of new drugs, this risks pushing the balance of its work towards classification assessments rather than broader policy issues
- >The UK is unusual among EU countries in having the Home Office as the department responsible for drug policy
- >There is little political space for informed debate about policy options
- >Localism and devolution may lead to policy experimentation but limit the ability of the government to pursue a single drug strategy and to share knowledge.

In most discussions, drug policy is presented as a simple struggle between two opposing value systems: whether to liberalise our approach to drugs or to wage war on the producers, traffickers and users. This debate is an extension of moral views on whether drug use is intrinsically wrong. Supporters of either outlook dominate the airwaves, the press, blogs and social media.

In this environment, expert views and evidence get labelled as coming from either one outlook or the other and treated with suspicion, so we lose not only a measured review of evidence but also the possibility of having the kind of nuanced, practical discussion that we need.

A crucial question is whether anything can be done to facilitate a more informed, objective and less sensationalist debate about drug policy in the UK. With this in mind, we believe that there are four areas where the ways in which we make and deliver drug policy are limiting our ability to have more cost-effective policies.

A crucial question is whether anything can be done to facilitate a more informed, objective and less sensationalist debate about drug policy in the UK.

THE SHORTAGE OF INDEPENDENT ADVICE AND ANALYSIS

The Advisory Council on the Misuse of Drugs (ACMD) has provided sensible and balanced analysis on a range of diverse drug policy issues for over 40 years.¹⁸⁰ In essence, the ACMD provides two types of advice to Ministers: (i) scientific assessment and advice about whether particular substances should be controlled and, if so, in which class and schedule they should be placed, and (ii) expert advice on a wide range of drug policy issues, drawing on research evidence and professional and public consultation, with the aim of improving public policy. In earlier years, much of the ACMD's work was directed at this second area, such as its work on AIDS and drug misuse, prisons, probation, policing, treatment, children, and parents with drug problems; much drug policy and government-initiated interventions stemmed from its findings.

The very small budget of the ACMD is coming under increasing strain, with limited support available for the voluntary members during their work. While the ACMD's work includes a recovery committee, there are significant areas of policy that are not being examined, such as the impact of law enforcement interventions. With a more devolved approach to policy beginning to emerge, it may be opportune to revisit the role and contribution of the ACMD in order to see whether and how these two functions can be optimised.

(i) the function of assessment of harms

The classification and scheduling of particular drugs has become the focus of public and political debate, and in the process the media and politicians have started assuming that this is the only route to exerting control over drug use. Yet experience suggests that this is not the case. In practice, the stage has been reached where there is an expectation that all new psychoactive substances will be subjected to legal control, while any suggestion of changing existing classifications has become highly controversial.

There is a good case for now considering whether the current process for assessing and classifying drugs needs to be re-modelled. This was initiated by Charles Clarke when he was Home Secretary, but the process was dropped by his successor.

When the Misuse of Drugs Act was passed in 1971, the principal aim of the classification and scheduling system was to guide the courts about sentencing. Subsequently, the Sentencing Council has been established in England to ensure, in part, better sentencing consistency. In 2012 the Sentencing Council published new guidelines for drug offences.¹⁸¹ As is discussed elsewhere, we have reached the conclusion that the ABC drug classification system should be reviewed.

The ACMD has raised the possibility of a new statutory body being established, which would be responsible for determining whether a new substance is very similar (an ‘analogue’) to other controlled drugs.¹⁸² While we have concerns about this approach to classification,¹⁸³ this idea of establishing an independent body, which could make decisions on levels of control, may be promising.

There is a good case for now considering whether the current process for assessing and classifying drugs needs to be re-modelled.

In New Zealand, a Law Commission review of their drug laws, which are very similar to those in the UK, proposed a different solution to the regulation of new drugs.¹⁸⁴ The new regime would require manufacturers and importers of a new substance to obtain an approval for a substance before releasing it onto the market, based on trials that find it to pose a ‘low risk’. A new independent regulatory authority would determine applications for approvals. If the

regulator decided that a substance was so harmful that it should not be approved, the regulator would refer the substance on to be considered for inclusion in the prohibited drugs regime. Prohibition would also be considered if the regulatory regime proved to be ineffective in minimising the harm of a regulated drug.

(ii) Research and policy analysis

Policy makers should be strongly in favour of better knowledge and evidence in policy making. While the government has established a cross-departmental drug research coordination group and is seeking to boost EU collaboration on drug research, the reality is, at a time of austerity across all government departments, research has been afforded a lower budget priority.

Policy makers should be strongly in favour of better knowledge and evidence in policy making.

Government spending on research to support the drug strategy has declined over the past few years. There have been some exceptions, such as the Medical Research Council and Economic and Social Research Council’s joint addictions research programme. However, this is focused on certain research interests and many drug policy issues and challenges are not being examined, especially those relating to efficacy, cost-effectiveness and alternative policy options. The UK fares badly in investment in research when compared with some other countries. For example, in Australia there is a substantial programme of drug policy research carried out through a network of university research centres, some of which are funded by the Federal and State authorities alongside substantial independent foundation funding.

In a review of the lessons from one of the few independently funded research programmes into drug policy, the Joseph Rowntree Foundation observed, “If evaluations are to be impartial and if we want government-supported research to contribute to our wider understanding of drug issues, it may be best conducted elsewhere in an arm’s-length organisation that recognises and responds to the needs of policy-makers but also prioritises the need for us to understand more about drug-related problems in the UK and what the most effective responses may be”.¹⁸⁵

The Canadian Centre on Substance Abuse also has a legislated mandate to provide national leadership and evidence-informed analysis and advice to mobilise collaborative efforts to reduce alcohol and other drug-related harms. Its annual costs, principally met by the government, are about £4.7m. We believe there is a strong argument for establishing something similar in the UK which could provide authoritative independent support to policymakers in Westminster and the devolved governments. It would not necessarily have to be a body carrying out the research itself but could be responsible for commissioning research by other groups and then analysing and reporting the findings.

CONSEQUENCES OF HOME OFFICE LEADERSHIP

There has been some debate about the merits of the Home Secretary having the responsibility for the coordination and leadership of drug policy.

It was not always the case that the Home Secretary had this responsibility. Between 1994 and 2002, the Lord President of the Council (the senior Cabinet Office Minister) provided coordination and leadership. This responsibility was transferred to the Home Secretary in 2002. In their report, the Royal Society for Arts Drugs Commission recommended that responsibility for leading the drug strategy should be passed to the Department for Communities and Local Government.¹⁸⁶

An argument for this is that Home Office leadership encourages a view of drugs as largely a crime issue rather than a matter for health responses. As identified earlier, in Wales, Scotland and Northern Ireland there are differing arrangements about which Minister coordinates policy.

In many other countries, especially in the European Union, national leadership and coordination is provided by the Ministry of Health. Throughout the UK there has been a renewed focus and political interest in public health since 2010 and especially on issues such as alcohol. In England a new body, Public Health England is being set up which will include substantial resources being transferred to support drug treatment.

We should consider changing the political leadership and coordination of drug policy.

In some ways, the argument about who leads or coordinates drug policy might be seen as an academic one. In our study of the governance of drug policy, we could find little concrete evidence that different departmental leadership delivers different outcomes.¹⁸⁷ Those people we interviewed felt that the quality of the leadership

was probably more important than which Secretary of State had responsibility for coordination and leadership. Indeed, the argument was advanced that without the strong influence of the Home Office and their overriding interest in reducing crime, efforts to expand drug treatment and recovery services would never have happened. Those leading health, it is argued, will always have other and more pressing priorities. As one participant observed, “big political beasts make things happen”.

But there remain reasons why we should consider changing the political leadership and coordination of drug policy, and we return to this issue in Chapter Five.

LACK OF CONSTRUCTIVE POLITICAL DEBATE

There is already substantial political consensus about drug policy across the UK. As one ex-Permanent Secretary pointed out to us, drug policy is largely a politically settled matter, with the positions of at least the two main parties in England converging on the need to sustain efforts against organised crime, and to provide help for people addicted to drugs to achieve long-term recovery. Yet many communities, families, treatment providers and increasingly the police do not agree that there is ‘no real problem’ with drug policy that requires attention. Or in other words, many argue that the system is in some ways at least partly broke and needs mending.

Probably most politicians are of the view that while drug policy may be imperfect, the alternatives are too risky or uncertain and, as one ex-Home Secretary said to us, the case for change has not been made adequately made. But, by not considering the alternatives, we risk missing productive policy options.

By not considering the alternatives, we risk missing productive policy options.

As we highlighted at the outset, politicians are now questioning whether drug policies are working as intended. The experience of the debate about the use of animals in research is instructive for policymakers. After many years of the Home Office avoiding public discussion of the issue on the basis that it was seen as too controversial, later experience showed that it was relatively simple to have an evidence-based debate about the subject. Across many public policy areas, whether GM crops, abortion, homosexuality, civil partnerships or nuclear energy, what was once considered a ‘no-go’ area to question still remains the subject of controversy. But policy alternatives are debated, and increasingly are using evidence and informed analysis.

It is seen as particularly controversial to suggest that drug laws should be amended, which is perhaps why ministers and senior professionals generally only speak their mind about drug policy once they have left office, or in the early stages of their careers. This suggests the political space for developing an informed consideration of options and reaching consensus is too narrow.

In this context, the rationale for the classification of particular drugs lacks public transparency and is sometimes contested, particularly for cannabis. In addition, the relationship between the classification of different drugs and regulation of drugs used for medical purposes, such as heroin derivatives used for pain relief, can be confusing.

This situation is further confused by different groups using terms such as 'legalisation' to mean very different things. Sometimes it is used to refer to the complete absence of restrictions on production or sale, while at other times it is used to describe a system of restricted sale, such as that for alcohol or tobacco products. For more details of the different terms used in the debate, *see Box 10*.

Box 10:

LEGALISATION OR DEPENALISATION?

Decriminalisation: refers to the repeal of laws that define drug use or possession (but not selling or distribution) as criminal offences. It does this through either total repeal of penal punishments (ie prison sentences) or shifting the basis to civil penalties, such as fines or removal of a licence, or administrative processes, as in Portugal. In Portugal, drug use and possession are still legally prohibited, but violations are deemed to be simply administrative offences and are dealt with by 'Commissions for Dissuasions of Drug Addiction' rather than criminal courts.

Depenalisation: refers to the reduction of the level of penalties associated with drug offences, usually those for personal use or possession. For example, 'depenalisation' applies to the introduction of warnings or cautions for cannabis possession, rather than potential time in prison.

Legalisation: refers to making drug use, possession, production and distribution legal. Unlike decriminalisation, legalisation would repeal all penalties, criminal and civil, for use, possession, production and distribution of a substance. However, 'legalisation' would most likely still require other types of controls and regulations to be put in place (eg restrictions to licensed proprietors, and age restrictions on sales).

Regulation: imposes conditions on the manufacturing, dispensing, approval and marketing of substances. These laws bind manufacturers and distributors and penalties range in severity and may be civil or criminal. Examples include food labelling requirements, age restrictions on sales, and the more stringent controls for dispensing medicines.

From 'Taking Drugs Seriously', UKDPC/Demos 2011

LOCALISM AND DEVOLUTION: OPPORTUNITIES AND RISK

The devolution programme implemented since 1997 has opened up different approaches to drug policy throughout the UK. Although the Misuse of Drugs Act is a Westminster reserved power, responsibility for much of the health, educational and local enforcement efforts have been devolved, initially to the new administrations in Scotland, Wales and Northern Ireland. More recently in England, responsibilities are increasingly being devolved to local councils (who will have responsibility for the drug treatment budget which will no longer be ring-fenced) through Health and Wellbeing Boards and to new institutions such as Police and Crime Commissioners, Clinical Commissioning Groups and Academy schools.

This new settlement appears to be enabling three connected things to happen: (i) subtly different interpretations of UK-wide strategies, as, for example, in Wales where there is a combined drug and alcohol strategy and in Brighton where a local commission is looking at policy alternatives (ii) policy innovation, for example in Scotland with minimum alcohol pricing and in many areas of England with new approaches to commissioning services and (iii) challenges to the implementation of UK-wide policies, such as the Scottish Government's concerns about applying constraints on drug users claiming welfare benefits.

In the area of drug policy, there has been much concern over many years about a potential 'postcode lottery' which, by implication if not design, the new localism will facilitate. As reflected in the ACMD's report on Policing,¹⁸⁸ as far back as 1994 there was concern about disparate local policing, prosecution and sentencing practices for drug offences. In drug treatment services, the pressing issue has been about differing access to services between localities and more recently, about diverse commissioning practices across the country.

As a number of public policy commentators have observed, we appear to want both localism and to ensure consistency of service. It remains to be seen whether new approaches to improving the outcomes of public spending, such as through payment by results, will iron out some of these inconsistencies. In many respects this tension is an illustration of the inevitable challenge for a national drug strategy which is implemented locally through hundreds of local public institutions and civil society bodies via tens of thousands of professionals including police, teachers, doctors, nurses, prison and probation staff.

CHAPTER 5 RECOMMENDATIONS

In this report, we have focused on identifying challenges, examining evidence, and suggesting alternative ways of approaching drug policy. In this final chapter, we make specific policy recommendations to address these challenges.

Before doing so, we would like to make an important and perhaps surprising statement: we do not know definitively whether these proposals will work to reduce problems associated with drug use in the UK. As an organisation that exists to promote the use of evidence in drug policy, it would be inappropriate for us to assert with complete confidence that these proposals will achieve their objectives, without unacceptable costs or unintended consequences.

However, our assessment of the current evidence supports their introduction. Policy success in one case may not translate to another, for example when a policy is introduced on a larger scale, among different groups, or implemented by different practitioners. This is a well-described phenomenon with the roll-out of pilot interventions across many public policy areas. Therefore, while we may be confident that these policies are worth trying, we do not claim that they would necessarily lead to unalloyed successes in all circumstances. But we should be able to move beyond creating effective policy simply by anecdote, producer interests, or by predetermined ideological positions.

For this reason, it is crucial that the introduction of these policies should be matched with significant efforts to monitor their impact. This will be valuable not only for demonstrating any successes in order to justify further expansion, but also to reduce the harm and costs caused by any cases where the changes are not beneficial. The data from this research should be used to shape future policies, so that the most efficient interventions are given the highest priority.

In presenting our recommendations, we have generally followed the structure of Chapters Three and Four. The one exception to this is in our recommendations on drug laws, which we have listed separately in recognition of the level of interest they may receive.

While we may be confident that these policies are worth trying, we do not claim that they would necessarily lead to unalloyed successes in all circumstances.

It is crucial that the introduction of these policies should be matched with significant efforts to monitor their impact.

For more detailed conclusions and recommendations about issues across drug policy, see the reports that we have developed over our six years of work, which are available at www.ukdpc.org.uk.

We have already described how the traditional drug policy goals of prevention, treatment and enforcement are means rather than ends. This results in a narrow focus which restricts their effectiveness. There is a need to focus on broader goals to which all these policy approaches can contribute. We suggest working towards the goals of how society and government can support individuals to behave responsibly, and how they can enable and promote recovery from drug dependence.

SUPPORTING INDIVIDUALS TO BEHAVE RESPONSIBLY

The idea that wider social and environmental factors can turn an individual's vulnerability to drug use into actual drug use, and to that use becoming problematic is well established. Equally, it is clear that there is a relationship between drug use and a range of other risky behaviours. This suggests that simply tackling drug problems and drug-using behaviour on their own will be insufficient to deliver responsible behaviour. Such efforts have to be integrated and coordinated with other social and economic policies.

Key opportunities for policy to support these include:

- *Tackle structural problems that increase risk of drug problems*

Social problems, such as income inequality, lack of a sense of community, feelings of exclusion and disenfranchisement, are likely to have an impact on

The traditional drug policy goals of prevention, treatment and enforcement are means rather than ends.

whether someone develops drug problems. It is important that this is recognised within social policy more widely. The potential impact on drug problems should therefore be considered in broader social policy impact assessments. This applies nationally and locally, and needs to consider particular sub-groups within the population who may be disproportionately affected.

Reducing social problems like inequality in the UK may bring dividends in diminishing the number of people who use drugs and other substances and then go on to develop dependency. But such progress lies outside the immediate realm of drug policy. Consequently, much of drug policy appears to be a sticking plaster. This is in no way to denigrate its importance and contribution (as our own commitment to the field indicates). But if we want to make inroads into the drug

dependency that blights so many individuals, families and communities, then the evidence suggests that we also need to reduce inequalities and other associated social problems.

- *Develop and evaluate early interventions to help families and communities build resilience to drug problems alongside other problems*

These programmes have the potential to provide a wide range of benefits beyond reducing drug problems but the evidence for their effectiveness is mixed. Nevertheless, there is some evidence for the cost effectiveness of some of these programmes, and this needs to be expanded and developed further. While it is likely that the overall impact on drug problems will be modest, there will be benefits in other areas as well.

- *Provide evidence-based prevention programmes to support less risky choices*

There is little evidence that drug-specific education makes a difference to the prevalence of drug taking. But we can give young people accurate information about drugs and other substances and their risks to influence drug-taking behaviour. While the evidence for cost effectiveness of drug-specific education is weak, there is evidence

Schools need to be provided with the necessary information to make sure they are in a position to choose cost-effective programmes.

to support broader programmes that address behaviour more generally and build self-efficacy, help with impulse control and teach life skills and these should be part of the national curriculum.

However there are also programmes that have been shown not to work and these should not be supported. Schools need to be provided with the necessary information to make sure they are in a position to choose cost-effective programmes. We need also to reframe what we intend drug education to achieve. Its purpose ought not to be about preventing drug use, (otherwise it will be perceived to have failed); its value lies in helping provide a broad knowledge base for young people about substances and situations which they will be likely to come into contact with as they mature.

- *Promote interventions which reduce the harms of drug use*

There will always be some use of psychoactive substances, and some people will become dependent on them. There is good evidence supporting a number of ways in which people who use drugs can be enabled to do so in such a way that the harm to themselves and nearby community are minimised. These include traditional

harm-reduction programmes, such as needle and syringe exchanges to reduce the spread of blood-borne viruses, and drug consumption rooms, where those continuing to use drugs can do so with medical support to hand, and promising innovative approaches relating to recreational use, such as pill-testing services available in or near nightclubs.

Enforcement should involve the affected communities in identifying problems and setting priorities.

- *Involve local communities in law enforcement and assess its impacts*

The evidence is weak for the efficacy of most traditional drug enforcement activity, especially that directed at major and middle-level drug dealers and criminal networks as well as border interdictions. But what there

is supports interventions that take a problem-solving approach and that involve local communities. The traditional indicators, of numbers of arrests and amount of drugs seized, do not necessarily reflect success in reducing the availability of drugs and the damage to communities.

A smart approach to enforcement that more clearly focuses on harm and differentiates between offenders at different levels in the supply chain and according to the harm they cause also has growing support from the evidence. But a more systematic approach to monitoring and research is needed.

Numbers of people arrested or volume of drugs seized are poor proxies for understanding whether enforcement activity is making a sustainable difference.

All drug enforcement operations should be assessed to demonstrate their proven impact on communities, to allow for continuous improvements and better value for money. At the community level, enforcement should involve the affected communities in identifying problems and setting priorities to help focus on the most harmful aspects of drug markets. Research on the impact of different approaches to enforcement on drug-related harms should also be undertaken to show what works under

what circumstances and what approaches provide best value for money.

Many attempts at enforcement such as crackdowns, intelligence gathering operations, border interceptions and so on have never been subject to robust independent appraisal as to their value for money. Relying on numbers of people arrested or volume of drugs seized are poor proxies for understanding whether such enforcement activity is making a sustainable difference.

STIMULATING AND PROMOTING RECOVERY FROM DRUG DEPENDENCE

The new focus on recovery from drug dependence provides an important opportunity to increase the effectiveness of drug policy. However, as is recognised in the drug strategies across the UK, improved rates of recovery from dependence require the involvement of more than just treatment systems and government services.

National and local efforts to provide stable accommodation and get people into work are commendable, even if many professionals doubt that this will be easily achieved given the current economic circumstances and the limited housing stock. But it is also about more than just government services, although it is important that all policies work together to promote recovery, something that is not always the case at present.

- *Tackle stigma towards people with drug problems and their families*

Society as a whole needs to be engaged if we are to achieve the goal of reintegrating people with drug problems. For this to be successful, tackling the damaging stigma towards people with drug problems will be vital to provide a foundation and then an environment in which recovery is possible. This needs to be wide-ranging and government can set an example, including through its announcements. A wider stigma ‘campaign’ could improve public and professional knowledge and understanding of drug dependence and recovery. If recovering drug users relapse, it will not be simply that they have ‘failed’ but rather, we will have failed them.

If recovering drug users relapse, it will not be simply that they have ‘failed’ but rather, we will have failed them.

There is also a need for work with employers, to promote the benefits of employing people in recovery from drug dependence. The public sector should set an example by employing more people in recovery.

- *Make the criminal justice system more focused on recovery*

Different policies need to work together rather than against each other to promote recovery. There needs to be more support for smart enforcement programmes, such as Operation Reduction, that divert drug-dependent offenders into the treatment system instead of the criminal justice system and that work with communities to support them to reintegrate.

People with drug problems are more likely to achieve recovery if they have a supported and supportive family.

Reducing the numbers of those sent to prison and improving integration between services in prisons and as part of community sentences and community-based services, can also contribute to a criminal justice system that is more recovery-focused.

The period when someone is released from prison is a particularly difficult time and while

various efforts over many years have sought to improve outcomes in this vital phase, the goal of better reintegration remains a distant one. There is much that could be done to enhance policy and practice in this area.

- *Provide greater support to families of people with drug problems*

People with drug problems are more likely to achieve recovery if they have a supported and supportive family. The involvement of adult family members of people with drug problems can promote recovery for their drug-using relative, but they also need support in their own right. This needs to be reflected in local area planning processes as well as in service development alongside the need to support children of drug-misusing parents. For families where substance misuse is intergenerational, new models of family intervention should be further developed and evaluated.

There is some evidence that mutual aid really helps recovery, and local groups should be supported.

- *Continue to develop treatment systems, mutual aid networks and communities that support those recovering from drug dependence*

To support recovery, a wide range of treatment, mutual aid and supportive local community approaches is required. Opportunities for action include promoting recovery through balanced treatment systems, which take account of

the varied and individual nature of recovery, recognise diverse needs, and are underpinned by a competent workforce. The role of local communities including employers, faith groups and generic services should be enhanced, particularly if stigma among these groups is reduced.

This requires investment in a skilled and competent workforce, as well as sustaining the level of spending on treatment and recovery services by the government and local councils. There is some evidence that mutual aid really helps recovery, and local groups should be supported.

THE LAWS ON DRUG PRODUCTION, SUPPLY AND POSSESSION

Our conclusions about how the law might be changed are structured in a possible order in which they could be introduced. We are aware that some are shorter term and some longer term adjustments. We do not seek to describe how they could work in detail, as we anticipate this to be the responsibility of others to progress, particularly given our proposal for a political forum to recommend next steps for drug policy. Our concern has been to consider how the control systems could be changed at a strategic level. Of most importance is careful monitoring and evaluation of the impacts of any reforms.

- *Review the process for classifying controlled drugs*

Given the challenges to the way in which drugs are currently classified, including the rejection of expert advice on some classifications, such as for ecstasy and cannabis, we have concluded that the 40-year-old ABC classification system and the process of providing advice to ministers and parliament has significant weaknesses. For many people it has lost credibility.

There should be a wholesale review both of the Misuse of Drugs Act and the underpinning classification system. Such a review ought to examine the possibility of devolving decision-making responsibility to an expert body which could be accorded a statutory role to make classification decisions, with appropriate democratic safeguards.

The 40-year-old ABC classification system has significant weaknesses.

This could enable it to revisit the relative classification of individual drugs, based on assessed relative harms, in order to end up with a more coherent framework. The ABC system is not perfect but it has an inherent logic, even if there is often only limited evidence upon which decisions can be based. The Misuse of Drugs Act could be amended to confer delegated decision-making powers either to the ACMD or to a new statutory body.

- *Reduce sanctions for drug possession*

For the reasons outlined in Chapter 3, the law on the possession of small amounts of controlled drugs, for personal use only, could be changed so that it is no longer a criminal offence. Criminal sanctions could be replaced with simple civil penalties, such as a fine, perhaps a referral to a drug awareness session run by a public health body, or if there was a demonstrable need, to a drug treatment programme. The evidence from other countries that have done this is that it would not necessarily lead to any significant increase in use, while providing

The evidence from other countries that have done this is that it would not necessarily lead to any significant increase in use.

opportunities to address some of the harms associated with existing drug laws.

Given its relatively low level of harm, its wide usage, and international developments, the obvious drug to focus on as a first step is cannabis, which is already subject to lesser sanctions than previously with the use of cannabis warnings. This is something which has been gathering momentum in

other countries. If evaluations indicated that there were no substantial negative consequences, similar incremental measures could be considered, with caution and careful further evaluation, for other drugs.

These changes could potentially result in less demand on police and criminal justice time and resources. Given the experience of other countries, our assessment is that we do not believe this would materially alter prevalence levels, while allowing resources to be spent on more cost-effective measures to reduce the harms associated with drug use. We would expect the net effect to be positive.

- *Address production and supply*

Some people argue for the removal of criminal sanctions not only for possessing drugs but also for their production, trafficking and supply. Among the suggested advantages of this are increased tax revenues, putting a potential end to the criminal control of supply chains and associated violence, and an increased level of safety for users of controlled drugs.

One of the lessons from the tobacco and alcohol markets is that commercialisation can lead to some disastrous consequences.

However, other than possibly for cannabis, we do not believe there is sufficient evidence at the moment to support the case for removing criminal penalties for the major production or supply offences of most drugs. One of the lessons from the tobacco and alcohol markets is that commercialisation can lead to some disastrous consequences

for the health and wellbeing of the public. As a result there have been moves in the alcohol and tobacco markets to put more trading restraints and regulations in place to reduce the effects of commercialisation.

We appreciate that some will argue that the risks of the commercialisation of controlled drugs could be contained with careful regulation and that our position does nothing to deal with the negative consequences of the current system in places such as South or Central America, Central and South-East Asia or increasingly parts of Africa. It also would not address existing problems with drug contamination and unpredictable dosage levels. But our assessment is that such a change could lead to some hugely negative unintended consequences, and should be treated with caution.

For the most ubiquitous drug, cannabis, it is worth considering whether there are alternative approaches which might be more effective at reducing harm. For example, there is an argument that amending the law relating to the growing of it, at least for personal use, might go some way to undermining the commercialisation of production, with the associated involvement of organised crime and the development of stronger strains of cannabis ('skunk'), that we have seen in the UK and other countries in recent years.

Fragmenting production could undermine organised crime networks.

Fragmenting production could undermine organised crime networks. Perhaps the most expedient course to take here would be to re-examine sentence levels and sentencing practice to ensure that those growing below a certain volume of plants face no - or only minimal - sanctions. The impact of any such move would need to be carefully measured and evaluated so policymakers could make informed decisions about future actions.

- *Review penalties for all drug offences*

More generally there is a case for Parliament to revisit the level of penalties applied to all drug offences and particularly those concerned with production and supply. Even though maximum sentences are rarely applied, in recent years there has been a clear drift upwards in the length of imprisonment for drug production and supply offences. This incurs costs in terms of burden on the taxpayer, yet there is little evidence to support the idea this is a deterrent, or more importantly, any long-term impact on drug supply.

We conclude that there ought to be a major review of the sentence framework under the Misuse of Drugs Act. Such a review lies outside the remit of the Sentencing Council which anyway has recently developed new guidelines for the courts. We propose a more fundamental review of the Misuse of Drugs Act including the justification for punishment levels across all types of drug offences.

We suggest that Parliament could do this itself or could look to a body such as the Law Commission. The priority for such a review should be to collect and evaluate evidence to ensure that penalties are working effectively to deliver proportionate justice for victims of drug-related crime, and to act as a deterrent for those whose activities are causing the most harm.

It is hard to continue to ignore many of the contradictions inherent in current approaches to potentially harmful substances that also can confer some benefits.

- *Establish consistency in controls over all psychoactive drugs*

Our final conclusion related to the law is more fundamental. One of the strongest criticisms of current policy is that harmful substances are dealt with through a range of legislative frameworks. For example, solvents are regulated through the Intoxicating Substances Act; alcohol and tobacco are regulated through trading standards and licensing as well as through

taxation policies; while cannabis is classified under the Misuse of Drugs Act. This is not only inefficient, but because of such inconsistent control measures, it is sending confusing messages about the potential harms of such substances, especially to young people who have access to a plethora of information.

It is hard to continue to ignore many of the contradictions inherent in current approaches to potentially harmful substances that also can confer some benefits. We therefore recommend a review to consider the implications of consolidating all legislation that covers potentially harmful substances, including alcohol, tobacco and solvents, as well as other drugs that are used for cognitive, appearance or performance enhancement, such as modafinil as a study aid or anabolic steroids for building muscle mass, into one Harmful Substances Control Act.

IMPROVING STRUCTURES AND PROCESSES

It is over 40 years since the Misuse of Drugs Act became law and the UK's drug problem is now much more severe than it was in 1971, even though in recent years there have been some significant gains. We have previously argued that drug consumption patterns are, in large part, driven by cultural and socio-economic factors rather than drug policy in itself. New psychoactive substances pose new challenges while at the same time our understanding of the problems associated with licit substances has grown.

The debate about drugs is a hotly contested and polarised area and anyone entering it runs the risk of being characterised as being on one side or the other. However, it is clear that the UK's drug problem is complex and multi-faceted, and simple solutions will not be cost effective. But we can do better in helping people behave more responsibly and when they fail to do so, assist them recover and reintegrate into society, or, if they are involved in serious crime, to punish them more effectively and proportionately. It is time to consider new legislative approaches fit for 21st Century problems.

- *Introduce independent decision-making on drug harms*

Both the Advisory Council on the Misuse of Drugs (ACMD) and the New Zealand Law Commission have proposed that an independent body could be empowered to take delegated decisions about controlling new drugs. There is some debate about the merits and downsides of setting up a body to take such decisions and whether such a body might be entrusted with reviewing the current arrangements for controlling existing drugs.

Some experts have argued that either the ACMD or a new statutory body, with democratic safeguards, might assume delegated responsibility for taking decisions about the classification and scheduling of all substances, whether new or existing. The National Institute for Health and Clinical Excellence (NICE) and the Medicines and Healthcare products Regulatory Agency (MHRA) operate in this manner and although there are inevitable controversies, by and large the systems work well and are respected. With appropriate parliamentary oversight and accountability, we see no reason in principle why decision making over the process of classification might not be delegated in its entirety to a new statutory body. This might avoid some of the more inaccurate headlines which accompany the process of drug control.

We therefore recommend that the government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.

The government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.

- *Improve research and policy analysis*

We need a new mechanism for embedding evidence and knowledge development into the drug policy process, incorporating evaluation of the drug strategy, and a coordinated programme of research and knowledge dissemination to politicians, policy-makers, practitioners, the media and the wider public.

If drug policy is to be effective and provide value for money, it is important to build learning and evaluation into the process.

If drug policy is to be effective and provide value for money, it is important to build learning and evaluation into the process. This needs to include learning from when things fail: if something is not working it should be stopped or changed and then re-evaluated.

While the ACMD has conducted some influential reviews and is respected internationally, we believe there is a need for a new independent body to build on this success, which could take on new functions to provide independent leadership and coordination of research and policy analysis.

Working in collaboration with new bodies such as the College of Policing and National Institute for Health Research (NIHR), School for Public Health Research, as well as the established research councils and the devolved administrations, a new body could be charged with commissioning and managing research alongside evaluating the impacts of drug and alcohol strategies and intervention programmes. Such a body could take a role across the UK, which would allow it to exploit the opportunities for natural experiments arising from diverging drug policies.

The argument for a successor body to ACMD is strong, both to develop our knowledge and to respond to the pressures of the economic situation. The issue arises, of course, about how such a body might be funded. In addition to applications being made to the various research councils there may be a strong case for some of the resources being raised through the forfeiture of assets from drug-related crime. Perhaps some £10 million a year could be redirected for this purpose. We believe that the principle of re-channelling seized assets to help develop and improve our knowledge and understanding is a sound one, and a strong business case could easily be built to validate this. Such a body might be attractive also to some charitable trusts and foundations, given its independent status.

- *Move the political lead for drug policy*

In the longer term, the prevailing policy and public debate needs to shift to one that is predicated on fostering an environment that values responsible behaviours, and which promotes recovery for those who develop drink or drug problems. This national conversation is best led by those dedicated to promoting better public health. This does not diminish the need to take strong action against those who break the law, such as those involved in serious or organised crime. It is the commercialisation of the production, distribution and sale of psychoactive substances about which we must remain vigilant.

The national conversation is best led by those dedicated to promoting better public health.

Transferring responsibility for coordinating and leading national drug policy from the Home Office to the Department of Health would facilitate the development of a more active public health approach to drugs, that can improve public and political understanding about how the UK should best respond to the drugs challenges over the next few decades.

We do not think that transferring leadership will bring substantial change, at least in the short or medium term. But as a symbolic measure it would signal a fresh attitude to drug policy.

- *Create a cross-party political forum to progress discussion about future policy*

We have already suggested that more independent research and analysis coordinated by a new body could provide more informed factual and analytical contributions to the debate about drug policy. In the past, one route for examining issues of major public concern would have been to set up a Royal Commission, but this approach has fallen out of favour in recent years. Parliamentary Committees provide valuable insights and challenge policies. This has happened with drug policy through both the Home Affairs Committee and the Science and Technology Committees.

In recent years, ad hoc expert commissions have been established, often chaired by a leading public figure, for example, on pension reform. Very occasionally, efforts have been made to achieve cross-party consensus on key issues, such as the establishment of the Commission on Funding of Care and Support, chaired by Andrew Dilnot. More recently, the Coalition Government has enlisted the services of a former Labour minister (eg Alan Milburn and Frank Field), to advise them on issues such as poverty. Recently, Peter Mandelson made a similar recommendation with regard to airport policy: “My proposal would be for the parties to hand the

issue to an independent panel of wise people which, working to a clear timetable, would assess the evidence and recommend the best approach”.¹⁸⁹ All of these are designed in one way or other to put contentious issues into a more politically neutral space, with the aim of identifying new policies and forging a wider debate.

Fundamental questions about the direction of drug policy need to be considered in a cross-party environment.

We believe that fundamental questions about the direction of drug policy need to be considered in a similar cross-party environment. The most productive way of making substantial improvements to drug policies may be for the leaders of the main parties in the Westminster and devolved

governments to commit personally to setting up a cross-party forum tasked with exploring the question of ‘what next for UK drug policy?’. This body should also seek to engage the public, with the goal of both reflecting and informing public opinion on these issues.

When some serious questions are being asked about the cost effectiveness of current policies, we need to try and create a fresh national conversation to achieve progress.

• ***Evaluate local approaches***

Devolution and localism should be seen as unique opportunities for natural experiments in drug policy which can, and should, be properly evaluated. Unfortunately we can find little evidence that either national or local public service bodies are considering this opportunity, except where they are initiated by central government, such as the payment by results programme or the Randomised Injectable Opioid Treatment Trial (RIOTT).

Across the fields of policing and healthcare, innovative approaches are both possible and desirable.

Across the fields of policing and healthcare, innovative approaches are both possible and desirable, for example whether and how the drug law is implemented, such as for possession of cannabis, or public health based efforts to provide help for those that continue to inject drugs. In the UK, we are

poor at systematically developing independent knowledge about the impact of different approaches and transferring this knowledge into wider networks.

We have already mentioned the pressing need for an enhanced independent drug policy research capacity in the UK. But to complement this in a devolved

environment, there is also a need to ensure that knowledge is spread more widely. In the US, the Federal Government funds a major programme of grants of over \$10 million for regional Addiction Technology Transfer Centres. The purpose of this programme is to develop and strengthen the workforce that provides addictions treatment and recovery support services to those in need.

National drug strategies must pay attention to the crucial need to build our research and knowledge base.

If we continue to pursue national policies of devolution and localism in policing, health care and education, we can no longer rely on osmosis or the market to ensure that the evidence about the impacts of different approaches is spread and acted upon. National drug strategies must pay attention to the crucial need to build our research and knowledge base, and provide a mechanism to ensure this is transferred to the people that matter at the local level, whether these are local councillors, Health and Wellbeing Boards, Police and Crime Commissioners or professionals in a range of disciplines.

CONCLUSION

We cannot ignore the fact that there are various markets for certain drugs, which are governed by the normal rules of supply and demand. Governments across the world have sought to manage these markets by prohibiting these drugs, except in certain circumstances such as for medicines or research. But the markets have not behaved in the way governments intended. The full panoply of control and regulatory tools, with substantial enforcement resources to back them up, have not been able to significantly reduce drug problems, and in some cases to prevent them increasing. At best, controls may have kept the lid on the scale of the market. At worst, they may have exacerbated drug problems.

This is not an argument for abandoning any attempts to control mind-altering drugs or to limit the harm that can be caused by their production, supply and use. The real challenge is in the development of drug policies that are based on the best evidence we can generate, and which can balance competing demands and interests. It is something on which our political leaders, domestically and internationally should seek to make new progress.

We think that six years of work by the UK Drug Policy Commission have not only contributed to the development of policies that will be more cost effective in addressing the UK's drug problems, but have also demonstrated the value of independent analysis of evidence.

Our research has identified a number of specific policy proposals, which we are confident could be incorporated into practice for everyone's benefit. But more valuable would be a change in UK drug policy's relationship with evidence. A commitment to the use of evidence to inform which policies are adopted, combined with rigorous trials of new and existing policies, and a willingness to act on the results of this research, would go a long way towards ensuring that the UK has an effective and good value response to the use of mind-altering drugs.

The real challenge is in the development of drug policies that are based on the best evidence we can generate.

Our aim is that this, above all, will be the legacy of the UK Drug Policy Commission.

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We all have an interest in knowing which policies work in tackling problems associated with drug use. Many members of the public, and many politicians, believe that our drug policies are not working. But the debate about how we address the challenges of mind-altering drugs is polarised in a way not seen in most other policy areas.

The UK Drug Policy Commission was established to address these problems in a different way. Its aim has been to show how independent scrutiny of evidence can produce both better results and more effective use of resources in drug policy and practice.

Existing drug policies have struggled to limit the damage drug use can cause, and now new challenges are emerging. The rapid development of new drugs is changing drug markets too quickly for the traditional methods we use to control drugs to be effective. The economic crisis may be impacting on the nature of drug use and drug problems and, with fewer resources, the capacity of services to respond will be limited further. Added to that, the speed and scale at which services are being devolved to a local level may create increasing and unpredictable variations in the kind of services offered in different parts of the UK.

In this report, UKDPC proposes a radical rethink of how we structure our response to drug problems. It provides an analysis of the evidence for how policies and interventions could be improved, with recommendations for policymakers and practitioners to address the new and established challenges associated with drug use.

UKDPC aims to foster a fresh approach to drug policy: one in which evidence takes priority, creating light rather than heat in the debate on drugs, so that we can create an environment that works to reduce dependence on drugs, safeguards communities and delivers value for money.