The Fabian Society

The Fabian Society is Britain's leading left of centre think tank and political society, committed to creating the political ideas and policy debates which can shape the future of progressive politics.

With over 300 Fabian MPs, MEPs, Peers, MSPs and AMs, the Society plays an unparalleled role in linking the ability to influence policy debates at the highest level with vigorous grassroots debate among our growing membership of over 7000 people, 70 local branches meeting regularly throughout Britain and a vibrant Young Fabian section organising its own activities. Fabian publications, events and ideas therefore reach and influence a wider audience than those of any comparable think tank. The Society is unique among think tanks in being a thriving, democratically-constituted membership organisation, affiliated to the Labour Party but organisationally and editorially independent.

For over 120 years Fabians have been central to every important renewal and revision of left of centre thinking. The Fabian commitment to open and participatory debate is as important today as ever before as we explore the ideas, politics and policies which will define the next generation of progressive politics in Britain, Europe and around the world. Find out more at **www.fabians.org.uk**

About the author

John Mann has been MP for Bassetlaw since 2001. Following the closure of the coal mines, the local area has seen a growing problem of heroin abuse. In September 2002, John held a public inquiry into heroin in Worksop Town Hall and has since worked with national and local government, schools, treatment providers, the police and others to reverse the epidemic. He has also studied drugs policies overseas, travelling to Holland, Australia, New Zealand and Jamaica.

Fabian Society
11 Dartmouth Street
London SW1H 9BN
www.fabians.org.uk

Policy report 60
Editorial Director: Tom Hampson

First published 2006

ISBN 0 7163 3060 1

British Library Cataloguing in Publication data.
A catalogue record for this book is available from the British Library.

Printed and bound by Bell & Bain, Glasgow

As with all Fabian Society publications, editorial control remains solely the responsibility of the author, and the support of the partner does not imply endorsement of the views or recommendations contained in the research or report. This publication may not be reproduced without express permission of the Fabian Society.

Acknowledgement

The Fabian Society and the author are grateful to Schering Plough for their kind support of the production of this pamphlet.

The Real Deal

Drugs policy that works

John Mann MP

FABIAN SOCIETY

Contents

Introduction 1

1 | The drug laws can work 6

2 | Learning by example 14

3 | The Bassetlaw inquiry 21

4 | A fresh start 30

References 39

Introduction

We enjoy talking a lot about drugs in Britain, yet somehow we never find the time to have a serious policy debate. Reading British newspapers, it is clear that cocaine is today's drug of choice for headline writers. Drug use amongst the middle-classes has never been so mainstream and we like to be outraged and titillated by stories of rich pop stars, supermodels and their drug use. For those with softer tastes, there is always the great cannabis debate. Should we legalise it? Should we impose softer or harder penalties on its use? Or – having reclassified it from class B to class C – maybe now is the right time to move it back to class B again?

Meanwhile, Britain's most socially-damaging drug goes ignored. Heroin has now become Britain's invisible disease. Gone are the days of the 1980s when the drug's profile ensured that the cast of *Grange Hill* emplored schoolchildren to 'just say no'. Today, heroin is spreading through housing estates and run-down towns and villages. And its damage is enormous. While cocaine and cannabis are this year's media stars, heroin is thought of as yesterday's drug. But it is causing tomorrow's crime.

When I became MP for Bassetlaw in 2001 there were 600 heroin addicts. These people were behind the vast bulk of the acquisitive crime in my constituency. Caught in a cycle of crime and addiction, and passing regularly in and out of the criminal justice system, their lives proved that the British drugs system does not work. The system is a

failure and it's an expensive failure at that, costing taxpayers at least £100,000 per individual per year.

Dramatic change

In the first nine months of 2002, 12 of my constituents died as a result of their drug use. As a new MP, I decided to set up my own inquiry into the problem to find out about the impact it was having on my community, and why drugs policy was failing to deal with the issues. Over 100 drug addicts, a large number of local families, and national policy experts took part. Their testimony highlighted the ways in which our approach to drugs is failing.

The simple changes we have implemented so far in treating drug use as a medical problem in Bassetlaw have reduced drug-related crime by 33 per cent. In July 2002 there were two addicts in Bassetlaw receiving medical prescriptions for heroin abuse, and there were 80 burglaries a month reported in Worksop (the main town in the Bassetlaw constituency). In July 2006, the number of addicts receiving treatment from their GP had risen to 400, and the number of burglaries reported each month had fallen to 20, a fall of 75 per cent. The statistics are clear: medical treatment of an identified drug addict through primary care works.

The UK policy is flawed in both approach and administration. Unlike the European mainland and Australia, ours is led by the criminal justice system rather than by the medical profession. Drug use is consequently seen purely as a criminal act, which means that effective treatment for drug use is seen as a peripheral issue to be dealt with after criminal sanctions. For this reason, the UK system fails because instead of going to the heart of the problem, it invests vast sums of money in tinkering around on the periphery. Acquisitive crime is the outward manifestation of drug use. Just as one cannot tackle any problem by dealing only with its knock-on effects, so a drugs policy cannot work effectively if it only deals with the crime element of the problem.

This situation is exacerbated because our drugs policy is run as a franchise operation, with many organisations and individuals wanting a slice of the action. The confusing myriad of Drug Action Teams, Drug Reference Groups, Drug Prevention and Advisory Services, NHS Trusts, Drug Treatment and Testing Orders and so forth means that the treatment administered to addicts in one area can be wildly different to that administered within a different town a few miles away. It is also not a system that is easily negotiable by the small number of addicts who decide to refer themselves for treatment, and nor does it contain many coercive elements that force them into doing so.

Proposals

Across Europe there are practical and transferable solutions that would make a significant difference to our drugs problem in the UK. Many of these evidence-based projects are highly cost-effective and many deal with young, out-of-work drug addicts who have been involved in repeat offending – often in acquisitive crime.

In Bassetlaw we showed that you can initiate local approaches to drugs with dramatic effects. But until we have a refocused national strategy that tackles addiction and its causes, this will only scratch the surface of one of Britain's most chronic health problems.

This pamphlet sets out how this can work, with proposals rooted in practical experience both from Britain and abroad. I identify six ways in which a reformed and revitalised drugs policy can be effective.

1. Treatment by local GPs

We need to get the relationship between health and criminal justice right. At the moment it is confused. Lead responsibility for drug treatment should be given to Primary Care Trusts, and this should be monitored through assessable key performance indicators.

2. No barriers to treatment

The drugs bureaucracy needs rationalising. But more importantly this should be done in such a way that it is easily negotiable by the addict attempting to seek treatment

3. Simplified drugs classifications

We need to rethink the way we classify drugs. This is not about shifting cannabis endlessly from one category to another. Nor is it about a decriminalised free-for-all. This pamphlet argues for a rethink of the whole basis for drugs classification. Why do we have a system based on the chemical strength of different drugs when the most important distinction is between those that harm the individual, and those that cause broader social harms?

Drug classification should be simplified into two categories:

Class 1: Drugs whose consumption is likely to lead to actions that harm others.
Class 2: Drugs that damage the user's health.

Within each category, we might then apply a different policy mix of prohibition, restrictions, regulation and advice.

4. Cutting supply

Revenue and Customs should concentrate much more of its activity on cocaine due to its price sensitivity.

5. Coercion

We need to realise that coercion is necessary to tackle addiction. This will challenge liberal orthodoxies. But the reality for addicts is that free choice doesn't exist. Coercion into treatment should be recognised as not only legitimate but necessary in order to get drug users off chronically addictive drugs such as heroin.

6. Saving the taxpayers' money

   Drug rehabilitation should be redefined as the ability to live in ones own community, out of crime and in employment. Intermediate labour markets need developing to get former addicts back into the employment market.

Too much discussion of drug policy is fatalistic and suggests that nothing constructive can be done to change things for the better. Our experience in Bassetlaw shows that this is not true, and that striking results in health, employment and crime rates are possible. These lessons now need to inform national policy. The scale of the problem we are dealing with nationwide should not be underestimated, and drugs continue to have a destructive impact on life chances, especially in disadvantaged communities such as the former coalfield areas, and in the more deprived areas of the UK, particularly the north of England and in Scotland. So there must be a clear moral injunction for progressive politicians to make this issue a priority, based on the evidence we now have of what works.

We need a nationwide strategy. The next steps could include more extensive pilots in the communities most affected, and there is a strong case for the Scottish Executive and Assembly to study how the devolved administration can apply these lessons across Scotland. But political leaders and media commentators need to shift the focus of how we think about drugs, to create the constructive space for new policies which can vastly reduce the damage drugs cause both to the life chances of individual users and to our communities.

1 | The drug laws can work

Drugs legislation in Britain has long been at odds with the actual use and impact of drugs in society. The Dangerous Drugs Act 1920 was a temporary measure, grounded in conservative fears about moral degeneration, which – via the Misuse of Drugs Act 1971 – lives on into the twenty-first century.

The Misuse of Drugs Act marked the Government's belated attempt to catch up with the expansion of drug use during the 1960s, when amphetamines, cannabis and LSD all began to be used widely for the first time. It brought together all controlled drugs under the same statutory framework and established the first statutory advisory body, the Advisory Council on the Misuse of Drugs, which classified drugs not according to their impact on society, but by their impact on individual users.

Three decades on, when the use of drugs in Britain has changed almost beyond recognition, we are still operating under this essentially moralistic regime. Drugs today have swept into working class communities. The issue facing government now is not recreational use, but addiction, and we need a new framework to face up to this new challenge.

The cost of drug addiction to British industry and society as a whole is formidable. In 2002, the Home Office estimated that the total economic cost each year – including costs to the health

service, courts, prison, and benefits – is between £2.9 and £5.3 billion.[1]

Once social factors, such as the cost of drug-related crime, are taken into account, this figure rises to between £10.1 billion and £17.4 billion, with problematic drug users accounting for 99 per cent of the total. The most expensive elements in 2002 were prison (which accounted for 25 per cent of the total) and state benefits (21 per cent). In the case of addictive drugs – particularly heroin – this expenditure is an annual recurrent cost, making it uniquely destructive to the economy.

In my constituency of Bassetlaw, where the average age of addicts is in their early 20s, the social benefit costs alone rise to more than £1 billion over the life course. The Legal Aid bill, meanwhile, comes to around £500,000 annually within the constituency. The Home Office has calculated that early intervention programmes designed to target potentially problematic juvenile users could save the Government as much as £56,000 per individual, per year.

It is easy to see the savings that an improved strategy on addiction could generate, but there are hidden savings as well. The Advisory Council on the Misuse of Drugs estimated in 2003 that between 2 and 3 per cent of children in England under 16 had parents with serious drug problems.[2] This figure rises to between 4 and 6 per cent in Scotland. Such parental use can compromise children's health from conception onwards.

It is difficult to calculate how many deaths are caused by drug use. The Advisory Council found that estimates of immediate accidental deaths as a result of drug use in 1998 varied from 1,076 to 2,922, depending on which of three approaches was used to calculate this 'core statistic'. Given this discrepancy, the Home Affairs Committee recommended that any national strategy should focus on outcomes rather than processes as indicators of success.

A brief outline of drugs policy since 1998

Government drugs strategy is embodied in the Cabinet Office document 'Tackling Drugs to Build a Better Britain'. The strategy was launched in 1998 and was updated in 2001. The strategy is target-based and focuses on four main areas:

1 **Young People**
To help young people resist drugs. Target: to reduce the proportion of people under the age of 25 reporting the use of class A drugs by 50 per cent by 2008.

2 **Communities**
To protect communities from drug-related anti-social and criminal behaviour. Target: to reduce levels of repeat offending amongst drug misusing offenders by by 50 per cent in 2008.

3 **Treatment**
To enable people with drug problems to overcome them.
Target: to increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008.

4 **Availability**
To disrupt the supply of drugs. Target: to reduce the availability of class A drugs by 50 per cent by 2008.[3]

There are a number of problems with current drugs policy. The Home Affairs Committee and DrugScope have criticised the Government's policy for being both immeasurable and insufficiently grounded in evidence. Home Office Minister Bob Ainsworth told the committee:

> When we drew up the Drug Strategy, I do not think anybody felt or claimed that every single piece of it was pinned down, that we had evidence to back up targets in every case… Some of the targets – it was openly acknowledged at that point – were aspirational.[4]

Witnesses to the committee repeatedly stated that drugs is fundamentally a health issue, not a matter for the criminal justice system, and that it would be more effective to treat it as such. Yet in 1998, 63 per cent of all money allocated to the drug strategy was spent on criminal justice.

The National Drug Prevention Alliance claimed that the key problem lay not with the strategy itself but rather in its implementation, which was being undermined by what they saw as 'ideology and turf' disputes between different government departments and agencies.

The Government re-launched its drug strategy in late 2002. The updated strategy placed a greater emphasis on treatment and problematic drug users and committed more resources to implementation. Approximately £450 million of central and local government funding was spent directly on drug treatment services in England in 2003/04, excluding prison-based treatment. The updated strategy drew sharp attention to the savings that can be made to the community by investing money into the treatment of problematic drug users, showing that for every £1 spent on treatment, £3 was saved in criminal justice costs alone. As part of the new emphasis on treatment, the strategy included an expansion in community and residential rehabilitation capacity, and the prescription of clinical heroin (diamorphine) to heroin users. The strategy maintained that the 'one size fits all' approach to treatment was neither effective nor desirable, and committed the treatment agencies to providing a menu of services tailored to the specific needs of the individual.

Nonetheless, the updated strategy remains hampered by tensions. A false debate simmers within the drug bureaucracy about the role of free choice within drug treatment. It is widely held that detoxification can only work if the addict is willing to undertake it, and that forcing an individual to undergo a treatment against his will is counterproductive and will end in failure. Not only is this not the case, but it is not borne out by evidence from European countries such as Sweden and even Holland who see coercion as a necessary and vital part of any drugs policy.

In the UK there are a number of options available for medical treatment but, unlike in Sweden, Holland, or Australia, these are criminal justice-led. Coercion in the UK means primarily Drug Treatment and Testing Orders, which were introduced through the Crime and Disorder Act 1998. Such Orders are issued by the courts but managed by the National Probation Service in partnership with local drug agencies. Such partnerships have no history of working together and often, as was identified in the 2002 Home Office Select Committee report, turf wars limit the success achieved by these initiatives. Through a Drug Treatment and Testing Order, courts are able to sentence those offenders aged 16 or over who are considered to be susceptible to treatment and who express willingness to do so to receive non-custodial community based treatment for drug addiction, and to undergo regular random and compulsory drug testing. The court reviews the offender's progress under treatment on a monthly basis. If the offender fails to respond to treatment, the court has the power to recall the offender to court and re-sentence for the original offence. This could mean a prison term.

Although treatment within prison and through criminal justice-led measures such as Drug Treatment and Testing Orders and conditional cautioning are a step in the right direction, the emphasis still is on criminal justice rather than effective locally administered medical treatment. Addicts can access medical treatment through the criminal justice system, but they cannot be coerced into treatment within the community as the notion still prevails that treatment can only be successful if the addict agrees to undertake it. Yet effective treatment of an addict before they have come in to contact with the criminal justice system would mean that they could be spared a criminal record, a major barrier to the 'normal' lifestyle that they so often crave.

The UK philosophy of 'free choice' does not take into account that a person with a chronic and chaotic addiction to a class A substance such as heroin is not capable of making a free choice. The lack of ability to make such a choice – the prerequisite for any form of treatment or reha-

bilitation – is putting such treatment out of the reach of the addicts who need it most.

Supply side measures

The National Criminal Intelligence Service estimates that between 20 and 30 tonnes of heroin are smuggled into the UK each year.[5] Annual seizures of heroin in the UK amount to around only 2 tonnes a year, approximately one third of all heroin seized in the European Union (EU).[6] Seizures in the EU have doubled over the last decade.[7] The vast bulk of heroin imported into the UK and Europe originates in Afghanistan, which accounts for about three quarters of the world's opium production.

Most heroin reaches the UK through ports in the south east of England and the main distribution point for the UK is London. Buyers come from as far away as Scotland to purchase heroin. There are large heroin markets in all major cities throughout the UK, with supply lines to smaller towns in the surrounding areas. Heroin is quickly moved from place to place in ever decreasing quantities until it reaches dealers on the street, who then operate within a fairly small area.[8]

The trafficking of illegal drugs is exceptionally lucrative. The profits to be made from drug trafficking are such that even large-scale seizures barely dent the profits to be made. For instance, the price paid to a Pakistani farmer for opium, according to the United Nations, was $90 a kilo in 1994. The wholesale price of a kilogram of heroin in Pakistan is almost $3,000 while in the United States it would cost $80,000. On the street, at 40 per cent purity, the retail price is $290,000.[9] For every kilo of heroin successfully transported to the US, one could buy a further 96kgs in Pakistan.

The National Criminal Intelligence Service's cocaine unit estimates that the annual street market value of cocaine is between £2 billion and £3 billion. Cocaine tends to enter the European Union via the Iberian Peninsula and the Netherlands for further distribution. In 2003, Spain and the Netherlands accounted for almost 76 per cent of the amount of cocaine seized in EU member states.

Cocaine (including crack cocaine), and heroin are widely acknowledged as the two most harmful drugs on the streets of the UK today, in terms of both crime and health. A significant part of the UK drug strategy focuses on the seizure of illicit substances before they can be sold on the street. The number of seizures of class A drugs has tripled over the past decade from 10,780 seizures in 1992 to 33,350 in 2002. Heroin has been the class A drug seized most frequently with 15,370 (comprising a total quantity of 2,730kg) seizures in 2003. By comparison in the same year, 3,580kg of cocaine was seized, but the number of seizures, only 6,640, was much fewer than those deployed against heroin traffickers.

Cocaine is a drug which, unlike heroin, is price sensitive and subject to the traditional market forces of supply and demand. When a large seizure of cocaine is made and the substance is scarce, the street price rises. However, the street price for a gram of heroin in the UK has remained fairly stable since 1993 and usually costs between £50 and £80, although in some areas the price can be much lower.[10] The wholesale price per kilo has dropped substantially since 1998 to an all time low of £13,000 in 2001.[11]

As heroin is physically addictive, investment in effective treatment measures will affect the market in the UK. It would be preferable, therefore, to give priority to tackling the heroin problem through tackling demand, rather than attempting to stop the drug entering the UK street market. No attempt to push heroin off the streets by straining the supply, and thereby raising prices, will be successful. Heroin addiction is, by its nature, all consuming. Addicts to the substance do not so much desire it as require it to feel normal and stave off the horrendous withdrawal symptoms:

> Like I said, early rattle… it's scary. First you get hot and cold sweats, then you start vomiting. Sneezing, eyes watering, really bad muscle spasms. And worst but not least you can't sleep… Sorry, I forgot to mention your stomach is turned upside down, cramps, diarrhoea, the lot. It's not very nice.[12]

> No one who's [not] been on it can understand. It's a nightmare, but you're awake. When you get your first fix in the morning to get rid of your rattle, the very next thought in your head is where your next fix is coming from, etc. In the end the (heroin) was not even doing anything to me at all. All it did was make me feel normal. What sort of life is that?[13]

This kind of evidence, presented by addicts in Bassetlaw, demonstrates that we must tackle the demand for heroin before we get overly concerned about its supply. The demand for cocaine, on the other hand, is highly sensitive to fluctuations in supply, and we will return to this later.

Drug treatment is currently defined as psychological and social rehabilitative interventions designed to help the addict gain access to the world of work, help with housing and social inclusion. Whilst there is nothing wrong with such policies, they should be based around the principle of locally-provided medical assistance as the first step on the rehabilitative process, rather than the entire menu of options available. In addition, far more needs to be done to help addicts access treatment. The UK antipathy towards curtailing the individual's freedom of choice is not an effective approach when it comes to chaotic drug users. Many drug addicts in Bassetlaw begged to be forced into treatment as they recognised that their physical addiction to heroin rendered the notion of free choice impossible. Some even went to the lengths of purposefully getting themselves arrested in order to access the drug treatment programmes mandatory within the local prison service. Coercion is not only a legitimate tool to force addicts into treatment but a very necessary one if such treatment is to be successful.

2 | Learning by example

Heroin addicts do not have access to the kind of free will that most of us are able to employ in our daily lives. They crave heroin at any price, at any personal and social cost. Attempts to limit the supply of the drug will only generate more crime in the communities that can afford it least. Rehabilitation of addicts must be at the heart of any new drugs strategy, and the starting point for rehabilitation is inarguably health treatment through primary care. Although drug use is often seen as a criminal justice issue, its affects on users in terms of their behaviour (criminal and otherwise) can be treated relatively simply through the use of a substitute medication.

This is borne out by evidence from Europe, most notably the Netherlands. In spite of the fact that Holland holds the somewhat unenviable reputation as the world's cannabis capital, the Dutch approach to what they see as more serious addictions, such as crack cocaine and heroin, is successfully led by the health services. Treatment for heroin use is viewed as a medical and psychiatric issue, for which medical provision should be made. Every patient is assigned a treatment plan and although this is primarily concerned with medical prescription, it extends itself to other relevant fields such as employment, housing, and community. This approach has led to a reverse of the heroin epidemic since the 1980s, and the average age of the heroin addict is now over 50 and increasing. Holland's heroin problem will, quite literally, die out.

In France, GPs and pharmacies, often working as sole trader businesses, successfully treat drug addiction. Their success in treating 80,000 heroin addicts with buprenorphine in local community practices has become part of the pattern of life. 67 per cent of those treated no longer use heroin or relapse onto it, over the 10 years of their state-led programme. Professor Marc Auriacombe compares this favourably with the success rate for other chronic relapsing diseases.[14]

Although recent policy has demonstrated the Government's willingness to move in the direction taken by European countries such as Sweden and the Netherlands, there remains one important difference between these respective philosophies: the process by which the addict accesses the drug bureaucracy. In England, the onus is still heavily upon the addict to self-refer into a treatment programme. Unfortunately, most chaotic users do not perceive themselves as free individuals, but slaves to their addiction, and it is time that UK drugs policy embraced coercion as a means of allowing addicts to access treatment.

Some countries make the link between crime and the need for treatment more forcibly through the drug court system. Drug courts were developed in the United States in the late 1980s and early 1990s as an alternative to traditional criminal justice prosecutions for drug-related offences. The object of these courts was to combine the close supervision of the judicial process with the resources and support services typically available through alcohol and drug treatment services. Drug courts aim to reduce the level of drug related offending, whilst offering effective treatment to those offenders with drug problems. Additionally, this cuts the costs of incarcerating non-violent drug addicts. The prospect of a judicial sentence is used as a motivating force to keep the individual in treatment.

The National Association of Drug Court Professionals estimates that typical incarceration costs the US between $20,000 and $50,000 per person, per year. The capital costs of building a prison cell can be as much as $80,000. In contrast, a comprehensive drug court system typically costs between $2,500 and $4,000 annually for each offender.

Evaluations from the State of Oregon and Dallas County, Texas have shown that for every $1 invested in drug court, $10 saved by the criminal justice system.

Sweden has the most coercive approach to drug treatment of all our European partners. Whilst the Swedish drug laws are a good deal more strict than ours, the means by which the Swedish addict can access treatment through criminal justice is not unlike the system we have in the UK. But the major difference between Sweden and the UK is that the Sweden believes that coercion is necessary and desirable outside the realms of traditional criminal justice. Whilst the 'drug criminal' will inevitably experience some form of mandatory treatment, the 'drug user', even if he or she is committing no crime other than illegal drug use, will often be forced into treatment. In fact, Sweden has legislation which makes treatment compulsory for those deemed to be a danger to themselves, their families, or their community – even if they have not been through the criminal justice process.

A 'drug user' can be put into treatment for a maximum of six months, dependent upon a court decision with the aim of motivating that person to undertake voluntary treatment for a longer period afterwards. In his evidence to the Home Affairs Select Committee, Ralf Löfstedt, an expert in Swedish drugs policy, estimated that 80 per cent of users forced into treatment in this manner went on to voluntary treatment afterwards. Swedish residential rehabilitation – involving a lot of countryside and fresh air – has proven to be of little use to a chronic addict, and Sweden has therefore closed most of its rehabilitation projects in favour of treatment through mainstream health provision.

Other Swedish models of coercion are more appealing and successful. For a teenager found using drugs including misuse of alcohol health treatment is immediate and compulsory. There is no confusion about free choice and individual liberty. Indeed it is compulsory for the parents of teenagers to be involved in drug counselling with their children. Teenagers will not be locked up in custody awaiting treatment; they will be locked in a secure detoxification ward of a hospital.

As in the UK, Sweden's implementation of their drugs policy depends upon co-operation between the criminal justice system, the courts and the local municipality or Drug Action Team. The Swedish system is decentralised as ours is, with funding, treatment, and treatment philosophy varying widely between areas. Unlike the UK system, however, the Swedes seem to have embraced the notion of co-operation between agencies, something that the UK has yet to do.

'Liberal' Holland's drugs policy also contains within it coercive elements. Holland views drug use as a medical problem that requires medical treatment and believes, unlike Sweden, in harm minimisation tactics such as consuming rooms (or 'shooting galleries' as they are colloquially known in this country) as well as the prescription of opiates such as methadone for treatment purposes. The Dutch drug bureaucracy recognises that addiction is an obsessive disorder and therefore well-organised coercion can help. Whilst they also recognise that co-operation between agencies and the court is not an easy task, their schemes have experienced success with the average age of a heroin addict now approaching 50.

The federal structure of Australia has seen a variety of coercive methods employed across the country. New South Wales has pioneered drug courts and early release into treatment for prisoners with the legal process directing people into treatment and retaining coercive powers if its agreement with the individual is broken. In Queensland, even cannabis possession leads to coercive health treatment as an alternative to custody. The new conditional cautioning paves the way for this model to be applied in Britain.

In Melbourne, needle exchanges have a duty to collect in all used needles. In the UK we have different authorities for clean needle distribution and dirty needle collection. When 3,000 needles were discovered in a derelict house in Bassetlaw, the scandal was that they were virtually all unused.

Neither the Swedes nor the Australians pretend that detoxification is a cure. For addiction to drugs like heroin the presumption is that detox-

ification will not work. In other words it is not an episode of treatment rather one part of a treatment system.

In the Netherlands, heroin has uniquely been demonised as the 'losers' drug'. It is an approach that has worked in vastly reducing numbers of young heroin addicts. Part of this has led to other drugs replacing heroin, but the Dutch argue that heroin is unique in its dependency and link to acquisitive crime. Their targeting of heroin is a deliberate displacement policy, aimed at affecting demand, and it is one we should copy.

Supply measures

In Australia and New Zealand, heroin supply dramatically reduced in 2001 due to warlord battles in the South East Asia 'golden triangle'. Heroin addicts immediately switched to amphetamines in Australia whilst in New Zealand they developed home made morphine by baking codeine tablets. In both examples, the physical addiction has led to drug dependency remaining. Unless and until that physical addiction is broken then normality is impossible. Regardless of how high the street price, chaotic heroin users are likely to increase their acquisitive crime rather than reduce consumption, to meet a price increase.

There is evidence to suggest, however, that use of cocaine is highly dependent on street price as the nature of the addiction is psychological not physical. Thus a cocaine addict will consume whatever is available, whenever they can afford it. Use of cocaine though is more sporadic. Within prison, several countries have found that cocaine dependency stops immediately on entering prison, but re-emerges as a craving as prison release is imminent. There is also less of a business case for turning cocaine into crack if the profit from cocaine is high. Crack as a substance is both more addictive and resultant behaviour more unpredictable. It is therefore worth the Government prioritising work with international operations that disrupt the flow of cocaine to the UK.

The Jamaican government has recognised the impact of the drug trade and the Ministry of National Security is working with the UK to tackle the

problem. It has been using law enforcement and defence resources to stop Go-Fasts (speed boats) from reaching Jamaica, as well as to stop couriers from leaving the country. In May 2002, the Jamaican government signed a Memorandum of Understanding with the UK government in order to better police cocaine trafficking between the two countries. The memorandum promised closer co-operation between the British and Jamaican Customs authorities, and introduced a programme to intercept drug mules in Jamaica before they boarded fights to the UK.

The program, known as 'Operation Airbridge', took effect on 1 June 2002. The initiative introduced special equipment to screen passengers for cocaine at Jamaica's two international airports. By using ion testing machines, specially-trained members of the Jamaican police force are now able to identify anyone who has had recent contact with cocaine, and stop them from boarding a flight.

Ion scanners use a procedure known as 'trace detection' to look for particles left behind from the handling of either narcotics or explosives. A suspect article of baggage or clothing is swabbed and analysis of the composition is then made by placing it in a spectrometer. The technology is both highly accurate and sensitive, and Britain plans to expand the use of ion scanners to the other Caribbean islands. In addition, £2 million in funding was provided for a new Customs mobile strike force team to reinforce frontier controls at UK airports. This force is designed specifically to tackle trafficking on high risk flights, and targeted at both drug mules or 'swallowers' and couriers carrying cocaine in their luggage or on their person.

The results thus far show that this program has been extremely effective. In its first year of operation, from June 2002 to May 2003, the number of 'swallowers' detected in Jamaica rose from 82 over the previous twelve month period to 216. At the same time, detection of 'swallowers' in the UK fell by 75 per cent from 730 to 185, despite an increase in detection efforts. In addition, a high profile publicity campaign with the message 'You Will Be Caught' was launched in Jamaica, targeting couriers who may have been misled about the consequences of their actions. The combination of

these factors has resulted in a decline in the number of cocaine couriers who are attempting to board flights to the UK, and a Renewed Memorandum of Understanding was signed between the UK and Jamaica in December 2003.

Operation Airbridge is an example of good practice and evidence that tackling cocaine trafficking is an endeavour that has to be undertaken multilaterally and internationally.

In conclusion, we should transform the current system into a health-led strategy with adequate coercive powers, complemented by supply side measures to tackle the illegal trade in certain drugs where money can viably be spent doing so.

Although locally-provided healthcare needs to be placed at the centre of any successful drugs policy – as examples from the Netherlands, Sweden, France and others demonstrate – that is not to say that there is not a role for criminal justice. Firstly, coercion is a legitimate and necessary tool when dealing with drug addicts, and the criminal justice system could play a unique role in forcing those who it comes into contact with into the treatment schemes discussed earlier. Instead of punishment being the aim and exercise of the police and the courts with regard to drug addicts, the involvement of the system could provide a vital avenue into treatment for the majority of addicts who are unable or unwilling to present for treatment themselves. Secondly, the UK policy needs to be more selective about the investment it makes into preventing drugs entering the country. There needs to be recognition that different substances will produce different types of addiction. Whilst fluctuations in the price of cocaine will produce fluctuating demand also, heroin is a morbidly addictive substance the price of which appears to have little effect on the level of demand. With heroin, cure is more effective than prevention although cocaine use can be improved by attempting to tackle supply.

Crucially, there needs to be consistency and effective partnership working between the health and criminal justice systems with the joint aim of channelling, possibly through coercive measures, as many drug users as possible into locally-provided treatment led by GPs.

3 | The Bassetlaw inquiry

The Bassetlaw constituency is located in north Nottinghamshire. It is an area that is rich with history: the Pilgrim Fathers departed to America from Bassetlaw, and James I performed the first execution of his reign while in progress through the area in the early seventeenth century. The area also contains a large part of Sherwood Forest, the historic home of the UK's most famous outlaw. It is a coal- rich area which, from the nineteenth century, relied on mining as the basis of its economic and social strength.

During the late 1980s and 1990s the pits were slowly closed, leaving many families and communities destitute and the old social norms and structures shattered. Young men who, in previous generations, would have started work in the pit at 16 were suddenly left with no future. Lack of educational aspiration meant that children were still leaving school as soon as possible, but facing an uncertain future in their community. Old social, community and economic structures, based as they were around the coal mine, broke down. It was exactly at this time that heroin began creeping into coal mining communities such as Bassetlaw.

According to government figures made available in 2002, heroin misuse in coalfield areas was then 27 per cent above the national average.[15] Michael Clapham MP (Barnsley West and Penistone) gave

some indication of the severity of the problem of heroin use in coal-field areas in a House of Commons debate:

> Barnsley has a drugs problem. The drugs action team reported that every 41st person in Barnsley regularly takes heroin. We have a population of some 237,000 people, which means that 6,000 people regularly take heroin. That is the source of crime in my area: 70 per cent of crime in my constituency and across Barnsley is drugs-driven.[16]

This sentiment was endorsed by another coalfield Member of Parliament, Jon Trickett (Hemsworth) who reported in the House of Commons that heroin was a particular problem in his constituency, particularly in his ex-colliery community:

> I want to give a voice to the concerns of many of my constituents who are facing a rising tide – almost a cancer – of drug taking, as are many communities in former coalfield areas. If one believes, as I do, that Government action can be benign and that it can try to remedy social evils such as drug taking, it is right that the Government should take action.[17]

Mr Trickett further reported that in Wakefield, the district in which his constituency lies, only 52 people were referred for treatment due to heroin problems in 1993-94. By 1997-98, 1,800 people had been referred due to heroin use. This coincides with the privatisation of the mining industry in 1994. Clearly, there is a causal link between the breakdown of the mining community and an increase in heroin use.

The inquiry into heroin use in Bassetlaw was held in the autumn of 2002. Its aim was to investigate the growing problem of heroin use in Bassetlaw and the measures being taken on all levels by the criminal justice system, treatment providers, and community schemes to deal with the epidemic. It sought to establish that a

pattern of heroin abuse peculiar to coalfield areas creates problems that the drugs policy at that time had not addressed and to make recommendations to the Government on this basis.

Over the three days the community panel, convened and chaired by myself, heard from all the agencies involved in all aspects of heroin addiction from police officers to the users themselves. The consequent report outlined the overhaul the panel felt was needed in the provision and availability of treatment to those willing to undertake it. The key problem identified was that there was no joined-up thinking in the way in which treatment was offered. Heroin addicts convicted of an offence and serving time in prison were given limited help but this essentially ended at the prison gates, with no follow up treatment offered as a matter of course in the community. Those who self-referred were directed to 'The Maltings', a package of six treatment services commissioned by the Nottinghamshire Drug and Alcohol Action Team. This service received a good deal of criticism from users and their families because it was perceived as distant, unsympathetic, often involved a long waiting period before a drug worker was allocated and most critically, it followed the philosophy of treatment only being given if the individual was tested free of drugs

Central to the panel's recommendations was the notion that there needed to be a radical overhaul in the way that treatment is perceived and administered locally.

With support from the community, several local GPs began to treat drug users in their local surgeries, in a similar way to how a GP would react if the patient suffered from asthma, diabetes or any other chronic relapsing illness. Bassetlaw began putting effective, medical treatment at the heart of its drugs policy instead of being reliant upon referral through the criminal justice process.

The results speak for themselves. In figures released by Nottinghamshire police in 2004, during the same period that the number of addicts undergoing medical treatment increased from 4

to 164, drug related acquisitive crime fell by 33 per cent in Bassetlaw. By July 2005 there were 320 people in treatment, over 65 per cent of the drug using population, of whom another 15 per cent had spent time in prison in this period.

It was clear to everyone from the former addicts, many of whom are now no longer addicted, to the police and the wider community that the Bassetlaw system of making medical treatment the basis for any drugs policy was the key to success. There needs to be an understanding within the drug bureaucracy and government that it is only with nationwide reform along the lines experienced in north Nottinghamshire that we can make real and quantifiable progress on the war on drugs. Of course, if we compare with mainland Europe, it is Britain, not Bassetlaw that is the aberration.

Heroin addicts in Bassetlaw repeatedly begged to be forced into treatment:

> At the moment to get into a Rehab they need to want to go in at their own accord and are able to slip back out again when they want to. Drug addicts know only one thing, they want a fix, they haven't a mind of their own. We must do it for them.[18]

> I spent seven months in a rehab at Town and I'm currently trying to get back there. This is because I know that there is a very small chance of me staying clean and sober if I stay in Worksop. The temptations and lack of support is immense.[19]

> When he admitted he had a problem and asked for help we did our best, with our limited knowledge to find it for him. We couldn't do anything for him, it all had to come from him. When he did ask the right people he found there was a waiting list. A long one! By the time he reached the top of the list he had 'friends' helping him instead.[20]

> My sister and her husband have a [age] year old son, my nephew, who got heroin. They have been to hell and back, they're very good parents, not at all bad folk. My nephew, like many more, he got in the wrong crowd… But, why is there no help on the NHS? I've been told its not new in some parts of the world, why, why, has it took so long to reach Britain? Please, for the youth of today, the little children of tomorrow, do something to help these kids.[21]

Such a change was welcomed in Bassetlaw. At the time of the heroin inquiry, 'treatment' meant a referral (after a long wait) to the much criticised Maltings, but the panel of the inquiry also felt that whilst these services provided social care and counselling, medical treatment was relatively rare and patchily administered. No one can deny that these services are an important aspect of a broader menu of drug treatment, but their role should focus around the secondary psycho-social care of an addict already receiving treatment for his use in order to be successful.

As a micro-evaluation of the success of treating drug use as a medical problem, Bassetlaw is an excellent example. In July 2002 there were two addicts in Bassetlaw receiving medical prescription for heroin abuse, and there were 80 burglaries a month reported in Worksop (the main town in the Bassetlaw constituency). In July 2004, the number of addicts receiving treatment from their GP had risen to 164 and the burglary rate had fallen to eighteen reported per month, a fall of 75 per cent. The statistics are clear, medical treatment of an identified drug addict through primary care works.

Coercion and the myth of free choice

The Bassetlaw heroin addicts all enjoyed the sensation of heroin. None wanted to be a heroin addict and all recognised that occasional recreational use is and was a fantasy. Many of the Bassetlaw addicts had used prison as a form of respite, what one might call a residential rehabilitation stay. What they repeatedly demanded was

to be forced off drugs and into treatment. In fact this demand was virtually a consensus. Most illustrated their frustrations about the requirement to prove their readiness for treatment. With a highly addictive drug like heroin the notion of free choice for the individual is an illusion and this logic of argument would be vehemently dismissed in other scenarios.

It is not just the addicts who want coercion. Their neighbours do. But so do their families. Most drug addicts routinely steal from their families who are least likely to report the matter to the police. Thus reported crime is artificially low and the market for cheap second-hand lawn mowers and tools is high. A circle of deprivation takes hold quickly.

One of the major criticisms of Drug Treatment and Testing Orders, conditional cautions, and indeed treatment in prison, was that their duty of care to the addict ended once their course of treatment had concluded, and there was no easy route into voluntary community treatment. Often in Bassetlaw addicts complained that, having undergone compulsory treatment in prison, they were left at the prison gates with two naltrexone tablets (so-called 'blockers') and no idea how to access follow-on treatment.

> When my son was in the cells he was given support and treatment within six hours. When my son was in prison he saw a worker and given treatment on his first day. When he came home he was given none. Why?[22]

> Why is it that when a user goes to prison and receives a detox course there is no support from probation service to help ex-offenders stay off heroin?[23]

> When I've left prison there's been no help, you come out homeless and when you haven't got your family you go back to friends who are users. Probation hasn't helped in any way. I did eight months

> and was with Maltings and the waiting list was so long. And I made a big effort but is just way too long for the help you need. The drug counsellors you see only tell you what you already know. There's not enough help for people that truly want to get out of this way of life.[24]

In addition, until 2002 the National Treatment Agency, the organisation responsible for overseeing treatment across the UK, had no jurisdiction within the prison service. There was no consistent, overarching treatment because of the lack of co-operation between the drug bureaucracy and the criminal justice system.

Employment

The lifestyle associated with large-scale use of opiates or class A substances is usually chaotic. Addicts told the panel of the Bassetlaw heroin inquiry that their day consists of waking up and going out to steal to buy heroin to shake off the 'rattle' (withdrawal symptoms), and then the rest of the day is focused on maintaining a comfortable level of heroin intake and committing further acquisitive crime to fund it.

Quite often the addict's friends and family are similarly afflicted and, as was the case in areas of Bassetlaw where large sections of the community were under the influence of the drug.

Serious drug use does not happen in a vacuum. Once the former addict is released from prison or has voluntarily referred himself for treatment with success, he is immediately placed back in the same community that gave rise to his troubles in the first place. In addition to this, any form of criminal record is going to inhibit his ability to seek employment. In Bassetlaw, the major industries included retailers and food processing plants, all of whom stated candidly that they would be uncomfortable employing someone with a conviction for shoplifting.

Schemes have been initiated by the Government to deal with this problem, but their failures contrast starkly with the huge success of all other employment initiatives, not least the New Deal. In March 2001, the Chancellor announced a £40m investment, over three years, to help clients with previous drug use problems into work. The resulting initiative, named Progress2Work, reflects the wider approach to helping those who are disadvantaged in the labour market set out in 'Towards Full Employment in a Modern Society'. Whilst demonstrating some success with stable or former heroin users, it has foundered in some key areas.

Evidence from the Netherlands shows that large companies are more reticent at employing former addicts than smaller companies is borne out by similar experience in the UK. Within Bassetlaw I have held several meetings bringing together employers, treatment providers, and others to attempt to work out a local action plan for getting former addicts back into the drug market. Whilst this scheme is still in its early stages, it is something that needs to happen on a national scale between Government and industry. Turning Point in Melbourne, Australia has turned its traditional rehabilitation centre into a vocational training centre. The British Turning Point, the Princes Trust, and many others are experts in rehabilitation for employment. In addition, the private sector has some excellent case study successes such as Reed Employment's housing bond link to employment.

It is critical that former addicts can reintegrate into the economic and social life of their community. If they find that, having kicked their addiction, they are unable to find employment because of their criminal record then they are likely to give up on their attempt to remain clean. This is another argument for coercive community-led treatment; if users can be identified and treated by local authorities before they become familiar faces to the police, it is likely that they will not be hampered by a criminal record acting as a barrier to their employment.

There is little research or evidence of what really works with drugs education. Whilst it is a core curriculum requirement included in the non-statutory Personal, Social and Health Education curriculum and also within the Citizenship Orders, the teaching of drug education is not consistent across the education spectrum, and often it is not delivered to an acceptable standard. The heart of the problem is due to a poor definition of what drugs education should be. The evidence from Bassetlaw suggests that high aspiration and self-esteem are central to a positive message and that anti-bullying policies are important to effective intervention.

In Bassetlaw a large majority of heroin addicts have low aspirations and low educational attainment, with heroin abuse taking on a wider circulation.

4 | A fresh start

In its present state the UK drugs policy is a confusing plethora of mixed messages regarding freedom of choice, coercion, health care, and morality. It is time that the entire system and the legislation behind it is reformed in order to accurately identify drug use as primarily a health issue. This does not merely mean an overhaul in terms of policy, but also what we mean by 'harmful' drugs and how these are classified to reflect the damage done by their use to the individual and society.

The importance of clarity in the drugs legislation cannot be overstated, as it is from these laws that the criminal justice system takes its cue on how to approach the problem of drug use. A new way of classifying drugs will influence the way in which transgressions are punished and the manner in which such punishments are administered.

However, the first and most important change must be the re-alignment of the UK drugs policy around the notion of treatment through primary care as the bedrock upon which further rehabilitation must be based.

Treatment through Primary Care within the NHS

Treatment for diabetes, asthma, and other chronic relapsing illnesses is accessed by the patient through his or her GP. Treatment for drug use is handled by the Netherlands in a similar fashion as their Government perceives that it has an obligation to provide treatment for this disorder in the same way it would any other medical problem.

Currently, in the UK the real treatment decision is as likely to be made by a probation officer as by a GP. The probation officer will follow the drugs worker's recommendations which will then often be agreed by a locum GP who merely signs the prescriptions and has virtually no contact with the patient.

Much more importantly, we need to see more prescribing of the drug, bupronorphine which has been successful in the treatment of heroin use in France, Sweden and Australia. The so-called 'liberal' Holland system on the other hand has a comprehensive medical treatment programme backed by a large amount of resources. Whilst Sweden and France use bupronorphine as their treatment prescription, Holland uses methadone, and Australia uses both. These three systems have significant success stories to tell. If the UK wants to emulate such success, its policy must be a treatment led system routinely using methadone and bupronorphine.

However, whilst France, Sweden and the Netherlands have been putting effective medical treatment at the centre of their drugs policy for a good number of years (in the case of Holland, since the 1980s), there has been a great reluctance amongst the drug bureaucracy to accept that that such treatment is essential and needs to be at the centre of any UK drug strategy. Methadone has long been the standard drug of issue for treatment in the UK but, as the Home Affairs Select Committee discovered, the places available to addicts wishing to get a prescription were very few.

A further criticism of methadone treatment was that it was not always prescribed in the correct dosages. The average prescribed methadone dose in the UK has been between 30mg and 50mg, whereas the national guidelines say that it should be 60mg to 120mg and an average of probably 80mg is what is used abroad. Skimping on the doses means that it cannot work as a heroin substitute and merely forces the heroin addict to 'top up' the dose with heroin thus negating the reason for the addict taking the methadone in the first place. Aside from being quite astonishingly wasteful (indeed, a better definition of the term 'false economy'

is hard to find) it demonstrates the lack of commitment to treatment as the building block on top of which all other forms of rehabilitation must take place.

The Updated Drug Strategy 2002 made commitments to increase the number of GPs and primary care professionals working with drug addicts, as well as announcing the intention to use diamorphine as a treatment drug for opiate use. Evidence from Holland and New Zealand suggests that this will work more effectively with much older long-term addicts, removing the moral dilemmas of over prescribing to young people.

The other significant reason for GP led treatment is the prevalence amongst chaotic drug users of other diseases such as HIV and hepatitis C, as well other illnesses such as anxiety, depression, and general ill-health. A medical professional is in the best position to treat the primary and secondary symptoms of drug use through prescription of the appropriate drugs. The addict can then be referred on to other forms of rehabilitation such as employment and housing schemes and counselling, but medical treatment must come first for the secondary rehabilitation to yield results.

There is still a long way to go before drug use is seen as the medical issue it is. In spite of progress made in recent years towards a treatment based approach to drug addiction, drug use is still seen as a criminal justice issue first and foremost. Responsibility for the reduction of drug abuse in the UK needs to be transferred from the jurisdiction of the Home Office to that of the Department of Health. This, as a primary step and would be a very positive one.

Extension of coercive powers

The notion that the only way for an addict to succeed in drug treatment is through freely and willingly signing up to a treatment programme and then undergoing, as was the case in Bassetlaw, several agonising nights going ‘cold turkey’ before treatment could commence needs to be challenged and discontinued.

Coercion is required and often essential. The Bassetlaw Heroin Inquiry heard addicts tell of their desire for coercion; indeed, the fact that many were attempting to get into prison to access treatment is a testimony to the desire and need for our system to resemble the more coercive models on the European mainland.

> [My son] says it is a full time job being a drug addict, planning where you are going to get your next fix from. He desperately wants help to come off it. He has had his chances and lost them, but the support is not there. His associates cannot afford to let him come off. They need his money to fund their own habit. A weekly meeting with a drug counsellor is not enough.[26]

The introduction of conditional cautioning in the UK is a promising step, and experience with cannabis use in Queensland, Australia demonstrates how a highly coercive system can direct people successfully into treatment. Such powers should be routinely available, but again require a primary care system willing to deal with referrals locally and routinely.

Simplified classification of illegal drugs

In the current system illicit drugs are classified to fall into line with the requirements of criminal justice legislation. Drugs are classified under the Misuse of Drugs Act 1971 and are divided up into three classes. Drugs such as heroin, methadone, cocaine, crack, Ecstasy, and LSD fall into class A. Conviction for possession, in a Crown Court, can lead to a maximum seven year prison sentence and a fine. The maximum penalty for trafficking is life imprisonment plus a fine. Class B drugs include amphetamines (speed), and barbiturates. The maximum penalty for possession of a class B drug, if the case reaches Crown Court, is five years, plus a fine. Class C, the lowest class of drugs, includes cannabis, mild amphetamines (such as slimming tablets) and Anabolic Steroids. Benzodiazepine drugs such as Valium are also categorised as class C

drugs. Maximum sentences are two years for possession and five years for trafficking.

With a drugs policy based on health rather than criminal justice concerns, it makes sense for such classifications to be replaced. There should be just two classifications. Class 1 should contain drugs that cause health problems and are likely, as a result of their consumption, to lead to behaviour that will cause harm to others. Thus, addictive drugs leading to acquisitive crime such as heroin should be class 1 drugs as should stimulants that can lead to violence as well as addiction. Class 2 drugs should be those that will damage your health but are unlikely in themselves to cause harm in others. Thus cannabis should be a class 2 drug. This model reflects health concerns, creates a coherent framework for criminal justice and takes and keeps drug classification out of the hands of politicians.

No barriers to treatment

The drug bureaucracy in Britain has become a franchise operation, with a confusing assortment of organisations and agencies with ill-defined responsibilities. Negotiating the confusing and often conflicting areas of responsibility with success and understanding is something that is beyond most chaotic drug users, and even on occasion members of the Bassetlaw Heroin Inquiry panel.

The panel was astonished to find drug workers and probation officers deciding treatment plans, which locum doctors systematically agreed to. The drugs world has a lexicon of its own. Addicts are not addicts, they are users. Heroin is not heroin, it is gear. There are DIPs and DATs, DAATs and CJIPs. NTA and DRG. Tiers one to four. DTTOs and PCTs, SHAs and many other acronyms besides. The end results are all too often DVTs and ODs (deep vein thrombosis and overdoses).

The addict seeking treatment in this country has to overcome considerable obstacles. Geographic location has a huge impact on what treatment is available to him. Drug Action Teams are responsible for the commissioning of drug treatment services across the local authority

area, and the services available vary widely according to the philosophy of the Drug Action Team. That is, many treatment services commissioned insist that an addict comes off the drug of addiction prior to commencing treatment in order to demonstrate commitment to the programme.. Drug treatment provision is inconsistent and administered by a plethora of different agencies with differing ideas as to what constitutes 'treatment', definitions of which can vary to encompass both counselling and diamorphine prescription.

In Bassetlaw, the panel found a revolving door of addicts trying to get treatment, waiting for appointments, trying detoxification, going back onto drugs, and again trying to get treatment.

Whilst the updated drug strategy did amend some of the success of GP-led treatment and the resulting fall in drug-related crime mirrors the success from abroad that the health services should be at the centre of a successful approach to drugs. However, health treatment should not be seen as merely an 'episode' in a treatment plan, it must be the basis of treatment itself. Schemes such as Progress2work, and initiatives to get addicts into stable housing are only going to succeed if and when health treatment is working.

For our drugs policy, to be successful, it must put primary care treatment at the heart of the strategy and involve the community, the workplace, and the criminal justice system in consistent and overarching treatment. Forcing drug addicts into treatment as soon as they are identified as having a problem is a necessary part of any successful drugs policy.

Work and employment

Treatment within the community with the support of the community has seen significant success in Bassetlaw and on the European mainland. However, work is fundamental to success.

The Learning and Skills Council with full Department for Education and Skills backing, is shifting resources to vocational education and training for young people. One small by-product of this change will be

the time filling courses that drug addicts are encouraged to go on. Time is a fundamental issue for anyone fighting a drug addiction. It is one reason why detoxification rarely works and more importantly why proper health treatment can fail. A former addict with lots of time on their hands is much more likely to resume drug taking, due largely to boredom.

Once the addict is in treatment with his GP, it is essential to reintegrate him back into the employment market. This has several benefits. Firstly, the addict becomes a taxpayer and can start contributing to the system rather than being dependent on it. Additionally, however, employment is the major form of rehabilitation.

The problem facing many former addicts in Bassetlaw and across the UK is that most employers are unwilling to take them on. This is especially true in the case of heroin addicts who often commit acquisitive crime to fund their habit; many employers will not consider employing someone with a criminal record. The consequences of such rejection are often detrimental to the former addict's continued rehabilitation. Not only are they denied the important and positive support structures that the workplace can offer, but if they perceive that there is no future for them as a fully functioning member of society then there is increased danger of a relapse.

There is no guarantee for employers that a drug addict is no longer a drug addict. Even with labour shortages, a drug addict is bottom of the queue. Criminal convictions for theft, an unhealthy lifestyle, little or no recent work history, no employer references: why should an employer take a chance, especially if the addict is likely to be known to workmates as a drug user? In Holland small employers are particularly used to high guarantees underlining their employment. In Sweden there is a moral imperative for employers to be socially responsible. Underpinning this social responsibility though is a crucial guarantee within the Swedish system: the GP.

With a buoyant labour market, employers can be persuaded on is that the issue of a criminal record can be overlooked if there is a substantive

verifier of the individual's ongoing drug treatment. There are two key verifiers that would suit the British system: the GP and the trade union.

The trade union is important in larger workforces where by definition there is likely to be more knowledge of the individual's past history, more ex-school friends, more houses, cars, and sheds burgled. The union can negotiate a clear and public agreement over what parameters should exist. They may be high, including regular drug testing, but they should be transparent if they are to work.

The external verifier should be the GP. No GP can assist employers without the full consent of the individual, but it is the individual who is seeking work and wants a fair chance.

I negotiated with Bassetlaw District Council over an individual who all parties agreed need not necessarily by identified, in this case even to them. The employee (who was a permanent employee with a drug addiction) entered treatment with a GP knowing that time off was needed for health treatment this would not, in itself, lead to dismissal or disciplinary proceedings.

Such agreements should be widespread covering return to work, time off for family, and confidentiality for current employees. It does not suit every employer to harbour secret and serious drug addiction, and this therefore requires a comprehensive policing. Large employers have little idea of how many days off or how much punctuality is lost through partners, parents, and grand parents dealing with an addict. How many employers ask for time off to accompany their son to court for burgling a 90-year-old pensioner, or their daughter for prostitution?

There needs to be further work done on developing intermediate labour markets with the aim of assisting former addicts back into the job market. Examples of success in this area include Turning Point who run a service in partnership with employers which gives practical experience to former addicts as well as providing a counselling and mentoring service. In December 2003, in partnership with local environment agency Green Business Network and Eastern Wakefield Primary Care Trust, Turning Point began work on a programme

designed to turn the area into the caviar capital of the UK. The scheme will provide jobs for up to fifty people who would otherwise find it difficult to find employment.

Interventions in the labour market are essential in order to tackle drug addiction. Whatever else is done and however well, nothing will succeed in permanently getting people off drugs unless it incorporates a return to work. As two parents said to me in introducing a young man to me, “you might not recognise him. This is our son, a taxpayer.”

The fact is that effective drug intervention culminating in a return to work is a net saving rather than a net expense to the taxpayer and to the Government.

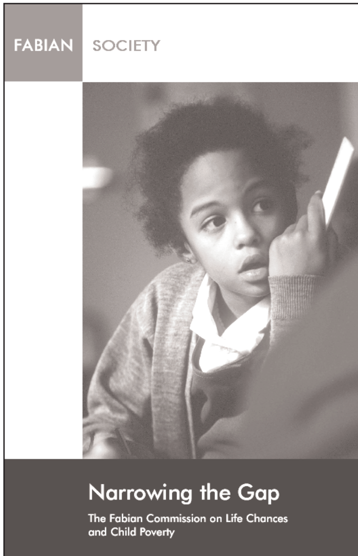
References

1. Updated Drug Strategy (2002).
2. *Hidden Harm: Responding to the needs of children of drug users*, 2004.
3. *Tackling Drugs to Build a Better Britain: Second national plan*, 1998.
4. 'The Government's Drug Policy: Is it working?' Third report of the Home Affairs Select Committee, May 2002.
5. UK Threat Assessment of Serious and Organised Crime 2001, National Criminal Intelligence Service (NCIS), p17.
6. *Annual Report on the State of the Drugs Problem in the European Union 2001*, European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA), p20.
7. *World Drug Report 2000*, United Nations Office of Drug Control and Crime Prevention (ODCCP), p39.
8. *UK Threat Assessment of Serious and Organised Crime 2001*, National Criminal Intelligence Service (NCIS), pp18-22.
9. *World Drug Report 1997*, United Nations Office of Drug Control and Crime Prevention (ODCCP), p126.
10. DrugScope, 'How much do drugs cost?', http://www.drugscope.org.uk/druginfo/drugsearch/faq_template.asp?file=\wip\11\1\2\cost.html
11. *UK Threat Assessment of Serious and Organised Crime 2001*, National Criminal Intelligence Service (NCIS), pp18-22.
12. Heroin Inquiry, Volume II, John Mann MP, October 2002.
13. Heroin Inquiry, Volume II, John Mann MP, October 2002.
14. Personal communications.
15. Written PQ from John Mann: To ask the Secretary of State for Health what the estimated number of heroin addicts is in (a) the United Kingdom and (b) coalfield constituencies. [41807].
16. House of Commons debate, 21 June 2001.
17. House of Commons debate, 2 July 1999.

18. Personal submission, Heroin Inquiry, Volume II, John Mann MP, October 2002.
19. Ibid.
20. Ibid.
21. Personal submission, Heroin Inquiry, Volume II, John Mann MP, October 2002.
22. Personal submission, Heroin Inquiry, Volume II, John Mann MP, October 2002.
23. Ibid.
24. Ibid.
25. Personal submission to the Bassetlaw Heroin Inquiry, available in Volume II of the report.
26. Heroin Inquiry, Volume II.

Special offer: join the Fabians for just £9.95 and get this book free.

'The Fabians ask the most difficult questions, pushing Labour to make a bold, progressive case on taxation and the abolition of child poverty.' – Polly Toynbee



How can we make poverty history at home?

One in five children still grows up in poverty in Britain. Yet all three political parties now claim to care about 'social justice'. This report sets a litmus test by which Gordon Brown, David Cameron and Menzies Campbell must be judged.

'Narrowing the Gap' is the final report of the Fabian Commission on Life Chances and Child Poverty, chaired by Lord Victor Adebowale.

The Fabian Society is the only think tank with members. Join us and help us put poverty and equality at the centre of the political agenda.

Join Britain's only membership-based think tank

Join the Fabian Society and receive a free copy of 'Narrowing the Gap', worth £9.95, **plus** the Fabian Review equality special issue, **plus** the next two Fabian pamphlets. Call 020 7227 4900 or email info@fabian-society.org.uk for more information.