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UK Drug Policy

Balancing Treatment and Punishment

During the New Labour years (1997–2010), significant redirection of drugs policy took place, especially in the area of treatment: new institutions and policies were developed under the guidance of the National Treatment Agency. However in 2010, when the Coalition (Conservative and Liberal Democrat) government was formed, with its goal to prioritise 'recovery', there were still an estimated 400,000 problematic heroin and crack cocaine users in the UK. The consensus then among drug treatment experts was that the priority should be to build on what had been achieved but develop better links between different health, social care and other services to support recovery. The new direction of policy towards recovery was accepted but the challenges had to be recognised: many of the people who were using drug services arrived at the door with multiple problems and needs. Often their drug use was linked to experiences of childhood abuse or adult trauma, to mental health problems, homelessness, family breakdown and other problems.[1]

Under Coalition and Conservative administrations since, the emphasis in drug treatment policy has been on 'recovery' but the wider context has

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been one of austerity fiscal policies. How has this impacted on the shape of the drugs problem, drugs services and drugs policy in general?

Even quite recently, people outside the UK operated under the illusion that there continued to be a distinctive 'British System' which provided heroin to dependent users under medical guidance. This did exist for some time but by the time our story begins had virtually disappeared, although its shadow remained in the influence of addiction psychiatrists and the drug dependency units until these began to fade in importance in the twenty-first century.

19thC discourse had viewed addiction as both a moral failing and disease. During World War One, emergency legislation further restricted opium. The *Dangerous Drugs Act 1920* initiated drug prohibition in Britain (Seddon 2010). The *Rolleston Report 1926* recommended appropriate medical use of morphine and heroin in addiction treatment: prescribing to those gradually being withdrawn; maintenance for those who, 'after every effort had been made for the cure of their addiction', could not be completely withdrawn. This became known as the British system, characterised by the 'majestic professional independence enjoyed by British physicians in the drug arena' (Trebach 1982, p. 185). The policy framework was set until the 1960s when a new form of addict appeared. While earlier addicts had often been created during medical treatment, new ones had been 'turned on' through contact with other addicts: these were seen as social misfits. Drug taking began to be perceived as a social problem, prompting calls for a new response from government.

From being a relatively simple (though often misrepresented) 'British system'—when 'little more than masterly inactivity in the face of what was an almost nonexistent addiction problem' (Downes 1977, p. 89)—British drug policy has evolved into its current complex, contradictory set of arrangements. This pattern is characterised by variety: in the strategies of the different nations of the UK; in services and police operations in different localities, especially as decisions and commissioning are devolved to local authorities; and in differences between what is pronounced publically and what happens in practice. Changes over time, influenced by funding issues and competition from other policy priorities, are not easily captured by simple labels or categorisations. At best, the current British case could be described as flexible and adaptable, even pragmatic:

at worst, the potential for discrimination can become injustice. But, while 'drugs' continues to provide copy for sensational media reports, the essential features of the debate seem hardly to have moved over the last 40 years. Entrenched positions remain.

Social Conditions

In the 1980s, the socio-economic context for policy development and change was one of rising unemployment and de-industrialization, with problems concentrated in declining communities. This coincided with an increase in the supply of heroin, the distribution of which expanded via criminal networks to the North of England and Scotland. External factors influenced the availability of heroin, such as the Iranian revolution and events in Afghanistan. Later in the 1990s, partly as a result of deliberate policies of regeneration, the expanding night-time economy provided the context for an increase in drug use and problems associated with clubs as well as drink. Some groups exhibited hedonistic consumption and intoxication. More drugs were being used by more people in more varied ways with increasing supply (partly because of the collapse of the Soviet Union and the efforts of organised crime) (Glenny 2008). Economic liberalism and the breaking down of border controls, especially in the European Union, facilitated this.

During the 1990s and in the years since, there have been major changes in the way young people have consumed drugs: on the whole, policies and service provision have failed to adapt to these changes. The overall shape for a time was of an increase in alcohol use and increased morbidity—what was defined as the 'ACCE profile' emerged—that is, the combined use of alcohol and amphetamine, cannabis, cocaine and ecstasy. So drug trends followed distinct waves: the first wave was that of the 1980s' use of heroin in North West England and London and Scottish cities; the second wave in the 1990s included the Welsh valleys and other English regions and towns. Alcohol became the primary problem for under 18s in services, with weekend Friday and Saturday nights involving anti-social behaviour and pressures on police and A&E departments.[2] More recently, use of synthetic drugs and cannabis has increased and overall drinking reduced,

although patterns of use in subgroups vary and most recently ecstasy has seen a resurgence. All of this points to the importance of fashions and trends and changes in patterns of drug-taking among young adults, with which policy and practice struggle to keep up.

Changes occurred also over this period in general social values, with a shift away from the welfare state towards a stress on market solutions, consumerism and individualism. New Labour's 'third way' ideas tried to find a middle way, stressing both rights and responsibilities. With the financial crisis of 2008 and turn to austerity policies, even more stress was placed on individual and family responsibility, as it was argued the state could not afford to provide so much in the way of services. Indicators of discontent were evident throughout the UK but generally ignored by the political class—such as the rise of the SNP in Scotland and the outcome of the Scottish referendum, growing support for UKIP and the majority vote for Brexit in the EU referendum, preceded by the riots of 2011 which had spread rapidly across major cities. Some saw these riots as a carnival of nihilism and hedonism. The Tottenham MP, David Lammy, commented that he was shocked to observe that the rioters were enjoying themselves and went on to argue that the backdrop to the riots, both in Broadwater Farm in 1985 and the 2011 riots, was two revolutions with which Britain has yet to come to terms. The social liberalism of the 1960s and the free market, liberal revolution of the 1980s. Together they made Britain a wealthier and more tolerant nation. But they have come at a cost, he said, combining to create 'a hyper-individualistic culture in which we do not treat each other well … Those who clambered through smashed shopfronts were not stealing bread to fill their stomachs; they were stealing consumer goods that they coveted'.[3]

Other analysis by sociologists at LSE contested the government argument that the riots were the work of organised gangs: the key fact they observed was that the gangs called a truce during the riots (which were initially sparked by the shooting dead of Mark Duggan, a Black British man, by police). The gangs saw the riots as an economic opportunity but also a chance to hit back at the authorities—the government and the police. These researchers pointed out that only 19% of those arrested in London during the riots were gang members, falling to 13% countrywide.[4]

Three Phases of Drugs Strategies

British drugs policy has altered in tone and direction since the *Misuse of Drugs Act 1971* (MDA) came into force but what changes have occurred have been within the limits set by this Act. The current classification system is contained in Schedule 2 to the 1971 Act and divides all the controlled drugs into three Classes—A, B and C. The main principle said to dictate classification is that the greater the impact a drug has on individuals and society, the higher the Class within which it will fall. Since the Act came into force, there have been various amendments to incorporate new drugs as they have emerged or to reflect perceptions—or evidence—of changes in the harmfulness and/or misuse of existing and previously uncontrolled drugs (Table 2.1). In 2006, a parliamentary report concluded that the 'current classification system is not fit for purpose and should be replaced with a more scientifically based scale of harm, decoupled from penalties for possession and trafficking' (Science and Technology Committee 2006, p. 3). This recommendation was not however accepted by government. The need to enact the *Psychoactive*

Table 2.1 Drugs classification system under the MDA

	A	B	C
Main drugs in each class	Powder cocaine, Crack cocaine, Ecstasy, LSD, Magic mushrooms, Heroin, Methadone, Methamphetamine, Injectable Class B drugs (such as amphetamines)	Amphetamines, Barbiturates, Cannabis, Codeine, Mephedrone, Ketamine	Anabolic steroids, Minor tranquillizers, Benzodiazepines, GHB/GBL, BZP, Khat
Maximum penalty for possession	7 years imprisonment plus unlimited fine	5 years imprisonment plus unlimited fine	2 years imprisonment plus unlimited fine
Maximum penalty for supply	Life imprisonment plus unlimited fine	14 years imprisonment plus unlimited fine	14 years imprisonment plus unlimited fine

Substances Act in 2016 demonstrated that the MDA was unable to deal effectively with the range of new substances that were becoming available.

A major change in the period was the increasing influence of membership of the EU, especially because of involvement in the EMCDDA and other European agencies. In general public sector and social policy, the period saw the growth of managerialism and the increasing influence of the new public sector management. With drugs, this was thought to come in with the institution of Drug Action Teams (under Conservative Prime Minister John Major) but developed rapidly under New Labour governments, facilitated by the rapid expansion of ICT—technological changes which allowed more effective performance measurement, monitoring and target setting, emphasis on outcomes, audit, and policy and practice evaluation.[5]

There have been three phases in the overall policy response with respect to drugs: a turn to harm reduction; the drugs-crime agenda; and a stress on recovery. From the 1980s (roughly 1986–1996), there was a move towards harm reduction, influenced mainly by the arrival of HIV/AIDS. In the 1980s, the respected ACMD led opinion, saying in a significant report that 'HIV is a greater threat to public and individual health than drug misuse. The first goal of work with drug misusers must therefore be to prevent them from acquiring or transmitting the virus' (ACMD 1988, p. 1). It recommended that services should be made attractive to drug users. In the years that followed, while abstinence remained services' ultimate aim, needle exchanges and maintenance treatment expanded and helped to contain the HIV epidemic (Stimson 1995).

In the second phase, the provision of more treatment services was seen as the policy answer to deal with an increase in acquisitive crime by diverting petty offenders into drugs agencies (from 1997 to 2010). In the third, after 2010, recovery became the banner goal, driven by frustration at the build-up in numbers in treatment, and there was greater stress on abstinence (Duke 2013). The perception of the key problem around which policy was oriented thus varied over the three phases.

Harm Reduction Phase: Conservative Years under Thatcher and Major

In the harm reduction phase, at first the main issue was the growth of a black market and an epidemic of heroin use. The old Drug Dependency Units had silted up, and there were complaints about a lack of services, especially outside London. This was partly addressed by an increase in funding for drug treatment through the Central Funding Initiative (MacGregor et al. 1991; MacGregor 1994). Later more funds became available for treatment under the heading of AIDS monies as the link between HIV and injecting drug use became apparent (Mold and Berridge 2010).

During the 1990s, there were changes to the funding of residential services with the introduction of community care through the *National Health Service and Community Care Act 1990*.[6] Other drugs began to be given more attention and there were fears that Britain would inherit the American crack epidemic. Raves and recreational use of other drugs, especially ecstasy, gained prominence (Ward 2010). Pressures built up to develop a more coherent and wide-ranging approach. There was 'a growing awareness that tackling drug misuse requires collaboration between a wider range of public services and the specialist voluntary and independent sectors who work with drug misusers' (Howard et al. 1994, p. ix). The numbers of notified addicts continued to grow, reaching 37,200 in 1995, and the amount of policy activity around drugs also increased.[7]

In response, *Tackling Drugs Together* (TDT) was introduced by the Prime Minister John Major in 1995 as the new strategy for England, with complementary strategies in Scotland and Wales: 'partnership' was at the core of the response. This is 'not just a job for Government—effective partnership to protect individuals and communities is the foundation of this strategy' said John Major. This strategy set the template for British drugs policy for almost 20 years thereafter and introduced Drug Action Teams and Drug Reference Groups whose principal roles were information collection, coordination and attention to local needs.[8] The key aims of TDT were to take effective action by vigorous

law enforcement, accessible treatment and a new emphasis on education and prevention to: increase the safety of communities from drug-related crime; reduce the acceptability and availability of drugs to young people; and reduce the health risks and other damage related to drug misuse.

This White Paper entrenched the division between alcohol and drugs as separate strategies, a long-standing barrier to developing integrated approaches, and emphasised the link between illicit drugs and crime. By establishing the idea of partnership, it aimed at a joined-up policy coordinated from the centre of government. Particularly important aims were to link the statutory and voluntary sectors and to link health and social care to the criminal justice system. It was also significant in its stress on the implementation of policy at the local level. In his introduction to the strategy, the Prime Minister referred to the idea that drug misuse 'blights individual lives, undermines families and damages whole communities.'

Drugs-Crime Agenda Under New Labour

Many of these themes and structures introduced by a Conservative government were continued under New Labour in government after 1997. DATs continued but responsibility switched to local authorities in keeping with Labour's preference for local rather than health authority responsibility.[9] Farrell and Raistrick commented, 'by the beginning of the new century, the key policy priorities had shifted once again. The major initiatives having moved from the public health sector to the criminal justice sector with crime reduction now driving the further investment in drug treatment services' (Farrell and Raistrick 2005, p. 108).

These policies were presented as a new 'third way' approach (triangulating to get the best of both worlds—state and market, liberalism and protectionism). The third way in social policy was defined by Julian le Grand (an influential health advisor) as having four ends: *Community*—that is partnerships, local involvement, attention to social exclusion; *Opportunity*—equality of opportunity not equality of outcomes; *Responsibility*—if people were offered opportunities they also had the

responsibility to take them; and *Accountability*—involving monitoring, reporting and transparency.[10]

Lord Raymond Plant saw all this as indicating a new settlement between the market, state and community (including the voluntary sector and local government). The political aim was to secure the consent of the contented majority to increased social expenditure—it was they who would have to pay taxes to cover welfare expenditure, skills training and human capital development.[11]

Within this Third Way complex were certain attitudes to deviants and the poor, including drug takers. The essence of the New Labour approach was that individuals need to be adaptable and willing and able to improve their skills. One way to try to include social problem groups was to encourage paid employment, which meant improving basic literacy and numeracy and social skills as well as encouraging the growth of new jobs. As it turned out, many of these new jobs—essentially low paid, insecure service jobs—were taken not by the long-term unemployed but by immigrants, especially from countries of an expanding European Union.

Initially at least, there was a concern to develop evidence-based policy and practice—including much funding of new research and the testing of ideas in pilots before rolling them out. There was devolution to country level, with variations in the shape of the strategy notable in Scotland, Northern Ireland and Wales. Local-level involvement was expected to have an important role, aiming to reflect local differences, interests and knowledge. Particular stress was placed on community involvement and service user participation. And drug and alcohol action would be linked to community safety decision-making, which was seen as equally if not more important than the link to treatment or public health concerns.[12]

Labour's first outline of a drugs strategy, *Tackling Drugs to Build a Better Britain*, published in 1998, aimed to help young people resist drugs, protect communities from drug-related anti-social and criminal behaviour, enable people with drug problems to overcome them and live healthy and crime free lives and stifle the availability of illegal drugs on the streets. The period began with a brief moment initiating a Drugs Czar approach and attempt to measure the value of the drug policy itself

by reference to the number of drug users and measures of the consequences of drug use. With a change of Home Secretary and following some criticism from the Home Affairs Select Committee, this approach was overturned and a more robust institution created in the form of the National Treatment Agency. The Chief Executive of this agency, Paul Hayes, set out clearly the essence of the politics of the New Labour strategy, constantly emphasising that it was only by stressing the link between crime and drugs that increased resources for drugs treatment were levered from the Treasury. And considerable new resources were allocated and thus had to be seen to be used effectively—giving a key role to commissioners, who would decide what to fund on the basis of measures of performance and standards and needs.

Underlying this approach was the idea that 'treatment works' and is cost-effective and that coerced treatment is as effective as voluntary treatment. A cohort study (NTORS) evaluated favourably drug treatment's cost-effectiveness (Gossop 2003). The NTA would oversee the very big increase in expenditure. Ring-fencing and tight control of the new monies were essential to success. The fear was that any increase in funding could leak away if put directly into the NHS. The NTA's remit was to expand the availability and quality of drug treatment and be responsible for monitoring expenditure from the pooled treatment budget (introduced in 2001/2 with £129 million available in that year—in addition to about £200 million of mainstream local expenditure).

The Department of Health Public Service Agreement which was the responsibility of NTA had two key targets: to increase the participation of problem drug users in drug treatment programmes by 50% by 2004 and by 100% by 2008; and increase year on year the percentage of users successfully sustaining or completing treatment programmes. Retaining people in treatment for 12 weeks became a specific policy. So, priorities were improving access, reducing waiting lists and paying more attention to co-morbidity. During these years, reducing drug-related deaths also became a particular concern, along with issues like giving more attention to crack use, discussion of the possibilities for heroin prescribing and links between cannabis and mental health.

In the *Updated Drug Strategy* 2002 under Home Secretary David Blunkett, policy was made to focus on the most deprived communities

and the most problematic individuals. The aim would be to disrupt middle-level drug markets. There would be a particular emphasis on dealing with the 'high risk' targets—the most deprived communities, class A drugs and problematic drug users (PDUs). Importantly, power was transferred back to the Home Office from the Cabinet Office. There was also increased stress on diversion into treatment and on compulsion and testing. The key aim was to increase the numbers in treatment with the aim of doubling the number in treatment from 100,000 in 1998 to 200,000 in 2008—and with an increase in the number completing or continuing in treatment.

Over its years in office, in practice, despite the Third Way rhetoric, New Labour continued the Thatcherite move to a more individualistic turn in social policy with reduced attention to the 'social' and more to 'the criminalisation of social policy'. They accepted the neo-liberal idea that most issues of health and welfare are the responsibility of individuals. Government may provide information (and sometimes facilities) but it is then up to the individual to make their choice. Government intervention should mainly focus on the social problems caused by the minorities who are not able to make rational choices and who thus cause disorder for themselves and others. Increasingly, the response was to lock up those who caused such problems, including young people. The overuse of coercion and the widening of the criminal justice net were key complaints from those who criticised New Labour.

Thus for New Labour, drugs treatment policy was linked to an array of other social policies, like modernising government and services, tackling social exclusion, regenerating deprived areas, enhancing equity and efficiency, involving service users, encouraging the voluntary (third) sector, working in partnership and in a joined up way and giving priority to young people—all set within the dominant evidence-based policy approach.

Important here too was the New Labour reform of devolution. The different countries of the UK developed their own strategies and policies but all were co-ordinated within the overall UK strategy. Scotland, while having a notable concern for public health and community issues, also showed interest in the effectiveness of treatment. It set up an Effective

Interventions Unit with the remit to show what works and to monitor cost-effectiveness. Wales included alcohol in its substance misuse strategy.

There was a plethora of initiatives in the New Labour years such as: Crime and Disorder Acts, Criminal Justice and Courts Act, New Deal programmes, the Youth Justice Strategy, Every Child Matters, Hidden Harm, the Licensing Act, the Respect Agenda, and the creation of NOMS. A dizzying array of new agencies, acronyms and targets appeared: FRANK, CARATS, DTTOs, CJIP-DIP, Drugs Intervention Record, along with mandatory drug testing, reclassifications of cannabis[13] and other substances, Models of Care and other guidelines, increased monitoring and devising of protocols.[14] Some attention was paid to prevention with the Blueprint programme aimed at 11–13-year-olds and in 2006 the Serious Organised Crime Agency was created.

The general thrust of policy was towards 'modernisation' and 'managerialism', modernising agendas in the NHS, in social services and in local government. Everyone was under pressure to show results, leading to a feeling and a fact of overload on all government-funded agencies.

The drug treatment field was transformed. The treatment budget rose from £142 million in 2001/2002 to £406 million in 2009/2010. Increasing numbers of drug users entered formal treatment, 207,580 adults by 2008/9, exceeding the policy target. The drugs workforce increased from 6754 in 2002 to 10,628 in 2007. New staff were recruited and trained. From being a relatively 'anarchic and quasi-religious movement', a more professional workforce appeared. Some asked whether this expansion had been at the expense of quality. In response, the NTA paid increased attention to training and to improving the standard of provision through the use of protocols and guidance and much attention was devoted to spreading good practice. Through the Drugs Intervention Programme and other measures, a dramatic doubling of the numbers in treatment occurred in these years.

However, while these achievements were being celebrated, disillusionment with methadone maintenance surfaced, creating a crisis in 2007. A BBC report 'revealed' that only 3% of drug users had left drug treatment free of all drugs (including methadone) in 2006/7. From then on, a clamour of voices criticised policy for focusing too much on numbers in treatment with not enough attention to the outcomes of treatment.

New Labour produced a *2008 Drugs Strategy* (*Drugs: Protecting Families and Communities*) which aimed to 'deliver new approaches to drug treatment and social reintegration'. This strategy gave more attention to children and families and said that drug users have a responsibility to engage in treatment in return for help and support. Innovative treatments (injectable heroin and methadone, contingency management) were mentioned. A key aim was to get users to move on from treatment and reintegrate into communities. It was hoped that a 'personalisation' approach and use of the benefits system—welfare to work—could be the way forward with drug co-ordinators in Job Centres linking drug treatment with employment support. Failure to engage with treatment could lead to loss of benefit. But there was little time to implement this approach as following on from the financial crisis, the government was ousted from power and replaced by a Conservative—Liberal Democrat Coalition in 2010.

The National Audit Office in *Tackling problem drug use 2009/10* concluded that there had been significant improvements in the provision, delivery and outcomes of treatment, including a reduction in the cost of each treatment episode, an increase in the number of users completing treatment free of dependency, a reduction in waiting times for treatment, and a reduction in the sharing of needles and syringes among injecting drug users.

The Recovery Agenda Under Coalition and Conservative Governments

After 2010, statistics had begun to show crime falling steadily: indeed from 2003, recorded acquisitive crime fell by 39% across England and Wales. This was attributed to the waning of the heroin epidemic. Morgan assessed the effect that heroin and crack-cocaine use may have had on acquisitive crime (i.e. theft-type offences) in England and Wales from 1980 (Morgan 2014) and concluded that the epidemic could account for at least one-half of the rise in acquisitive crime in England and Wales to 1995 and between one-quarter and one-third of the fall to 2012, as the epidemic cohort aged, received treatment, quit illicit drug use or died.

With the demise of New Labour and election of the Conservative-Liberal Democrat government and under the banners of 'localism' and 'public health,' radical changes were introduced into the NHS and drugs services. Most dramatic was the abolition of the NTA. In December 2010, the Coalition Government published its strategy, the shift in focus clear from the title *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*. These policies included threats of removal of social assistance if individuals failed to address their drug and alcohol dependency.

But central was the idea of recovery. The recovery movement believes that what matters is finding new sources of self-esteem and hope, the discovery of a new identity and involvement in new social groups. Recovery had first been made explicit in Scotland's Drug Strategy in 2008 (Scottish Government 2008). The issue of drugs had risen steadily up the agenda in Scotland partly because in 2007, 455 drug-related deaths were reported and 40–60,000 children were estimated to be affected by parental drug use.

From the turn of the century, the Scottish approach had diverged from that in England and Wales with a greater recognition that poverty and drugs go together. In 2001, 4000 people were on methadone in Glasgow. Serious drug problems were concentrated in poor areas on peripheral estates. What was needed, it was thought, was large-scale social investment in poor areas.[15] Scotland also paid more attention to public health issues. A 2008 Public Inquiry estimated that there were at least 39,000 people living with hepatitis C in Scotland and the numbers were rising each year. There were reported increases in the number of cases of liver failure. Deaths related to HCV had overtaken those from AIDS and at any one time 20% of prisoners were estimated to be HCV positive.[16]

The Scottish Government has been one of the strongest and most vocal supporters of the recovery movement. The emphasis on 'recovery' was seen as a way to move on from the polarised harm reduction versus abstinence debate.[17] In their strategy, *The Road to Recovery*, the principle was that the Scottish Government would invest in front-line treatment services and work with statutory and voluntary service providers and with communities, families and individuals to address the drugs problem. Harm reduction, abstinence, residential rehabilitation, community

rehabilitation and substitute prescribing were all seen as contributing to recovery. The essential idea was that recovery is more than health: it involves education, social work and employment. Key institutions were the 30 Alcohol and Drug Partnerships, virtual coalitions of delivery organisations, including the NHS, local authorities, voluntary organisations, police and fire services, children and family services, and prisons. These should all work together to deliver local strategies for tackling drug and alcohol issues, pooling resources to commission services in response to local needs and being collectively and individually held accountable for progress.[18] Reactions against what was seen as too liberal prescribing of methadone had built up in Scotland, partly fuelled by methadone-related deaths but also by criticisms that being 'parked on methadone' was not what service users wanted (McKeganey et al. 2004; McKeganey 2007).

In England, from 2005 onwards, the NTA had also recognised that getting people into treatment alone was not enough. Its view was that for treatment to be effective, people needed to be retained in treatment for at least three months. After that, they would need to move on and make changes in their lives. For this to happen, other services needed to become involved—the drug treatment system should not have to carry the burden alone. Housing, education, social care and child care also had to play their part.[19] Paul Hayes was also stressing as early as 2005 that treatment services should be responsive not just to traditional drug users but also to those referred from the criminal justice system, those using stimulants and young black people.[20]

The stress on recovery was given higher priority in the Coalition strategy. Key changes to the institutional framework were introduced by the Coalition government. The NTA's functions were absorbed into a new public health service, nationally and locally, in 2012. At local level, Directors of Public Health, jointly employed by Public Health England and the Local Authority, were given lead responsibility for the provision and performance of drug and alcohol services. It was estimated that existing drug and alcohol money would account for as much as one-quarter of the £4 billion budget of Public Health England. Health and Well-Being Boards within local authorities were expected to bring together the NHS and public health sides to promote joined up commissioning across local NHS services, social care and health

improvement. An additional institutional change was for the election of Police and Crime Commissioners, created by the *Police Reform and Social Responsibility Act*.

The Coalition government justified its restructuring thus:

> A decade of centralising, controlling government has left our public services strangled with red tape, focused on processes not outcomes, and weakened by the need to account to bureaucrats instead of the public. Too many decisions have been made nationally, rather than locally, without enough public involvement. The NHS, like other public services, has suffered as a result. The creativity and innovation of health professionals has been stifled while the public are frustrated at the lack of opportunities to speak up and make a difference to their local health services. Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know best what will work in their communities.[21]

In these new arrangements, councils had responsibility to assess local needs, promote joined up services and support joint commissioning.[22]

The treatment system was reframed around recovery as an organising principle (ACMD 2012). However, while NHS expenditure was relatively protected, austerity budgets in local authorities and other departments of state meant that a lack of funding for recovery-supporting action on jobs, housing, mental health and a range of other crucial interventions undermined the attainment of the drugs strategy's goals.

A number of problems remained at the end of this period, which a new drugs strategy still awaited in 2017 would have to address. Until 2014, drug-related deaths had been thought to be declining but these were now rising again, mainly because of the ageing and increasing vulnerability of the problematic drug using population. Paul Hayes, previously Chief Executive at the National Treatment Agency, now in his new role with *Collective Voice* representing the large service providers, summed up the situation. He commented that reintegration, a key aim of the recovery goal, had failed: people were not being routed via treatment into either long-term employment or secure housing. A hoped for 'seamless transition' between prison and community had not

materialised. The continuing failure of the NHS to invest in mental health services had impacted on outcomes for drug using people, who often suffer from complex mental health conditions. All the high rhetoric around localism had dissipated. The structures of Health and Wellbeing Boards, Clinical Commissioning Groups and Police and Crime Commissioners, with their various interests in healthy living and social care, physical and mental health service provision and crime reduction and community safety, were not, he thought, working well together. Paul Hayes noted that drug users are not a priority for either LAs or CCGs, and the decline in acquisitive crime, which access to drug treatment had helped bring about, had eroded the interest of police in championing treatment. The connection between the centre, regions and localities, which had been supported by NTA structures, had been cut, limiting not only the promotion and sharing of best practice, but also the provision of intelligence to the Home Office and Department of Health. Directors of Public Health lead on drug treatment for local authorities but this sits uneasily in a structure whose ambitions are prevention and general population health improvement. From 2018, the public health grant will be replaced by direct local authority responsibility for funding from business rates receipts—a change which will exacerbate inequalities in resources available to richer and poorer areas. This, together with a cumulative 20% real terms reduction in the public health grant, will pose severe tests for drug services in future, already affected by a shift in funding towards alcohol.[23]

The government led by David Cameron established a review under Dame Carol Black to consider the contribution of obesity and drug and alcohol use to welfare dependency. In calling for submissions of evidence to this review, the government stated that 'Long-term conditions such as drug addiction and alcohol dependence, or obesity, can seriously affect people's chances of taking up and remaining in rewarding employment. In England alone, research from 2008 and 2010 indicated that 1 in 15 working-age benefit claimants is dependent on drugs such as heroin and crack cocaine and 1 in 25 working-age benefit claimants are suffering from alcohol dependency. Assuming these ratios have remained broadly constant since the research was conducted, this analysis suggests that around 280,000 working-age benefit claimants are suffering from

addiction to opiates, and 170,000 from alcohol dependency (as of August 2014). Further… there are 200,000 and 300,000 children in England and Wales where one or both parents have drug misuse problems' (DWP 2015, pp. 8–9).

Collective Voice, responding to this call for evidence, pointed out that of the roughly 200,000 individuals in drug treatment in 2016, 160,000 have a history of heroin, or heroin and crack use. The typical heroin user is now aged between 35 and 50, their addiction began 20 or 30 years ago, and they experience a number of complex overlapping problems. Of those in treatment, 70% have mental health problems but only 20% are receiving help. The physical health of this ageing cohort is poor as a consequence of exclusion from GP services, smoking, poor diet, poverty and homelessness. Simplistic notions of welfare to work are inappropriate for this group of claimants as employers are reluctant to employ current or ex-drug users and are also reluctant to employ ex-offenders. In the current labour market, particularly in the north of England where the greatest concentration of heroin users lives, they are unlikely to be able to compete for scarce jobs.[24]

Another major reform introduced by the Conservative Government related to the emerging issue of use of novel psychoactive substances. In 2010, a system of temporary bans on 'legal highs' had been introduced. This approach was overturned by the majority Conservative government in 2015 with proposals for a Bill to control a wide range of psychoactive substances not covered by the UN Drug Conventions. This new Bill aroused controversy as it seemed to be set to prohibit everything capable of producing a psychoactive effect, unless specifically exempted, like coffee or alcohol. A parliamentary committee commented that 'the speed at which the Government has brought forward this legislation, without any consultation on the specific detail of the Bill, has resulted in some weaknesses in the legislation being identified' (Home Affairs Committee 2015, para 20). Critics saw the Bill as legally flawed, scientifically problematic and potentially harmful (Stevens et al. 2015). The Act, passed in January, came into force in May 2016.

This *Psychoactive Substances Act* made it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances—that is, any substance

intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence is 7 years' imprisonment. It excludes legitimate substances, such as food, alcohol, tobacco, nicotine, caffeine and medical products from the scope of the offence, as well as controlled drugs, which continue to be regulated by the *Misuse of Drugs Act 1971*. Seen as a success for scientific lobbying, it exempts healthcare activities and approved scientific research from the offences under the Act, on the basis that persons engaged in such activities have a legitimate need to use psychoactive substances in their work. Responding to pressures relating to public nuisance at the local level, it includes provision for civil sanctions—prohibition notices, premises notices, prohibition orders and premises orders (breach of the two orders will be a criminal offence) to enable the police and local authorities to adopt a graded response to the supply of psychoactive substances in appropriate cases. Importantly, and likely to lead to issues around policing practice, it provides powers to stop and search persons, vehicles and vessels, enter and search premises in accordance with a warrant, and to seize and destroy psychoactive substances.

Some criticized this Act for the inconsistencies introduced, as possession under this Act was not to be an offence although it continued to be so under the Misuse of Drugs Act. Alex Stevens said this was not just inconsistent but absurd.[25] One effect of the new Act was to reinforce the concept of the evil drug as the basis of prohibition (Seddon 2016).

Thus in these predominantly Conservative years from 2010 onwards, rapid and profound policy changes were introduced. Overall in social policy, an increased role was played by the Department for Work and Pensions. In Britain, in recent years the image of the poor presented in the press and on television has increasingly been of an underclass, an overweight, lazy, welfare dependent, petty criminal, generally white group and living in social housing. They have been depicted as uneducated, irresponsible and as bad parents. Drug-taking is seen as one part of a complex of problems concentrated in one strata of society, a facet of intergenerational poverty and explained in moralistic terms. This group are condemned as a burden on society.[26] Addicts were said to be getting nearly half a billion pounds a year in sickness benefits but the true cost was thought to be close to £1 billion after help with tax, housing and

NHS rehab. Figures reported in the *Daily Mail* showed that there were 1,921,340 people across Britain on sickness benefits—now known as Employment and Support Allowance (ESA)—in 2013–2014, receiving annual payments totaling £10.4 billion: 28,440 had a 'primary disabling condition' of drug addiction costing £156.7 million in ESA. (The statistics had been obtained under Freedom of Information laws.)[27] In response, a spokesman for the Department for Work and Pensions said: 'This Government has set out to change the way drug treatment is perceived and delivered—above all prioritising full recovery rather than short-term fixes. There is an increasing rate of people coming out of rehab who have successfully completed treatment and left entirely drug-free—with the latest statistics showing a rise of 15,000 people in England compared to 5 years earlier.'

While initially much was made of the rhetoric of the 'Big Society', the demands of fiscal austerity overwhelmed this and it was cuts in budgets at the local level which had greatest impact. Social policies increasingly focused on a hard core of problem families and groups and social problems were explained as the result of individual inadequacy with patterns of behaviour rooted in early childhood experiences. The interest in children had been developing from the report *Hidden Harm* (ACMD 2004) with more attention and awareness of the traumas and unhappiness experienced by the children of parents who misused drugs and alcohol (Clay and Corlyon 2010; Kroll and Taylor 2010). Conservative policies primarily focused on early years experiences. A Childhood and Families Task Force was established along with a What Works Early Intervention Centre to pursue these concerns. Particular attention was given to Troubled Families.

Other changes in these years effectively dismantled many of the reforms introduced by New Labour, justified by localism and austerity, including the ending of the Drugs Intervention Project (although some areas continued testing where the local PCC decided to commission). The transition from DATs to Health and Wellbeing Boards led to fragmentation and a lack of standardisation, with much local variation. A report from the House of Commons Select Committee on Health in 2016 criticised the gap that had opened up between public health and the NHS and the track record of Health and Wellbeing Boards. They

reported that 44% of Local Authorities planned cuts in services for drugs in 2015–2016 and 72% for 2016–2017 (Health Committee 2016, p. 24).[28]

Health and Wellbeing Boards are reported generally to lack interest in either drugs or chronic drug users. Some feel that treatment services should be funded by the NHS. If they are interested, this is with regard to parents, because of the LA's responsibilities regarding child care. For the drug treatment sector, the situation is one where they are between a rock and a hard place: just as their remit extended to encompass recovery and the building of recovery capital, the resources available are being cut, in some areas, dramatically. Mike Ashton argues this is no accident since the paradox 'flows from the roots of recovery in the imperative (as seen by national UK governments) to save money both on addiction treatment and on welfare and other benefits. What became known as "austerity" both drove the cuts and created the ground on which recovery grew as a positive and appealing way to call for more patients to leave and not re-enter treatment, support themselves and their families, get a job, and contribute to the economy' (Ashton 2016). Now that ageing opiate users dominate drug treatment, the question is how will drug treatment services need to change to respond to both their needs and those of younger groups exhibiting complex patterns of use of a wider range of substances?[29]

Indications of the interests of the Conservative Government with regard to drugs and crime can be found in its *Modern Crime Prevention Strategy* published in March 2016. The strategy focuses on what are seen as the six key drivers of crime—opportunity, character, the effectiveness of the Criminal Justice System, profit, drugs and alcohol. In the Foreword by the then Home Secretary Theresa May, she states, apparently approvingly, that 'Investment in drug treatment got more heroin and crack dependent offenders off drugs.' This document also anticipates a new drug strategy which will build on the approach published in 2010 'to restrict the supply of drugs and tackle the organised crime behind the drugs trade, prevent drug misuse in our communities, help people resist getting involved in drugs, and support people dependent on drugs through treatment and recovery' (Home Office 2016, p. 6).[30]

In Sect. 6, Drugs as a Driver of Crime, the Strategy reviews evidence, concluding that drugs drive crime through: the economic motivation to obtain money to fund drug use; the psychopharmacological effects of psychoactive drugs; and the actions of organised crime groups supplying the market. And, in addition, drug possession and supply are in themselves offences. The Strategy notes that there has been a long-term downward trend in drug use among adults and young people over the last decade, and a long-term upward trend in numbers recovering from dependence. However, drug misuse has stabilised over the last 5 years and emerging threats such as new psychoactive substances pose fresh challenges. Following the long-standing interest in estimating the costs of crime, the Strategy notes that 'The social and economic cost of drug use and supply to society is estimated to be around £10.7bn per year, of which £6bn is attributed to drug-related crime' (Home Office 2016, p. 30). Treatment is endorsed as effective saying getting users into treatment is key, as being in treatment itself reduces their levels of offending—and the Criminal Justice System offers a number of routes in. Full recovery from dependence should be the aim of treatment and evidence suggests that recovery is more likely to be achieved and sustained if users are given support to improve their "recovery capital"—particularly around housing and meaningful employment' (Home Office 2016, p. 30). Significantly, this section goes on to note that 'for a small cohort of entrenched, long-term opiate users who have not achieved recovery through optimised oral substitution treatment, there is evidence that heroin assisted treatment (supervised injectable heroin) reduces crime' (Home Office 2016, p. 31). The Strategy also endorses 'good quality Personal, Social and Health Education (PSHE) and school-based interventions designed to improve behaviour generally (e.g. by building confidence, resilience and effective decision-making skills)' and brief interventions for those in the early stages of drug misuse. The section goes on to indicate that the forthcoming new Drug Strategy will 'build on our current balanced approach—to reduce demand, restrict supply and build recovery—and tackle drugs as a key driver of crime'. These two pages on drugs (testament perhaps to the dark arts of civil servants) signal what can be expected in the next Drugs Strategy.

These laudable aims, which match in many ways with the May government's apparently distinctive commitment to social reform, will however have to be funded, and in the context of uncertainty produced by Brexit, the question will be whether local areas will be left to provide the money. Unless additional funds are provided specifically from central government, the prospect is grim and the gap between the fine rhetoric and actual practice will widen. The issues that matter at local level are social care expenditure, families and safeguarding, and severe pressures in all mainstream services are likely to prioritise providing for more 'deserving' groups and responding to crises.

While a new Drugs Strategy was awaited at UK level, legislative changes, aimed at increasing the availability of naloxone, came into force in October 2015. In Scotland, a new Recovery Outcomes Web (ROW) tool was developed, which will form part of a new national Drug and Alcohol Information System (DAISy) expected to be operational from autumn 2016. The Welsh Government published *Working together to reduce harm: Substance misuse strategy annual report—2015*, which reviewed progress made towards the objectives cited in their substance misuse strategy. Priorities included the publication of the new 2016–2018 delivery plan and the commencement of work on a new substance misuse strategy for Wales 2018–2028. In Northern Ireland, the third annual report of progress towards outcomes contained within the drug strategy, *New Strategic Direction (NSD) for Alcohol and Drugs Phase 2, 2011–2016*, was published.

Drugs, Crime, Policing and Prisons

So far policies reviewed have mainly focused on the demand side. What happened regarding supply- side policies in these years? How were drug users dealt with if they were not seen as sad or mad but as bad, not as problematic but as recreational users or dealers? More substances were incorporated into the MDA, such as magic mushrooms and khat, and the categorisation of substances in general tended to become higher and sanctions harsher (Stevens and Measham 2014). How to define the 'dealer' was discussed, looking at the thresholds of quantities found when

judging possession for personal use or for supply.[31] Reuter and Stevens in 2007 had noted that the use of custodial sentences for drug offenders increased substantially between 1994 and 2008. The annual number of people imprisoned rose by 111%, and the average length of their sentence increased by 29%. Taking into account the rise in the average sentence length (37 months for drug dealing in 2004), the courts handed out nearly three times as much prison time in 2004 as they did 10 years earlier (Reuter and Stevens 2007, p. 10). Over the years we are reviewing, the prison population roughly doubled.

The Crime and Courts Act 2013 made it an offence to drive or be in charge of a motor vehicle with a blood concentration of specified drugs above a certain limit.[32] The Serious Crime Act 2015 strengthened the Proceeds of Crime Act 2002 enabling assets held by defendants and others to be frozen and recovered. This Act also made it an offence to throw an article or substance into a prison.

Cultivation of cannabis within the UK increased in these years and an offence could lead to a charge of production, classed as a trafficking offence. Production or cultivation carries a real risk of a prison sentence. The average length of a custodial sentence for cannabis production remained stable at around 1 year until 2006 but saw a steady increase thereafter probably as a result of the increased incidence of large-scale home-grown cannabis cultivation. The severity of the penalty depends on the individual circumstances of the case, such as the size of the operation and any mitigating factors. While maximum sentences appear relatively high in UK compared to other European countries, these are not used often. If charged with possession with intent to supply, a prison sentence might result. Importing or exporting is most likely to get a prison sentence. Another offence is that of allowing premises to be used for drug misuse: this led to some issues for people running shelters for homeless people at times.[33]

Figures from the Office for National Statistics (ONS) record total drug offences in 2014 at 178,719: trafficking 28,021; possession 150,698. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences but a fine, community sentence or conditional discharge are the most common disposals for possession offences. During 2012, having steadily risen between 2007

and 2011, the number of cannabis convictions fell by 6% but were still far higher than in 2007 (+35%). The majority of drug offences were dealt with outside of a court setting (67%). Of the drug offences settled outside of court, over half were in the form of a cannabis warning (57%), followed by cautions (31%) with penalty notices for disorder accounting for 12% (ONS 2015).

Of the 56,301 individuals sentenced at court for drug offences in England and Wales during 2013, 16% were given immediate custody. The most common sentence was a fine (37% of cases). The vast majority of those convicted of import/export offences received immediate custody (86%) with an average custodial sentence length of 67.4 months (over five and a half years) for Class A importation offences (Burton et al. 2014, Table 9.4).

The *Misuse of Drugs Act 1971* provided police officers with powers to stop and search for drugs if they had reasonable suspicion that a citizen was in possession of harmful illicit substances. Over 550,000 searches for drugs took place in 2009/10 in England and Wales. In 2011, serious rioting erupted in London and other cities. Thereafter, a Freedom of Information Request revealed, offences relating to cannabis recorded by English and Welsh police forces—including penalty notices, cautions, charges and summons—fell by almost a third from a peak of 145,400 in 2011–2012 to 101,905 in 2014–2015 (Ramesh and Jayanetti 2015).[34] This has been seen as a silent relaxation of drugs policy in the past 5 years. London Metropolitan Police recorded 40% fewer cannabis possession offences in 2014 than in 2009–2010.

The background to this was that a paradoxical result of the 2004 Cannabis Warning System was an increase in the number of searches in following years. This overtly more liberal measure allowed officers to write a warning for cannabis possession, if the person had not been caught in the previous 12 months and was 18 years old or above. This allowed the officer to generate a sanctioned detection in less than an hour, a process that could take 10–12 hours with a shoplifting case. It was the speedy generation of a sanctioned detection that encouraged a dramatic rise in drug searches and increased feelings of resentment in some local areas towards the police.

Ethnographic research by Daniel Bear has shown the role of police decision-making at street level, which can be linked to racial discrimination and city riots (Bear 2013). He reported that stop and search activity was directed at finding drugs nearly 50% of the time and across the London area the number of drugs stops had risen considerably. There is a very high rate of stop and search amongst BME populations. A key finding was that officers found drugs in the borough he researched less than 7% of the time they searched someone for drugs.

On Wednesday 29 June 2016, it was reported that an Inquest jury had concluded that a teenager who died when his moped crashed was trying to get away from police pursuing him in unmarked cars. Henry Hicks, aged 18, lost control of his vehicle in north London following a high-speed chase. The IPCC expressed significant concern over the way police in Islington had treated the white teenager in the years before his death. Between the ages of 14 and 17, he was subjected to stop and search a total of 89 times but never charged with any criminal offence. On the night he died, Hicks was found to have been carrying seven bags of skunk cannabis worth £70–£140.[35]

Based on analysis of official statistics provided by the Ministry of Justice and the Metropolitan Police Service for 2009/10, a study by Release and the LSE found that stop and search increased steadily from 2001/2 from less than 750,000 to a peak of almost 1.3 million in 2010/11, more than 1.2 million of which were carried out under PACE and associated legislation. Despite a slight decline, there were still more than 1 million stop searches carried out in 2011/12. Half or more of these searches were for drugs. In 2009/10, the overall search rate for drugs across the population as a whole was ten searches per 1000 people. For those from the white population, it was seven per 1000, increasing to 14 per 1000 for those identifying as mixed race, 18 per 1000 for those identifying as Asian and to 45 per 1000 for those identifying as black. Black people were, in other words, stopped and searched for drugs at 6.3 times the rate of white people, while Asian people were stopped and searched for drugs at 2.5 times the rate of white people, and those identifying as mixed race were stopped and searched for drugs at twice the rate of white people. Across England and Wales, only 7% or so of drug stop and searches ended in arrest. As a result of almost 550,000 stop

and searches for drugs in 2009/10, only 40,000 people were arrested. Across London, Black people are charged for possession of cannabis at five times the rate of White people. Black people in London who are caught in possession of cocaine are charged, rather than cautioned, at a much higher rate than their white counterparts. In 2009/10, the Metropolitan Police charged 78% of Black people caught in possession of cocaine compared with 44% of Whites.

New problems arise all the time while some simply get worse, like that in the prisons. Attention to problems in prisons is not new: in 1996, ACMD produced a report on *Drug Misusers and the Prison System: An Integrated Approach* following others on *Drug Misusers and the Criminal Justice System*. Drugs offences are a major contributor to the prison population (almost 13,000 prisoners, over 15% of the prison population). A majority of these involve drugs other than cannabis. Around two-thirds of those in custody are reported to be recent drug users with an estimated 40% of prisoners received into custody being problematic drug users, 40% of whom identify themselves as people who inject drugs (Burton et al. 2014). A significant number of people are introduced to opiates for the first time while in prison.

In 2014–15, the rapid increase in the availability of new psychoactive substances (such as 'Spice' and 'Black') was said to have had a severe impact in prisons, leading to debt and associated violence. Survey responses suggested the ready availability of illegal drugs in prisons (HM Chief Inspector of Prisons 2015). A peer-led inquiry conducted by the ex-offenders' organisation User Voice between December 2015 and April 2016 revealed widespread use of drugs in prisons. A total of 805 prisoners were surveyed in nine gaols, and it was found that a third had used spice in the previous month. The majority of survey participants estimated that between half and nearly all prisoners had used spice in prison, which had contributed to an increase in violence and ill health.[36]

This report had been commissioned by the NHS following concerns raised by an increase in medical emergencies in prison: call-outs had risen by 52% from 14,475 in 2011 to 22,055 in 2015, with 39 deaths in custody linked to NPS between 2013 and 2015. Mark Johnson, the User Voice founder, said: 'People are going into prison—and coming out—with undiagnosed and untreated existing mental health and substance

abuse issues'. The extent of mental illness among prisoners began to be recognised as a problem, although definitions of what counts as a mental illness were still disputed.

Rob Ralphs carried out research on the development of a synthetic cannabinoid market in an English prison. He found prisoners were using spice, mamba and other brands including vertex. Staff he interviewed perceived widespread use, a perception confirmed by prisoners. One route of supply of drugs into prisons was through a deliberate, contrived recall to prison among men discharged under licence. This was an unintended consequence of the 2014 *Offender Rehabilitation Act* and prisoners participated in this as a way of paying off debts.[37] Reasons for use of NPS in prisons included 'head shift', that is use was functional as it 'takes away the bars'. In addition, NPS were preferred because they were hard to detect by current mandatory drug tests. Use of NPS is also reported to be a problem in supportive housing and rehabs, as well as among the street homeless, and has been exacerbated by recent severe cuts in prison staffing levels.[38]

Conclusion

On becoming Prime Minister in July 2016, former Home Secretary Theresa May appeared to recognise the discontent and divisions in British society and indicated a turn towards social investment policies. She announced:

> If you're born poor, you will die on average 9 years earlier than others. If you're black, you're treated more harshly by the criminal justice system than if you're white. If you're a white working class boy, you're less likely than anybody else in Britain to go to university. If you're at a state school, you're less likely to reach the top professions than if you're educated privately. If you're a woman, you will earn less than a man. If you suffer from mental health problems, there's not enough help to hand. If you're young, you will find it harder than ever before to own your own home. If you're from an ordinary working class family, life is much harder than many people in Westminster realise.

Following a snap General Election on June 8 2017 which resulted in a Hung Parliament and was marked by a rejuvenated Labour Party, Mrs May Prime Minister re-iterated her aim to govern in a way that would 'put fairness and opportunity at the heart of everything we do ... and ... build a country in which no one and no community is left behind'.

This analysis seemed to mark a shift away from simply blaming the victim[39] and ought to foreshadow increased expenditure on social infrastructure in education, training, housing, mental health services and regional and urban regeneration. The need for such interventions is clear when we look at the situation on the ground and consider how drug and other social policies have impacted on local communities.

Notes

1. Drug Treatment Consensus Statement, June 2010.
2. Howard Parker speaking at National Drug Treatment Conference, Glasgow Scotland, March 2008, 'Changing alcohol and drug misuse trends'.
3. The Guardian Weekend, 19 November 2011, pp. 26–33: extract from Out of the Ashes: Britain after the riots, published 2011, Guardian Books.
4. Tim Newburn, Alexandra Topping and Ben Ferguson, 'Reading the Riots'. The Guardian 7 December 2011, pp. 5–9.
5. In previous years, before the introduction of the National Drug Misuse Monitoring System, information was limited to data collected on the Addicts Index which was ended in 1997. Reports to the Home Office by medical practitioners under-represented the situation, with these figures referring only to England and included only consultations relating to opiates and cocaine. Little was known about the actual numbers presenting to services. The Regional Drug Misuse Databases then counted only new agency episodes, and the number of individual users newly presenting within a 6-month period. About half were seen at community-based services. Continuing cases would not be included. These figures also excluded the numbers seen by probation, social services, needle exchanges, outreach and penal establishments. It was accepted that the picture reflected by these data was a significant under-representation of the total number of people in contact with agencies.

6. The 1990 NHS and Community Care Act was implemented in April 1993 and continued the new paradigm for the welfare state whereby finance would be separated from provision and market mechanisms would be introduced into the public sector. Especially with regard to social care, the previous system was said to have provided what were seen as 'perverse incentives' for the rise of private residential care. This was especially so for the elderly but drug rehabilitation was also affected. In future, local authorities would decide whether and how to meet need: there would no longer be open-ended funding via the then DSS.
7. The fears that treatment services would be cut and that an American style abstinence agenda would come to dominate were widespread in the drugs treatment field in the 1990s, along with fears that needle and syringe exchanges and other harm reduction services would be banned. This was in spite of the fact that, since 1986, the Department of Health had earmarked additional funding through health authorities for the expansion of services for drug misusers in England. Through a mapping exercise conducted for the Task Force on drugs services effectiveness (the Polkinghorne Review), a census conducted in August 1994 estimated that 67,000 clients were being seen in 1042 separate drug treatment services in England at any one time, double the number of notified addicts. This number excluded needle exchanges and GP surgeries: there were at the time about 1000 syringe exchange schemes and more than 1200 pharmacies participating in needle exchange. Prison and probation were also excluded from this count. Of the 1042 services, 387 could be categorised as dedicated/specialised drug treatment services (although distinguishing one service from another in a network of services was not an easy matter) (MacGregor and Smith 1998). By 1995–1996, a total of £26.75 million pa was being provided as additional ear-marked funds for treatment services with additional funds in Scotland, Wales and Northern Ireland. A total of 300 needle and syringe exchange schemes had been set up since the mid-1980s.
8. DAT core membership included representatives of police, health and local authorities and usually also included Chief Probation Officers, occasionally prison governors, customs and excise and the local DPI representative where in existence. Chief Executives of Health Authorities had been given the responsibility for calling the first DAT meeting, although not necessarily for becoming the first Chair. Drug Reference Groups varied considerably across the country, in number, structure and

make up. Some were based on geographical boundaries, especially in larger rural areas, rather than health or local authority areas. The involvement of the 'community' was limited with key players on DRGs being local 'drug experts' and practitioners, not necessarily those living in the communities affected (Duke and MacGregor 1997).

9. From April 2001, DATs were aligned with local authority boundaries. Because of the assumed close links between drugs and crime, DATs and Crime and Disorder Reduction Partnerships (CDRPs) in unitary authorities were expected to integrate.
10. Julian Le Grand, speaking at Seminar on Modernising Lewisham at Goldsmiths College, University of London, May 4 1999.
11. Raymond Plant speaking at Seminar on Modernising Lewisham at Goldsmiths College, University of London, May 4 1999.
12. The Morgan Report was influential on police policy and practice in developing the community safety agenda and in 1992 the Criminal Justice Act introduced 'partnership' as the approach to community sentences.
13. In January 2004, cannabis was downgraded from a Class B to a Class C drug. Some 97,000 people a year were being arrested for cannabis possession and faced widely varying sentences in courts across the country. Five months after reclassification, arrests for possession dropped by a third. The Home Office estimated that 180,000 hours of police time could be saved each year (Toynbee and Walker 2005: 220). It was later classified again as B (Monaghan 2011).
14. For example New Guidelines. Drug Misuse and Dependence: Guidelines on Clinical Management, issued in 1999. These made key recommendations, in particular referring to the 'responsibilities of all doctors to provide care to drug users for both general medical needs and for drug-related problems'. And Models of Care (NTA) a commissioning framework for drug treatment first issued in 2002 and amended periodically thereafter.
15. Mike McCarron, 'Lessons from Scotland', DrugScope Conference, 6 November 2001.
16. David Goldberg, Health Protection Scotland, speaking at NIDC Conference, Glasgow Scotland 2009.
17. The idea of recovery was gaining ground in other parts of the UK as well: for example the 2007 Orange Guidelines emphasised recovery and reintegration as a successful outcome.

18. The Scottish Parliament voted to provide £100 million extra for drug treatment, with the main investment in abstinence-based programmes. Scotland has a positive vision of recovery, including the need to challenge stigma and address the needs of chronically excluded people.
19. Paul Hayes, Chief Executive of NTA, speaking at NTA Treatment Effectiveness Launch, Mermaid Theatre London, June 30 2005.
20. Paul Hayes, Chief Executive of NTA, speaking at NTA Treatment Effectiveness Launch, Mermaid Theatre London, June 30 2005.
21. Consultation documents, Local Democratic Legitimacy in Health, Departments of Health & Communities and Local Government, 22 July 2010.
22. Foreword by Cabinet Ministers Andrew Lansley (responsible for Health) and Eric Pickles (responsible for local government) in Consultation documents, Local Democratic Legitimacy in Health, Departments of Health & Communities and Local Government, 22 July 2010.
23. Paul Hayes, 'Drug-related deaths hit record levels in England and Wales'. The Guardian 9 September 2016; Collective Voice 'Briefing for Health Select Committee roundtable with practitioners', 19.04.2016; 'The 2016 drug strategy gives us an opportunity to address key deficits', Paul Hayes, Collective Voice, April 2016. http://www.collectivevoice.org.uk/category/blog/ [accessed 10/13/2016].
24. Collective Voice—response to the independent review into the impact on employment outcomes of drug or alcohol addiction and obesity. http://www.collectivevoice.org.uk/blog/the-black-review-more-opportunity-than-threat/ [accessed 10/13/2016].
25. Speaking at ESRC Seminar on NPS, University of Kent 7 September 2016.
26. Mail online, 1 February 2015: Martin Beckford '£435 million in sickness benefit handed to drunks and junkies, with 75,000 signed off work for their addictions given up to £108 a week.'
27. Mail Online, 1 February 2015.
28. Expenditure on drug misuse services for adults in England in 2013/14 was £581.1 million, with a further £74.9 million being spent on services for young people (Crawford et al. 2016).
29. In 2009/10, the number of young people reporting a cannabis problem was over 13,000, that is, 87% of the total population of young people in contact with drug treatment services. This became a major issue.

30. The Home Office at this point also anticipated working with the Department for Communities and Local Government to deliver the expanded Troubled Families Programme which aims to reach out to families with a broader range of problems including crime, anti-social behaviour, drugs and alcohol misuse, gangs and youth violence, domestic violence, child sexual abuse, serious and organised crime, and radicalisation, as well as families where there is a perceived risk of becoming involved in criminality.
31. Drugs in class A include cocaine, ecstasy, heroin, tryptamines such as LSD, magic mushrooms, methadone, methylamphetamine, and injectable amphetamines. Class B drugs include amphetamines, benzofuran compounds, cannabis and synthetic cannabinoids, synthetic cathinone derivatives including mephedrone, ketamine and analogue compounds including methoxetamine and pipradrol related compounds. Class C includes anabolic steroids, benzodiazepines, GBL, GHB, khat, piperazines (such as BZP) and tranquillisers (Crawford et al. 2016, p. 38).
32. Crawford et al. (2016), Table 2.1.
33. For further information, see http://release.org.uk/drugs-law.
34. A revision to the Police and Criminal Evidence Act in 2015 included amendments to the meaning of 'reasonable grounds for suspicion'. An officer must have an objective basis for suspicion and personal factors can never support reasonable grounds for suspicion. Misuse of stop and search could lead to formal performance or disciplinary proceedings (Crawford et al. 2016, p. 40).
35. The Guardian, 29 June 2016 'Teenager died knowing he was in a police chase', p. 12.
36. Charles Howgego, The Guardian, 15 June 2016, p. 38
37. The Offender Rehabilitation Act 2014 came into force on 1 February 2015. The former Probation Trusts were dissolved, and their responsibilities were transferred to either the newly established National Probation Service, which is responsible for providing supervision to the highest risk offenders in the community, or Community Rehabilitation Companies (CRCs), which supervise lower to medium risk offenders.
38. R. Ralphs, ESRC seminar on NPS, University of Kent Canterbury, 7 September 2016.
39. There were indications that the new PM was influenced by her Christianity and by the ideas of Joseph Chamberlain, a nineteenth-century politician and social reformer.

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