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Drugs Research: An overview of evidence and questions for policy

June 2010

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Neil McKeganey

This report outlines the results of the largest independent programme of drugs research of its kind within the UK.

In 2001 the Joseph Rowntree Foundation embarked upon a unique and challenging programme of research that explored the problem of illicit drugs in the UK. The research addressed many questions that were often too sensitive for the government to tackle. In many cases, these studies represented the first research on these issues and the policy implications have been far-reaching.

The topics covered in the report include:

- The policing of drug possession.
- The domestic cultivation, purchasing and heavy use of cannabis.
- Non-problematic heroin use, heroin prescription and Drug Consumption Rooms.
- The impact of drugs on the family.
- Drug testing in schools and in the workplace

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1 Introduction

Charlie Lloyd and Neil McKeganey

Illicit drugs are an emotive topic. The very word ‘drugs’ can engender fears about the safety of children, anger at the impact of drug-related crime on communities and pity for the plight of homeless, addicted users. For some with personal experience, it raises the spectre of past or present addiction and frequently, feelings of guilt, loss and regret. But for large numbers of users and ex-users, the word will bring to mind old or recent memories of enjoyable, shared experiences, whose pleasure was only heightened by their illegality. People care about drug issues and their concerns are driven by very different experiences, understandings, values and ideologies.

The resulting strength and variety of public reactions to drug issues carries implications for how they are described and debated in the press, parliament and other public forums. Stories about drug issues arouse strong emotions in their readers and therefore help to sell newspapers. This ensures that drug stories are covered in great detail and drug policy is therefore developed and enacted under the full glare of public and media scrutiny, giving exaggerated importance to policy decisions and forcing politicians to think carefully about the way that their pronouncements will play with the voting public.

In such an environment, research evidence plays a vital role. While its reliability and implications are likely to be contested, it carries the potential to challenge irrational beliefs and opinions; and pave the way for effective policy and practice. The need for research evidence in such a politicised and emotive field was one of the chief motivations behind the Joseph Rowntree Foundation’s (JRF) five-year Drugs and Alcohol Research Programme, funded over the period 2001–05, the last report on this programme being published in 2008. A total of £1.5 million was spent on the Drugs and Alcohol Research Programme over the five-year period. The main aim of this report is to reflect on what we have learned from this work and what these findings and

conclusions mean for policy and practice in the drugs field.

Another driving force behind the setting up of the Drugs and Alcohol Research Programme was the general paucity of evidence in the drugs field. As had been pointed out in the ‘Royal Colleges’ report (Royal College of Psychiatrists, 2000), the total spend on drugs research at that point represented only 0.02 per cent of the £1.4 billion devoted to drug-related problems. While government expenditure on drugs research has increased substantially since then, so too has the total spend devoted to tackling drug problems. Expenditure on research therefore continues to be a very small fraction of the total spend, compared to some other countries. As the programme has developed, it has become increasingly clear that some fundamental questions in the drugs field remain unanswered and, indeed, unaddressed. For example, it was recognised early on that we knew remarkably little about the most commonly used controlled drug in our society – cannabis.

Policy context

The specific policy context is addressed in each of the chapters that follow. However, by way of a general scene-setting, perhaps the defining policy initiatives of the last decade have been the rapid increase in funding for drug treatment and the complicated sequence of policy changes surrounding the classification of cannabis. While the latter is dealt with in detail in Chapter 2, the former merits brief coverage here. Between 2001/02 and 2008/09, central government funding (known as the ‘Pooled Treatment Budget’) has nearly tripled: from £142 million to £398 million. There were increases every year until 2008/09, when the budget was frozen at the 2007/08 level. The budget for 2009/10 is slightly higher at £406 million.

This very large increase in expenditure on treatment reflects the central aim of the Labour

Government's drug policy of reducing crime through treating problem drug users. While the previous drug strategy (HM Government, 1998, 2002) was wide-ranging and all-inclusive in scope, it is clear that, in terms of expenditure, the priority has been treatment – and in particular treatment within the criminal justice system (Duke, 2006; Reuter and Stevens, 2007).

The focus on crime reduction reflects the ascendancy of the Home Office as the lead government department for drugs policy. The first overarching government drug strategy – *Tackling Drugs Together* (HM Government, 1995) – was produced by John Major's Conservative Government of 1992–97. A key principle of this strategy was joint-working between government departments and the policy was developed and implemented by the Central Drugs Co-ordination Office in the Cabinet Office (MacGregor, 2006). This cross-departmental approach continued for the first few years of the Labour strategy, under the Anti-Drugs Co-ordinator (almost universally referred to in the press as the 'Drug Tsar'). However, in 2001, the responsibility for drug policy moved to the Home Office and subsequent drug strategies (HM Government, 2002, 2008) have increasingly

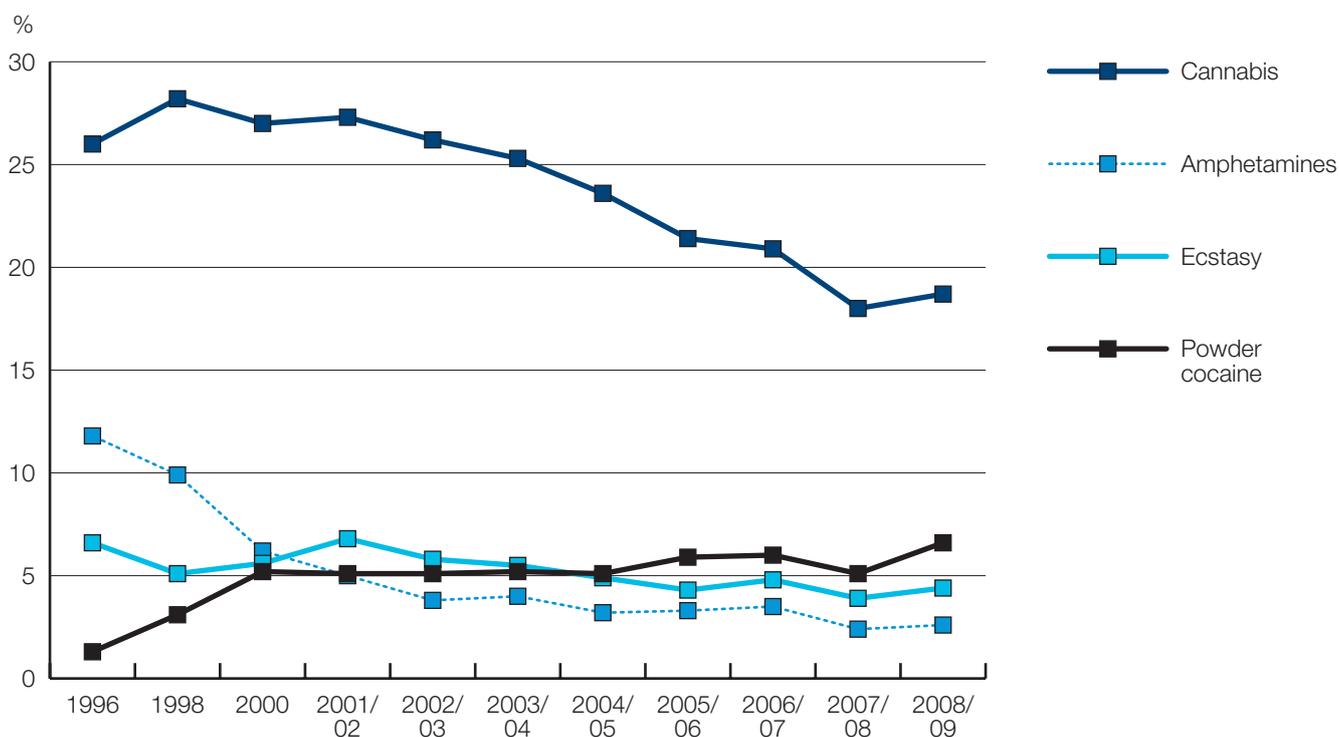
reflected Home Office policy concerns and, in particular, crime reduction through treatment (Reuter and Stevens, 2007).

Drug use over the period

The picture of self-reported drug use in the general population of young adults has been one of gentle decline, with the exception of powder cocaine, which has increased from 1.4 per cent having used the drug in the last year in 1996 to 6.0 per cent in 2006/07 and down to 5.0 per cent in 2007/08 (see Figure 1).

Trends in the number of dependent drug users are less easily measured. There has been an increase in treatment admissions over this period but this reflects increased treatment capacity, as well as any increase in dependent drug use. Drawing on a range of indicators, Reuter and Stevens (2007) conclude that there was a rapid escalation in heroin addiction over the 20-year period up to around the year 2000, after which there have been signs of stabilisation. Using more sophisticated estimation techniques, researchers have conducted estimations of the number of problematic drug users (opiate and crack users) in

Figure 1: Proportion of 16- to 24-year-olds reporting use of drugs in the last year, 1996 to 2008/09



Source: Hoare (2009, table 3.2, p 28)

England in the three years 2004/05, 2005/06 and 2006/07. These studies have found the numbers to be stable at around 330,000 (Hay *et al.*, 2008b).

Coverage and structure of the report

Our goal has been to draw the evidence together in order to make the programme more than the sum of its parts. We have therefore tended to focus on areas where we have more than one study to draw on and this is reflected in the structure. For this reason, we have not slavishly attempted to include substantial sections on every project – but a list of all of the projects funded is included in the Appendix.

We have focused in the main on the research relating to illicit or controlled drugs, rather than alcohol. The JRF has funded a separate programme of work on alcohol and it was therefore thought important to focus on what we have learned about the other drugs.

Chapter 2 is a substantial chapter where we bring together the five studies funded on cannabis. Chapter 3 focuses on problematic drug use, including the research on occasional and controlled heroin use. Chapter 4 focuses on the impact of drug use on families and communities. Chapter 5 focuses on innovative responses, such as heroin prescription, drug consumption rooms and drug testing in the workplace and at school. Conclusions and implications are drawn out in Chapter 6.

2 Cannabis

Charlie Lloyd

Of all areas of drug policy over the past six years, it has been cannabis that has consistently seized the spotlight. Since the *Report of the Independent Inquiry into the Misuse of Drugs Act 1971* in 2000 (Police Foundation, 2000), there has been almost unremitting media coverage of the question of classification, linked increasingly with fears surrounding the association between cannabis and schizophrenia and stronger strains of cannabis or 'skunk'. This public discourse formed the backdrop to the Foundation's five studies on cannabis. This chapter briefly reviews the evidence on trends in consumption of the drug, then turns to a review of the policy context, before dealing with each of the five studies and drawing some conclusions.

Cannabis use

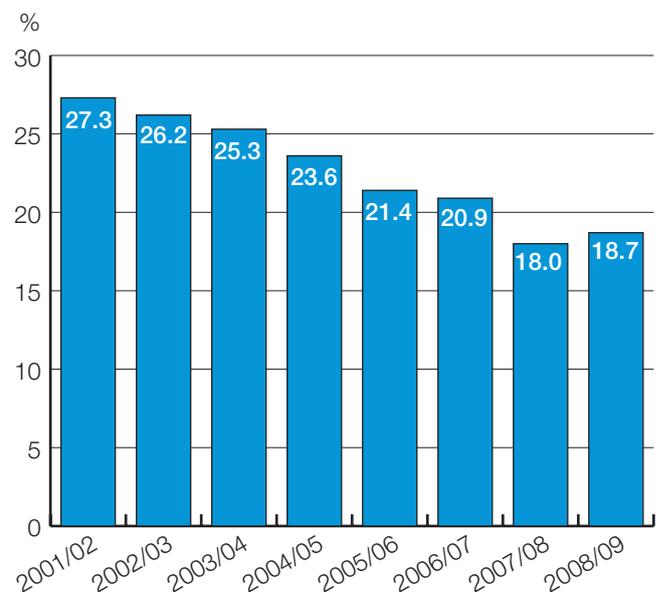
Trends in self-reported cannabis use among young people have declined since the turn of the century – both among 16- to 24-year-olds and among school pupils (see Figures 2 and 3).

While there is limited reliable trend data on the issue, there is nevertheless evidence to suggest that these slow decreases in use disguise a fundamental shift in the *type* of cannabis used. As will be described later in the chapter, there has been a dramatic shift away from smoking cannabis resin towards smoking herbal cannabis ('grass'), including 'skunk'.

The policy context

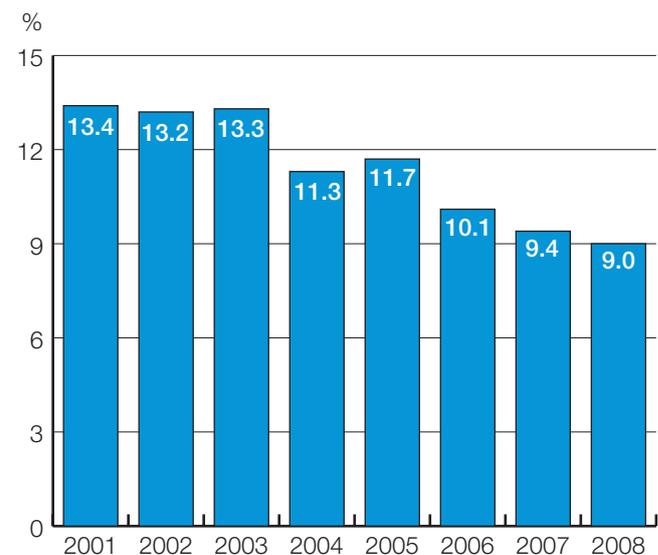
In 2000, the Independent Inquiry into the Misuse of Drugs Act, chaired by Dame Ruth Runciman recommended, on the basis of a thorough review of the evidence, that cannabis move from a Class B to a Class C drug. At this time, this would have meant that cannabis possession would have ceased to be an arrestable offence.¹ The-then Home Secretary, Jack Straw, and the Drug Tsar, Keith Hellawell, immediately dismissed the idea and in so doing,

Figure 2: Proportion of 16- to 24-year-olds reporting having used cannabis in the last year, 2001/02 to 2008/09



Source: Hoare (2009)

Figure 3: Proportion of secondary school-age pupils using cannabis in the last year, 2001 to 2008



Source: National Statistics/NHS Health and Social Care Information Centre (2009)

attracted widespread criticism from across the media for responding so hastily to such a carefully considered report.

After the General Election in June 2001, David Blunkett took over from Jack Straw at the Home Office and a month later called for ‘an adult, intelligent debate’ on the cannabis issue. It was also at this time that the ‘Lambeth experiment’ started under the aegis of Commander Brian Paddick, whereby the police began formally warning people found in possession of small amounts of cannabis rather than arresting them. No change in the law was required for this pilot as it was a matter of police discretion whether or not to arrest.

Another development at this time was the Home Affairs Select Committee inquiry into the government’s drug strategy (Home Affairs Select Committee, 2002). It was in his evidence to this inquiry that David Blunkett clearly stated his intention to re-categorise cannabis, in order to allow the police to concentrate on Class A drugs but also to protect the ‘credibility’, ‘clarity’ and ‘coherence’ of the law. He therefore referred the issue to the group charged with the task of advising the government on such issues – the Advisory Council on the Misuse of Drugs (ACMD). The ACMD produced its report in March 2002 (ACMD, 2002) – and supported the reclassification of cannabis. This was followed two months later by the Home Affairs Select Committee (2002) report on the drug strategy, which also supported the idea.

However, by this stage the media mood had changed (Warburton *et al.*, 2005a). There had been growing criticism of the Lambeth experiment in the tabloids – despite local residents largely seeing it as a positive development. Moreover, the removal of Commander Paddick from his post, following claims by his ex-partner that they had smoked cannabis together, provided further kindling for this antipathy.

On 10 July 2002, the government formally confirmed that cannabis would be reclassified to a Class C drug. This would have meant that the maximum penalty for possession would go down from five to two years’ imprisonment and the maximum for trafficking/supply from 14 to 5 years. Most significantly of all, it would have meant that cannabis possession ceased to be an arrestable

offence. However, contrary to widespread public perception, this is not what happened.

Cannabis eventually became a Class C drug in January 2004. At the very same time, the 2003 Criminal Justice Act also came into effect. This legislation made the possession of cannabis (but no other Class C drug) an arrestable offence. It also increased the maximum sentence for all Class C trafficking and supply offences from 5 to 14 years – the same as the maximum for Class B offences. This significantly reduced the practical difference between cannabis as a Class C drug and cannabis as a Class B drug: the maximum sentence for possession received at the Crown Court went down from five years’ imprisonment to two years but very few people get prison sentences for simple cannabis possession (Lloyd, 2008). The large majority of cannabis possession offenders are dealt with by the Magistrate’s Court, where the maximum prison sentence (three months) was unchanged, although the maximum fine decreased from £2,500 to £1,000. The only other change was that, for offences of supply and production of the drug, the maximum penalties at the Magistrate’s Court decreased from six months’ imprisonment and/or a £5,000 fine to three months’ imprisonment and/or a £2,500 fine. However, as the more serious offences of supply or production of Class C drugs are committed to the Crown Court for trial or sentence in any case (where the maximum sentence remained at 14 years imprisonment), this change is unlikely to have had much impact. So, while cannabis did move from Class B to Class C, it continued to be an arrestable offence and for the majority of cannabis offenders, who are dealt with for cannabis possession at the Magistrate’s Court, there is unlikely to have been any great change in sentencing.²

By 2004, media reporting on the issue was considerably more hostile – with the government being attacked in the run-up to the 2005 General Election for confusing young people about the legal status of cannabis. A new concern also appeared in media reports during 2004 and 2005 – claims of an association between cannabis and schizophrenia. By the time Charles Clarke took over from David Blunkett, it was felt that these concerns warranted another look at the classification issue (despite the lack of additional new research evidence on

the question). The ACMD stuck to its position and Clarke, after some deliberation, accepted its advice.

In June 2007, Gordon Brown took over from Tony Blair as Prime Minister and Jacqui Smith became the new Home Secretary. Less than a month later, in his second major policy announcement, Gordon Brown announced another review of the classification of cannabis. This was widely interpreted in the media as a personal desire on the part of the Prime Minister for cannabis to be reclassified. For the third time in six years, the matter was again referred to the ACMD and, once more, the ACMD recommended that cannabis remain a Class C drug. However, this time the ACMD's recommendation was ignored and Jacqui Smith announced that cannabis would be reclassified to a Class B drug, subject to parliamentary approval, by the end of 2008. On 26 January 2009, cannabis was moved back to a Class B drug.

JRF research

Despite the high level of public concern about cannabis, there has been a dearth of evidence on which to base policy decisions. The JRF therefore commissioned five studies in this area:

- the first major study of the policing of cannabis as a Class B drug;
- a follow-up to this study examining the impact of the switch to a Class C drug;
- the first research of its kind on the domestic cultivation of cannabis;
- research on the social impacts of heavy cannabis use;
- a study on how young people access cannabis.

The policing of cannabis

While the practical difference between cannabis as a Class B or C drug in terms of *sentencing* is actually quite small, potentially significant changes have been brought to the *policing* of cannabis through guidance from the Association of Chief

Police Officers (ACPO). Guidance was introduced in 2003 (ACPO, 2003) following the decision to reclassify cannabis, and in 2007 (ACPO, 2007) following Charles Clarke's decision to retain cannabis as a Class C drug and the introduction of the 2005 Serious and Organised Crime and Police Act (SOCPA). Most recently, further revised guidance was produced in January 2009 (ACPO, 2009), reflecting the second reclassification of cannabis: back to Class B.

The 2003 guidance stated that while the power of arrest was available for simple possession offences, the presumption was that in the majority of cases, a 'street warning' would be given (ACPO, 2003). Arrest would only be appropriate in aggravating circumstances, such as smoking cannabis in a public place, repeat offences or smoking near a school. The 2007 guidance had to take account of the SOCPA requirement that an officer needs to be able to demonstrate that any arrest is 'necessary' (ACPO, 2007). A similar set of situations where an arrest might be necessary was included in the guidance. The most recent (ACPO, 2009) guidance introduces an escalated policing response, whereby, in the majority of circumstances, the first possession offence will receive a cannabis warning, the second a Penalty Notice for Disorder (a fine for antisocial behaviour) and the third will result in arrest. Such a system clearly relies on reliable recording of previous offences, including cannabis warnings, on local police databases.

While, as shown above, cannabis use appears to have gradually decreased since 2000, recorded cannabis possession offences for the period 2004/05 to 2007/08 show a very different pattern (see Table 1).

A large proportion of cannabis possession offenders are young adults (May *et al.*, 2002) and for some of these, the apprehension for possession of cannabis will be their first interaction with the police. This makes this encounter potentially very

Table 1: Number of recorded cannabis possession offences, 2004/05 to 2007/08

2004/05	2005/06	2006/07	2007/08
88,263	119,917	130,395	158,086

Source: Crime Statistics, Home Office

significant. Another important aspect is the over-representation of young black men among those dealt with by the police for cannabis possession (May *et al.*, 2002). The policing of cannabis therefore carries significant implications for relations between the police and ethnic groups in many parts of the country. These issues, coupled with the dearth of research in the area, led the JRF to fund its first study on the policing of cannabis. The change in the classification of cannabis that took place shortly after the first study was completed, offered the chance to look at how cannabis policing changed post-classification and a second study was therefore funded.

The research

The fieldwork was focused on a pair of divisions within each of two forces in England. These pairs were selected to contrast in terms of the recorded levels of cannabis policing. In each site, observations of police activity, an analysis of custody records and interviews with police officers (a total of 150 interviews) were undertaken. This research process was undertaken in 2001 and repeated in 2004.

Discovery of offences

The 2001 research showed a number of paths by which cannabis possession comes to the attention of a police officer:

- *As a by-product of arrest for – or investigation of – another offence.* While a common occurrence, three-quarters of offences in an analysis of police data were for ‘simple’ possession – that is, not involving any other offences – suggesting that they are certainly not in the majority.
- *As a result of stop-and-search activity.* This is a very common way for cannabis possession to be uncovered – of 150 officers interviewed in the first study, 133 had made such searches for drug possession. Of the 133 searches, 37 resulted in the discovery of cannabis. Sixteen per cent of cannabis possession offences in the sample of custody records resulted from vehicle stops.

- *Inconveniencing persistent offenders.* Nearly half of the officers had used the offence as a way to impede the activities of a known offender and enable the police ‘to demonstrate and maintain their authority at a street level’ (May *et al.*, 2002, p 19).
- *Obvious evidence of use.* Offences were frequently detected because people were clearly smoking – or preparing to smoke – cannabis in a public place. Signs of use, such as torn cigarette paper packets, were a pretext for searches that resulted in the discovery of cannabis.
- *As part of an intended strategy or tactic.* Some officers appear to ‘specialise’ in cannabis offences. In the first study, two officers had made over 20 arrests each for cannabis possession in the previous year. One of the two held a strong opinion that cannabis was a ‘gateway’ drug to more serious drug use, likening himself to ‘a doctor fighting against cancer’. Cannabis possession can also act as a ‘lever’ to the discovery of other, more serious offences – for example where the possession offence is used as a reason to search a property.

Disposal

At the time of the first study, officers had an initial choice between two courses of action: to deal with the offence informally and get rid of the cannabis or to arrest (which could then lead to a caution or charge). At the time of the second study, when the second set of ACPO guidance (ACPO, 2007) had been introduced, officers had an additional option: to give a ‘street warning’.

Just under a third of officers interviewed in the first study always arrested if cannabis was uncovered. As one officer said, ‘Even if I found a bit the size of a pinhead I would nick them’. Others never arrested for simple possession: ‘I never nick anyone for cannabis, and never will, unless it’s a vanload’ (May *et al.*, 2002, p 26). However, the majority judged each case on its merits. In these cases, a number of factors were reported as influencing the decision: the amount of cannabis, previous criminal history, pressure of time and the

attitude of the offender. In addition, the researchers were able to examine the influence of a number of police officer characteristics on the decision as to whether or not to arrest. In a multivariate statistical analysis, length of service, police force area and whether or not the officer had used cannabis in the past were all significantly associated with the decision. Personal experience of cannabis was the strongest predictor – making officers less likely to arrest.

The disposal of offences varied strongly by police force area in both studies. In their study of the statistics from six forces, the authors of the first report found that the cautioning rate varied between 40 and 72 per cent of possession cases. In the second study, the proportion given a street warning varied between 22 and 42 per cent. The low rate of 22 per cent in site 1 was due to a force policy of arresting in all cannabis possession cases, which had been introduced in an area covering part of this research site. This policy had been introduced on account of the presence of open cannabis markets in the area. Warning rates in the other sites ranged between 39 and 42 per cent.

A person's likelihood of getting a conviction for a cannabis possession offence therefore varies considerably according to where in the country they are found in possession and the particular officer that happens to detect the offence.

Ethnicity

In their study of a sample of 2,600 cannabis possession offences on the Police National Computer, May *et al.* (2002) found that 8 per cent of offenders were black – a much higher proportion than one would expect on the basis of the general population (around 3 per cent for this age group). Asian groups were also over-represented but to a lesser extent. The second study found that black and minority ethnic (BME) people were heavily over-represented among cannabis possession offenders in three of the four sites and that they were 'somewhat over-represented' in the other. Given that self-reported cannabis use is similar among black and white groups and much lower among Asian groups (Aust and Smith, 2003), possible explanations for this over-representation include the higher proportion of BME residents in high-crime areas, where stop-and-search tactics are common,

and police targeting of BME suspects. Given the potential for such experiences to disaffect young BME people, this seems to be a priority issue for future research.

Young people

The use of street warnings does not apply to people aged 17 and under, who are subject to the 1998 Crime and Disorder Act's system of reprimands and final warnings. A reprimand may be given for a first offence (unless it is of a very serious nature, necessitating an immediate final warning or charge). A final warning must then be given for a second offence within a five-year period (again, unless it is of sufficient seriousness to warrant charge). A third offence within two years of the final warning should then result in a charge. Reprimands and final warnings are delivered at police stations and will normally therefore necessitate the arrest of the young person. This was spelled out in the 2003 ACPO guidance. However, the 2007 guidance, which had to take account of SOCPA, suggested that arrest was not always a necessity:

It is accepted that in some cases a police officer may find it necessary to arrest that [young] person in order to obtain the admission/evidence required. However, consideration should be given to less intrusive means if possible such as taking the young person home, verifying their name and address and referring the case for a disposal decision.

(ACPO, 2007, p 5)

There is therefore some uncertainty surrounding policy on young people found in possession of cannabis. There is also understandable disquiet about a system that deals with a 17-year-old in a very different (and arguably harsher) way than an 18-year-old. Police officers in the second study were asked whether they thought young people should be treated the same as adults and around half thought that they should.

Sanction detections

All government departments are required to meet Public Service Agreement (PSA) targets. One of the Home Office's PSA targets over the period studied – PSA3 – was to increase the annual number of

crimes for which offenders are brought to justice to 1.25 million by 2007/08.³ Street or cannabis warnings contribute to this figure as ‘sanction detections’ and as May *et al.* (2007, p 42) point out, ‘from the perspective of senior police managers, there are obvious advantages associated with increasing rates of street warnings related to improved performance on PSA3’.

In the second policing study there was evidence that police forces were increasingly recognising the potential of street warnings in this regard. An inspector in one site reported being under significant pressure from the area’s senior command team to increase the number of street warnings. Officers from another site ‘purposefully targeted offences of cannabis possession to ensure that they met their monthly “sanction detection” target. Our analysis of their custody record and street warning datasets showed that a third (49 out of 145) of the areas street warnings were derived from the work of a passive drug dog at a local train station...’ (2007, p 42). In one instance, 20 warnings were issued over a two-day period. Thus, another variable in the complex equation governing whether or not a person is likely to be found in possession of cannabis is whether or not that force is seeking to boost its sanction detection statistics.

Since the JRF research was undertaken, there has been a continuing and dramatic rise in street/ cannabis warnings (see Table 2).

This raises the question, as May *et al.* (2007, p 43) point out, of ‘whether it is a good use of police time to seek out cannabis offenders simply to meet the requirements of PSA3’ rather than wider policing goals.

The impact of reclassification on policing

May *et al.* (2007, p 44) concluded that ‘Overall our findings suggest that the reclassification of cannabis [from a Class B drug to a Class C drug] ... has had a smaller impact than advocates of the change hoped and than opponents feared’. The

Table 2: Number of street or cannabis warnings, 2004/05 to 2007/08

2004/05	2005/06	2006/07	2007/08
40,138	63,635	81,311	104,207

Source: Walker *et al.* (2006); Kershaw *et al.* (2008)

quite dramatic increase in the recorded number of people coming into contact with the police for a cannabis possession offence since 2004/05 suggests that cannabis warnings have substituted for informal warnings. However, there is also some evidence to suggest that forces may be ‘net-widening’ by seeking out cannabis possession offences in order to increase sanction detection statistics. There is also evidence that cannabis warnings have substituted for some cautions and arrests in some areas. Variation has continued to be a hallmark of cannabis policing – both at local area and individual officer levels.

Reclassification – or more specifically the confusion surrounding reclassification – also seems to have made officers’ jobs more difficult on the ground in some respects. Ninety-three per cent of officers in the second study reported having encountered members of the public who stated that cannabis was legal. Of these officers, a third said that such situations had created problems: situations could rapidly become antagonistic if offenders felt that they were being unfairly treated. However, as the authors point out, while there are undoubtedly people who are genuinely confused about the legal status of cannabis, there are others who may use feigned confusion as a defence. The researchers’ view is that the latter probably outweigh the former.

How and whether cannabis policing will change again now that cannabis has moved back from a Class C drug to a Class B drug is an open question. The Home Secretary has stated her view that ‘a system of escalation is necessary’ and has written to ACPO, ‘seeking its views on a clear and workable system of escalation that is consistent with reducing police bureaucracy and maintaining discretion’ (*Hansard*, 7 May 2008, Column 706). At the time of writing, ACPO has not yet produced any further guidance on cannabis policing.

Conclusions

While much of the public anxiety surrounding cannabis has focused on the classification of the drug, following the introduction of the 2003 Criminal Justice Act and the 2005 SOCPA), whether or not cannabis is a Class B drug or a Class C drug has become practically much less important. Of much greater significance in terms of the policing of

cannabis has been the changes introduced through the ACPO guidance. While the options for dealing with cannabis possession offences are now much clearer than they have been in the past, a number of serious concerns remain.

Perhaps paramount is the wide variations in practice. The 2003 ACPO guidance does not appear to have greatly improved the variations in policing at the force, Basic Command Unit (BCU) and individual officer levels. Some variation is accounted for by policies relating to particular areas – the 2007 ACPO guidance refers to the example of areas ‘where an open drugs (cannabis) market causes harm to communities’. However, such policies appear to account for only a small part of the variation in decision-making found in the research. The fact that two people who have committed exactly the same offence will be dealt with very differently according to what area of the country they are in, which officer discovers the cannabis and how busy that officer is, appears unjust. It is unlikely to contribute to good relations with the police – particularly if, as the research has shown, forces are purposefully targeting cannabis users simply to improve their statistics.

The over-representation of BME groups among people dealt with for cannabis possession is also a significant issue that demands further attention. Given that cannabis use among black and white people is similar (Aust and Smith, 2003), the explanation for this finding is likely to lie with either the disproportionate number of BME people living in heavily policed areas or police targeting of BME groups (or a mixture of the two). Further research is needed to determine what lies behind this over-representation.

Finally, there are concerns about the different way in which young people are policed for cannabis possession offences. As May *et al.* (2007, p 47) point out, ‘there is a good case for extending downwards the system of street warnings, at least to include 17-year-olds in certain circumstances....’.

Cannabis cultivation

The rapid growth in the domestic cultivation of cannabis in the UK over the past 20 years has led to fundamental changes in the nature of the drug and how it is produced, trafficked and consumed.

However, we have very little reliable information on this transformation and it was with this in mind that the JRF funded one of the few studies on the domestic cultivation of cannabis in the UK.

Trends

Twenty-five years ago, cannabis use was considerably less common and the vast majority of the drug was imported from Morocco, Afghanistan and Pakistan in the form of cannabis resin. Since then, there has been a dramatic switch to herbal cannabis or ‘grass’ – a switch that has been associated with increasing cultivation of cannabis in this country. While there is no reliable survey of cannabis potency in the UK, analysis of samples of cannabis seized by the police has shown that while 30 per cent of such seizures consisted of herbal cannabis in 2002; this rose to 55 per cent in 2004/05 and reached 80 per cent in 2008 (Hardwick and King, 2008). Furthermore, 97 per cent of the herbal cannabis seized in 2008 had been home-grown using intensive methods; the small remainder being imported herbal cannabis (Hardwick and King, 2008).

The legal situation

Those growing cannabis can be charged with either of two types of offence under the 1971 Misuse of Drugs Act: a production offence under Section 4 or a cultivation offence under Section 6. It is not entirely clear from the Act how these offences are differentiated but the implication is that ‘production’ would include activities other than simply cultivating a plant (that is, processing the cannabis into a useable form). To further complicate the situation, Section 4 was made a ‘trafficking’ offence under the 1986 Drug Trafficking Offences Act and, as such, carries a seven-year mandatory sentence for a third conviction – and the possibility of asset confiscation. This does not apply to Section 6 offences.

Police guidance dates back to ACPO guidance on disposals for drug offenders published in 1999. Unlike the current policy on cannabis possession, this guidance states that adults ‘will normally be prosecuted’ (Hough *et al.*, 2003, p 13) – and the recommendation is that they are prosecuted under Section 4 or as an offence of possession – but not under Section 6. The 2009 ACPO guidance

on possession for personal use clearly states that this guidance does not cover cultivation – even one plant for personal use – and that cannabis warnings and Penalty Notices for Disorder (PNDs) cannot therefore be issues for this offence ‘in any circumstances’ (ACPO, 2009, p 14).

The study

The study by Hough *et al.* (2003) was essentially exploratory: recruiting a sample of 37 cannabis cultivators primarily through cannabis-related websites. The researchers also sent a questionnaire on enforcement practice to 43 forces – of which 16 responded.

Findings

Of the 37 cultivators, nine were growing solely for their own use, three were primarily growing for perceived medical value, ten were ‘social’ growers, growing for themselves and friends; ten were both social and commercial in that they supplemented their income by growing for friends and five were commercial growers, selling to any potential customer. Two-thirds of the sample referred to the poor quality of cannabis resin and the risk of adulteration as a motivation. Half mentioned cost and a third mentioned contact with dealers. For example, one respondent said:

The reason I started to cultivate was primarily because of the high price and low quality of cannabis that is readily available from commercial dealers where I live.

(Hough *et al.*, 2003, p 8)

Another referred to the wish to ‘escape using dealers and the black market’. Some growers also referred to their enjoyment of growing cannabis as a hobby.

The amount of cannabis grown varied greatly according to the motivation for growing it – with some growing a few plants for personal use and, at the other end of the scale, one commercial grower having over 100 plants under cultivation at any one time.

Cannabis production offences

The Home Office includes all Section 4 and Section 6 offences as ‘production’ offences. The

number of such cannabis production offences has fluctuated significantly over the past 13 years. Offences reached a peak of just under 5,000 offences in 1995, followed by a decline to 1,500 in 2001, followed by a gradual increase to around 2,500 in 2003 and 2004 (Ahmed and Mwenda, 2004; Mwenda, 2005). Recent reports in the media suggest an increased number of seizures of cannabis from large-scale cannabis producers. However, the majority of offences appear to be more minor, with the majority receiving a caution or fine (Hough *et al.*, 2003). Recent statistics on seizures (Hand and Rishiraj, 2009) show a dramatic increase in seizures of cannabis plants: from 2,924 in 2004 to 9,372 in 2008/9. Eighty-three per cent of these plant seizures in 2008/9 was for 50 plants or fewer.

The forces that returned the researchers’ questionnaires reported varying approaches to dealing with cannabis production/cultivation. Six forces generally charged under Section 4 but the remainder adopted a more flexible approach and, in one case, usually charged offenders under Section 6. As part of the research on policing cannabis discussed above, the team also collected data on all cannabis cases occurring in the two forces studied. There were 17 Section 4 charges, the number of plants varying from one to 19, and 57 Section 6 charges, the number of plants varying from one to 133. This suggests that the use of Sections 4 and 6 is somewhat arbitrary. Court disposals also varied considerably, with one individual who grew 20 plants receiving a caution, and another who grew 28 plants being imprisoned for nine months.

Problems with the law

The presumption in favour of charging offenders and the potential mandatory sentence for a third production offence seems to indicate that growing cannabis is a more serious crime than possessing the same amount of the drug. As Hough *et al.* (2003, p 33) point out, ‘There would be little logic in a law that treated the cultivation of a cannabis plant for personal use as a more serious offence than the possession of cannabis from the same plant once it has been harvested’. In fact, it seems ‘less unacceptable that cannabis users should grow their own cannabis than that they should be exposed to

a market populated by criminal entrepreneurs' (p 33). The authors therefore conclude that 'One of the few effective policy levers available to government to destabilise the cannabis market operated by criminal entrepreneurs is greater toleration of social cultivation' (p 36).

The social impact of heavy cannabis use

Fears that cannabis use may be associated with the development of schizophrenia have greatly escalated over the course of the JRF research programme. Establishing the nature of this relationship is best addressed through longitudinal research that follows cohorts of people over time and recent reviews of this research have been published (e.g. Moore *et al.*, 2007). Such research was beyond the remit of the JRF programme and it was decided instead to focus on the question of whether heavy cannabis use among young people is associated with social impacts – education, relationships, work.

Melrose *et al.* (2007) undertook interviews with 100 young people (aged 16 to 25) who had used cannabis more or less on a daily basis for at least six months and 30 interviews with professionals working with young people. These young people were contacted through a range of sources including Connexions, Youth Offending Teams, training providers and colleges/universities.

When asked what form of cannabis they usually used, over 60 per cent responded that they used 'skunk'⁴ and a further 26 per cent said that they used a combination of resin and/or skunk and/or weed or 'whatever they could get' (2007, p 8). Skunk was generally preferred because it was thought to be less adulterated than resin and gave a better 'buzz':

I started smoking skunk, the powerful stuff, 'cos the puff [resin] I would smoke every now and then. But when I brought the skunk, that was it, it was a better buzz. It was more expensive but it was ... you'd rather pay more because you'd get a better buzz from it.

(p 8)

The researchers divided the young people up into 'low-heavy users', spending up to £40 per week on cannabis; 'medium-heavy users' spending between £41 and £100 per week; and 'high-heavy users', spending over £100 per week. Despite the high level of use among these young people, around half the sample did not define themselves as 'heavy users'. The young people tended to minimise the seriousness of their drug use by comparing it to Class A drugs. As the authors conclude: 'It is clear from these extracts that comparing cannabis with class A drugs allows these participants to minimise and even trivialise their own use and to construct it as relatively safe and unproblematic' (p 18).

Patterns of use varied and seemed to be linked to the young people's social situation. Those in higher education tended to use cannabis in a relatively controlled manner, compared to those with less structure in their lives, such as the unemployed or those on training schemes. The researchers gave an example of a young man on a training scheme who smoked a 'bong'⁵ first thing in the morning and then continued to smoke them throughout the day, sometimes smoking as many as 20.

The most frequently mentioned reason for smoking cannabis was 'relaxation'. Other common reasons given were socialising with friends, getting intoxicated and for something to do. For example:

The one thing I find with cannabis is it relaxes my mind a lot from daily stress. Even a little bit, it will help take that stress away.

(p 31)

As an extension of this, some young people seemed to use cannabis to manage their anger and avoid getting into fights:

I have anger management problems, I should have mentioned that. And, erm, it helps me in that sense as well 'cos it helps me keep my nose down if you know what I mean.

(p 32)

For many, cannabis-smoking – even at this heavy level – was clearly an enjoyable, sociable activity:

It's a really social thing. It's good fun to sit down with your mates and get a spliff on the go because it makes you talk more and it's just a lot of fun.

(p 31)

Cannabis use appeared to improve social situations. One user reported enjoying spending time with her friends but said that 'smoking makes it better ... I enjoy it more because I'm stoned' (p 33).

When asked directly, users found it more difficult to identify any negative effects of their cannabis use. As the authors point out, the 'young people on the whole did not really seem to consider their cannabis use in any reflexive way – it was just something they did' (p 34). Nevertheless, during the course of the interviews, it often became clear that their cannabis use was associated with a range of problems, including education, family relationships/homelessness, the criminal justice system and what the researchers categorise as personal costs.

Education

Almost half of the young people had been excluded from school at some point but only 13 reported being excluded as a result of their cannabis use. When questioned further about these incidents, it was clear that fewer still had actually been excluded for smoking cannabis – 'rather, their cannabis use had contributed to a range of problematic behaviours that had culminated in exclusion' (p 35). The young people also referred to the impact of cannabis on their school performance either through spending too much time out of school smoking cannabis or through being 'stoned' in class as in the case of the following respondent:

I used to smoke in school in breaks and I'd be stoned when I went into class, which meant I weren't doing my work quick enough or finishing by deadlines.

(p 36)

Such behaviour appeared to be particularly common among the more disadvantaged in the sample.

However, it should also be noted that many young people – especially those in higher or further

education – did not appear to be experiencing problems with their education. In fact, some reported that cannabis helped them to concentrate

Family relationships/homelessness

In some cases, the young people's cannabis use had been associated with problems in family relationships. In a few, it had contributed to the young person leaving home. For example, one young person, who was living in a hostel, said that she argued with her mum all the time about her being stoned and this had led to her leaving home.

While comparatively rare, of all the social impacts that appear to be associated with cannabis use, being forced to leave the family home must be one of the most damaging. Living in a hostel may lead to contact with other users and escalation of a young person's drug use and other forms of homelessness are likewise associated with ready access to Class A drugs.

The criminal justice system

Only a small number of the sample had been in trouble with the police and so the consequences of getting into trouble with the law did not rank high among the young people's accounts of cannabis-related problems.

Personal costs

Many reported that their cannabis use made them lazy or demotivated. As one described:

It kind of makes you lazy: you want to relax all the time. You're just smoking it so much and regularly, all the time, you don't want to do things, just wanna relax and not move basically.

(p 39)

This reportedly prevented students doing work and was therefore a contributor to educational underperformance. As Melrose *et al.*, point out, while heavy cannabis users frequently cite laziness as a side effect of the drug, this is not always the case (e.g. Barnwell *et al.*, 2006) and research has generally failed to detect such an effect in laboratory tests of motivation. Also, if there is such an association, it is unclear what the direction of the causation is; that is, whether people lacking motivation tend to smoke cannabis heavily or heavy

cannabis smoking leads to lack of motivation. Nevertheless, the fact that many young, heavy cannabis users ascribe their lack of motivation to the drug seems significant in itself, in terms of any intervention.

Interviewees also frequently talked of 'paranoia' – in the sense of temporary feelings of insecurity or anxiety. This has been found in many other studies (e.g. Terry *et al.*, 2004). As the researchers point out, it is interesting that, on the one hand, users site relaxation as an attribute of the drug and yet, on the other, cannabis can cause pronounced feelings of anxiety (Melrose *et al.*, 2007, p 39).

While none of these users appeared to have experienced serious mental health problems on account of their use, two users referred to a friend – and one to a boyfriend – who had been institutionalised on account of their (reportedly) cannabis-related mental disorder. The most extreme case was one young person's boyfriend, who in her words had suffered a 'drug-induced psychosis by smoking cannabis':

He just started going, talking riddles and, well making no sense and stuff like that and just weird stuff and he got sectioned.

(p 40)

In discussing the range of reported effects of cannabis, the authors point out that 'these impacts crucially seemed to be related to the degree of pre-existing social or personal problems and the current social situations the young people found themselves in...' (p 41). They go on to argue in relation to the 'high-heavy' users, that the relationship between social problems and cannabis is essentially an interactive or circular one: 'difficult life situations and circumstances did impact negatively on cannabis use and cannabis use in turn impacted negatively on these life situations and circumstances' (p 42). In a number of cases, conflicts with parents and step-parents led to homelessness and hostel residence, where their cannabis use tended to increase. This heavy cannabis use appeared to sap their motivation, preventing them from applying for jobs and reinforcing their social problems.

Young people's and professional's attitudes

The researchers compared the attitudes of the young people with the 30 practitioners and concluded that: 'Overall ... professionals appear to see cannabis as less harmful than the young people do' (p 50). Double the proportion of young people (61 per cent) believed that smoking cannabis regularly is likely to lead to mental health problems compared with professionals (29 per cent – although it should be emphasised that the whole sample was only 30 individuals). Young people were also more likely to think that cannabis use could lead to harder drugs and that is easy to become addicted to cannabis. As the authors point out,

This may well be because, as a result of their age, culture and class, professionals have direct or indirect experience of relatively harmless cannabis use. The young people ... by comparison may have absorbed media scares around 'skunk' and schizophrenia ... [and] are using high volumes of cannabis and, as we have seen, most of them are using 'skunk' which is allegedly more potent than forms that were previously available.

(p 50)

Conclusions

This research has created a complicated picture with regard to the relationship between heavy cannabis use and social problems. On the one hand, young people saw the drug as more dangerous than a group of professionals did. On the other, when asked about the drug's negative impacts on themselves they were initially at a loss to name them – and could only name the positive effects of the drug. It was only as the qualitative interview went on to consider other aspects of their lives that the damaging impact of this heavy use became clear. These findings carry implications for work with heavy users: when asked if they would seek help from outside agencies, most thought it was not a problem and that they would not therefore seek help. Cannabis use might therefore be best addressed by professionals who are seeing these young people for other reasons: problems with accommodation, employment, education or the law. However, this research suggests that

professionals working in these sectors may not take their cannabis use seriously – and this is likely to be reinforced by the young person’s own reluctance to view their own cannabis use as problematic.

The nature of the impact of heavy cannabis use on young people’s lives is not a simple one. This study suggests that troubled pasts can lead to high levels of cannabis use and that this heavy use then amplifies these problems. While most research has generally failed to find a sapping effect of cannabis on people’s motivation, this study has again offered evidence of cannabis users’ belief in such a connection. One possible explanation is that, at these levels of use, the young people were simply ‘stoned’ so much of the time that this directly incapacitated them in terms of applying for jobs or doing work for school or college. For some reason this is interpreted as apathy or laziness.

While the media, public and, to some extent, politicians have tended to focus narrowly on the association between cannabis use and mental health, this research suggests that we need to know more about how heavy cannabis use interacts with young people’s transitions into adulthood. Very frequent use of high-strength cannabis strains would hamper most people’s ability to function through the day – it may disproportionately affect the vulnerable or excluded.

Cannabis supply and young people

The last of the JRF studies focused on yet another feature of the drug that is very poorly understood: how young people get hold of cannabis (Duffy *et al.*, 2008). It is suspected from anecdotal evidence that young people often buy cannabis in groups – with one or two members of the group actually buying the cannabis with shared money and then dividing up the drug. Concern has been expressed that young people in this situation may not be aware of the fact that, in the eyes of the law, they are committing an offence of supply. The *Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (Police Foundation, 2000) identified this issue and recommended that, where a person has supplied cannabis to a social group, they should be proceeded against for possession.

This recommendation was not taken up by the government.

This study was funded to find out whether young people do indeed purchase cannabis in this way and whether they are putting themselves in danger of prosecution for supply or exclusion from school. The researchers interviewed 182 young people aged between 11 and 19 – half from rural areas in the South West of England and half from London. Only those who had used cannabis in the previous three months and/or had brokered access to⁶ or sold cannabis were included. The sample was recruited through youth centres, further education colleges, school exclusion units and Youth Offending Teams; and through ‘snowballing’ or accessing other interviewees from those already interviewed. People with experience of being excluded from school were purposefully selected to address the question of the role of cannabis use and supply – and 58 per cent had been excluded.

Sixty-two per cent of the sample were regular users, using cannabis once a week or more; 19 per cent of the sample as a whole smoked cannabis every day. As with Melrose *et al.*’s (2007) sample, the preference was for herbal cannabis: 55 per cent reported using ‘weed’ and 40 per cent ‘skunk’. Only 10 per cent of the sample reported using resin.⁷ Skunk use was considerably more common in the London sample, in comparison to those from the South West. The reasons for using cannabis were also similar, the most common being to relax or calm down.

Buying

Fifty-five per cent of the sample normally bought cannabis directly from a seller they knew personally – a friend, acquaintance or family member; 23 per cent were usually given it by a friend; and in 16 per cent of cases, friends bought cannabis on their behalf. *Only six per cent* of the sample usually obtained their cannabis by purchasing it from an unknown seller. The average age of sellers was 19 years. The stereotypical notion of the adult stranger pushing drugs to young people is therefore not borne out by this study.

While only 16 per cent normally bought cannabis as part of a group, this method was still a common way of buying cannabis for 70 per cent of the sample, although not the most common

method for the majority. Buying cannabis in this way was particularly common among the younger age group (15 to 17) who had little money.

Brokering and supply

Eighty-two individuals had supplied or brokered access to cannabis. Of these, 37 had brokered access and 45 had sold cannabis for profit. The researchers divided them up into a range of categories from brokering to heavy selling (three individuals). Duffy *et al.* (2008) state that 'the majority clearly distanced themselves from the description of a drug dealer' (p 25), seeing the term to denote someone making a large profit from selling to large numbers of customers. The researchers also found that 'the more heavily involved in selling they were, the more sophisticated they were about strategies for avoiding arrest for possession with intent to supply. This raises the possibility, of course, that the less experienced sellers might be more at risk of being swept into the criminal justice process' (p 25).

The study showed that eight out of the twelve moderate sellers had family members who were cannabis users – and this applied to at least one of the three heavy sellers. The researchers conclude that 'this may indicate that family involvement in cannabis use might increase the risk of becoming involved in selling. This may be due either to the normalisation of cannabis use in the immediate environment ... or other so far unexplored factors' (p 30).

School and police

Half the sample had taken cannabis into school or college at some point and 43 per cent said that they had used cannabis while on the premises. Twenty-two individuals had been caught in possession of, under the influence of, or smelling of cannabis. One had been caught brokering access to cannabis and one had been caught selling the drug. Twelve had been caught in possession and five of these were temporarily excluded, two were permanently excluded, two were given detention and no action was taken in the case of the other three. No action was taken in the case of the pupil brokering access to cannabis and the seller was temporarily excluded from school.

Eighteen per cent of the sample had previously been found in possession of cannabis by the police – a fairly common experience, as suggested by the earlier analysis of risk of apprehension. Thirteen individuals had been arrested and ten had been dealt with informally.

Knowledge of the law

Fifty-seven per cent of the sample correctly identified cannabis as a Class C drug. The young people were asked whether they thought that they would be treated any differently for obtaining cannabis for friends as opposed to selling drugs. Seventy-six per cent thought that they would be treated the same way; 18 per cent thought that they would not; the rest did not know.

Conclusions

The authors conclude that 'in practice current approaches to enforcement – whether through accident or design – manage to differentiate between social and commercial supply' (p 43). They go on to suggest that, in any case, it is improbable that the law would be changed. However, they suggest that there is a strong case for clear guidance from ACPO, the Crown Prosecution Service, the Youth Justice Board and the Department for Children, Schools and Families on how to deal with offences of social supply committed by young people.

This research also reinforced findings from elsewhere: skunk and other forms of herbal cannabis are the norm for cannabis smokers in this age group. Cannabis use does occur on school premises and, as in Melrose *et al.*'s (2007) study, this raises the question of whether cannabis use may be interfering with school work. Nearly a fifth of this group had come into contact with the police for cannabis possession, showing enforcement to be a significant issue both for the police and for cannabis users.

Conclusions

Perhaps the most important conclusion that can be drawn from this programme of work on cannabis is that there are some very significant holes in our knowledge about this, the most commonly used of the illicit drugs. The research funded represented

some of the first studies on cannabis policing, cultivation, dealing and social impact. However, some of the most elemental information is still lacking. There is growing evidence from this JRF research and police seizure data that skunk, and home-grown herbal cannabis more generally, has become the most commonly used form of the drug among young people. This trend has been widely recognised by people in the drug field – and probably even better recognised by young people using cannabis. However, we have had no really reliable trend data with which to demonstrate this fundamental change in use. The growing fears over the past five years concerning the ‘new potency’ of cannabis have therefore been based largely on anecdote and conjecture. This appears to represent a significant failing: there is a real need for a regular, detailed survey of cannabis users in this country (including questions on how the quantity used varies with perceived strength) and a good method of testing the strength of cannabis being used by cannabis smokers. Without such information on how habits and practices are changing, we cannot formulate the policies and practices that will really protect young people from the dangers that exist.

This research has also thrown up a number of other serious issues that warrant consideration by policy-makers. There are wide variations in practice in the policing of cannabis that cannot be argued away on the basis of operational or strategic needs. Other policing concerns centre on the over-representation of BME groups among people dealt with for cannabis possession and the very different way that young offenders are dealt with. These enforcement issues are of particular importance because a significant proportion of young cannabis users are likely to have their first contact with the police in this way. It is therefore imperative that policing practice is proportionate and fair.

Another dramatic trend – closely related to the increase in use of herbal cannabis – is the domestic cultivation of cannabis. The research here again shows there to be considerable variation and confusion on the question of enforcement. However, in this case, the confusion extends to the law itself with two separate offences governing the act of growing the plant and, apparently, very little agreement over which should be used when. This

seems to be an issue that would be best tackled by ACPO in fresh guidance on the question. There are strong arguments (originally made by the Police Foundation Inquiry back in 2000) for those growing a small number of plants to be dealt with in the same way as a possession offence. Indeed, it is an odd situation that, currently, those in possession of cannabis bought from a dealer are held as less culpable than someone who has grown the same quantity of the drug at home. Home-growing allows users to avoid contact with the illicit drug market and control the strength of their cannabis.

While an increasing proportion of cannabis is grown in the UK, the large majority of young people still have to obtain their cannabis from the illicit market – a market that seems to be able to reach people anywhere in the country. Nevertheless, young users do not tend to buy their cannabis from an older, unscrupulous and unknown ‘pusher’ – they are far more likely to obtain it through friends. This raises the question of whether young people buying cannabis on the behalf of friends are dealt with in the same way as profit-driven dealers (who can also be young people). The available evidence appears to indicate that they are not: enforcement approaches differentiate between social and commercial supply. However, again, there is a strong case for clear guidance on these issues from ACPO.

A somewhat surprising finding from the programme has been the number of young people who report taking cannabis into school and smoking the drug on school premises. As with other enforcement agencies, schools appear to have reacted pragmatically to this development. However, the actual use of cannabis on school premises seems a particularly worrying issue. Perhaps unsurprisingly, the research undertaken by Melrose *et al.* (2007) suggests that being ‘stoned’ in the classroom may not equate with academic success. This is a difficult problem to deal with – as some of the disciplinary responses, such as exclusion, may be more damaging than the cannabis use itself. This issue warrants further research in terms of the number of students using cannabis in school and the possible ways to discourage or prevent this.

There are important findings from Melrose *et al.*'s (2007) study suggesting that young people

with troubled pasts may be more likely to smoke cannabis heavily – and that this heavy use can amplify their problems. While the number of interviews is small (30), there is also the suggestion that professionals working with vulnerable young people may not recognise the potential seriousness of heavy cannabis use. This may relate to their own, very different, experience of smoking cannabis during their youth. This question deserves further research attention but, in the meantime, professionals working with vulnerable and excluded young people need to recognise that heavy cannabis use may well be adding a further burden of disadvantage to already disadvantaged young people, even if the young people themselves do not, on the face of it, see their use as a problem.

Lastly, it needs to be recognised that a large amount of public and political concern, effort and attention is being misplaced with regard to the cannabis issue. The cannabis classification question is largely a distraction: whether or not cannabis is a Class B or a Class C drug appears to have had a limited impact on policing and sentencing; and no effect on levels of use. While researchers and academics have increasingly appreciated this situation (May *et al.*, 2007; Pearson, 2007; Reuter and Stevens, 2007), it is still very poorly understood by the media (and, therefore, presumably the public) for whom cannabis classification has continued to be a central drug policy question. This has made cannabis classification a very significant political issue, with considerable attention paid to the question by Prime Ministers, Home Secretaries, shadow politicians and, therefore, the Westminster drug policy structure, including the ACMD. The concern is that it has distracted us from the real direct and indirect harms associated with the drug and its enforcement.

3 Problematic drug use

Neil McKeganey

The growth in the use of heroin within the UK over the last 50 years has been nothing short of remarkable. In the 1950s, heroin use was largely confined to the bohemian fringe in London, with many of those dependent on the drug sourcing it from private medical practitioners. In a single year, for example, one noted London psychiatrist provided in excess of 600,000 heroin tablets to her private patients, leading her to being described by one of the Home Office drugs inspectors as having caused a substantial proportion of the capital's heroin problem (Spear, 1965). If in the 1950s the number of heroin addicts within the UK could be counted in the hundreds, by the turn of the century researchers were estimating that the figure could be moving towards 400,000 (McKeganey *et al.*, 2006). The most recent estimate for the prevalence of problematic drug use (largely dependent use of heroin and cocaine) in England is 327,000 (Hay *et al.*, 2008b). The equivalent figure for Scotland is around 55,000 (Hay *et al.*, 2007), while for Wales the figure is thought to be around 8,000 (Wood *et al.*, 2000) with around 800 in Northern Ireland (McElrath, 2002).

Although the figure of 400,000 may seem large in terms of simple numbers, in fact the figure represents barely 1 per cent of the adult population in the UK. In this sense then, while one might be forgiven for believing that the UK has an enormous drug problem, in fact the scale of the UK Class A drug problem is tiny at least in population terms. However, in addition to these 400,000 problem drug users, there are people who have used either heroin or cocaine on an intermittent or occasional basis. The closest we have come to an estimate of all heroin and cocaine users is through the large-scale social surveys that have asked individuals about their drug use. The difficulty with those surveys, however, is the fact that individuals may be inclined to under-report their use of any highly stigmatised drug such as heroin. They are also less likely to include more chaotic users and will

not include those in prison. It is perhaps for these reasons that the British Crime Survey estimate of the number of heroin users within the UK produces a number that is less than the total number of heroin users known to be in treatment (Roe and Man 2006). By comparison, powder cocaine users (as opposed to crack users) tend to be less chaotic and more likely to appear in surveys. Moreover, as the drug is seen in a less negative way than heroin, social surveys may be better able to report a figure for cocaine use that is closer to the true level of use of the drug. The 2007 British Crime Survey for England and Wales, for example, found that 5 per cent of 20- to 24-year-olds report having used cocaine in the last year (Hoare and Flatley, 2008).

Despite the tiny percentage of the UK population who is dependent on heroin and cocaine, the current (and previous) UK drug strategy is principally focused on these two drugs. The reason for the prominent position of these two drugs within the strategy is easy to understand given the view that these are the two drugs that are believed to cause the greatest harm to users, their families and communities. Recent research reviewing the level of harm associated with 20 different substances (including tobacco and alcohol) recently placed heroin and cocaine in the top two positions (Nutt *et al.*, 2007). That Class A drug use is associated with enormous harm is beyond dispute. In terms of drug-related deaths, for example, there are around 2,000 deaths associated with heroin each year in the UK. It is thought that around 40 per cent of drug injectors in the UK are Hepatitis C positive, many of whom will progress to serious and in some cases terminal illness over the next 15 or so years. Although the level of HIV infection among injecting drug users within the UK is thought to be below 1 per cent, there are concerns of a recent rise in infection rates (Health Protection Agency, 2007). There are thought to be somewhere in the region of 350,000 children in the UK with one or both parents dependent on illegal

drugs (ACMD, 2003). On the basis of research involving the drug testing of arrestees, it has been suggested that as much as 60 per cent of crime may be connected in some way to the use of illegal drugs (Bennett, 2000). Surveys carried out of in prison have reported that in Scotland 69 per cent of prisoners have used illegal drugs prior to incarceration (Scottish Prison Service, 2007). With regard to the impact of serious drug use on families, the ACMD (2003) has reported that only 46 per cent of 221,000 drug-dependent parents had their children living with them and only 37 per cent of drug-dependent fathers had their children living with them.

Aside from the catalogue of negative statistics associated with problematic drug use and drug injecting, qualitative research carried out for the JRF has provided a powerful illustration of the negative impact of serious drug use on families and communities. Marina Barnard (2005), for example, undertook research for the JRF on the impact of drug abuse on families, showing that whether the drug use involves the parent or the children it is very often the entire set of family relationships (parents, siblings, grandparents, aunts, uncles and cousins) that is affected. One of the children with drug-dependent parents interviewed in the research undertaken by Barnard described the circumstances of her childhood in the following way: 'It was as if she was the child and I was the mum.... It was a nightmare an absolute nightmare. I don't think that I had a childhood at all' (Barnard, 2005, p 22). Similarly, one of the parents in Barnard's study described the sense of powerlessness he felt during the period when his two sons' drug use was at its most chaotic:

Me and Shona [wife] for ten years our life got kinda took away from us. I felt we were in a big hole hanging on to the sides ... I think it was the helpless, the powerless stuff, you know I was powerless. In ma whole life I was never fucking powerless or helpless. I could deal with anything that came ma way but I could'na deal with this. I could'nae change it. I could'nae make it better.

(Barnard, 2005, p 9)

Other research within the JRF Drugs programme looked in detail at the impact of drug use and drug

dealing on communities. It is worth providing a couple of illustrative examples of the sorts of things community members said about the impact of illegal drug use and drug dealing within their area:

My neighbour is a junkie, the whole street is full of them.

(May et al., 2005, p 27)

They come to the door selling things for drugs. They are always prowling for drugs.

(May et al., 2005, p 27)

They deal drugs outside my house.

(May et al., 2005, p 27)

Drugs cause the decay in the area with crime prostitution and street robbery. The potential to commit crime increases. It has sigmatized the area.

(May et al., 2005, p 27)

The capacity of a local drug market to undermine previously very close social relationships has been demonstrated in other research. McKeganey and colleagues (2004a), for example, undertook research in Scotland in a community that was described by residents as having been previously very close and supportive. According to local residents, however, once illegal drugs had arrived in the community the atmosphere changed markedly and even previously close friendships broke down:

Everybody's families in the area used to be dead close but now people's mums won't speak to my mum because of my habit. The way the mothers are looking at it nobody likes anybody anymore because his son used to sell drugs to ma son ... it's like there is a bad atmosphere in the scheme.

(local resident, quoted in McKeganey et al., 2004a, p 356)

On the basis of these qualitative research findings and the raft of quantitative indicators referred to earlier, there can be no question that problem drug use, can and does have a profoundly negative impact on individuals, families and communities. For the most part, our understanding of the impact

of heroin use is derived from research involving those whose drug use has become chaotic, who may be dependent on the drug and who are in treatment for their drug use. The result is that we know very little about the experience of those who use heroin in a more episodic or controlled way. Exploring alternative patterns of heroin use, including the possible non-problematic use of heroin, has not been a priority of government-sponsored research, which has, by contrast, tended to focus on understanding the nature and impact of plainly chaotic and destructive heroin use. One of the benefits of charitably funded research is that it can be rather less shaped by current government priorities and policies and can, for that reason, address issues and questions that are only rarely tackled in government-funded research. In the case of the JRF Drugs Research Programme, research was funded looking specifically at what may be termed 'controlled heroin use', that is, the use of heroin in a non-chaotic way. Research was also undertaken within the programme on street policing of heroin in the UK. In the remainder of this chapter, we outline the results of these studies.

Occasional and controlled heroin use not a problem?

Any research on heroin users faces the methodological problem of how one contacts research respondents. Where the focus of research is on individuals who have developed a problem as a result of their drug use, the answer to this methodological problem tends to be for the researcher to recruit their sample from drug treatment centres. In the case of those individuals whose heroin use does not appear to be causing them a major problem, recruiting subjects at a range of drug treatment facilities clearly makes no sense at all. The difficulty of contacting these individuals is further compounded by the likelihood that their preference will be, in all probability, for their drug use to remain hidden. There are then no lists or databases of controlled non-problematic heroin users that can be scanned to produce an interview sample. Warburton *et al.* (2005b) sought to get round the problem of the hidden nature of the population they were interested in by employing a range of research methods including an online

survey advertised through internet discussions groups, e-newsletters and organisational websites. The aim, through these advertisements, was to contact individuals who had used heroin at least once in the previous six months, who identified as relatively problem free and who did not have any current heroin-related legal or health problems. Of the 246 individuals who completed the online survey, 123 met the study criteria. Crucially, the team were interested in looking not simply at non-dependent heroin users (that is, those whose use was occasional and intermittent), but those who although dependent on the drug nevertheless seemed to have developed a controlled use of the drug. Because the research team drew their sample from an online survey, it was not possible to comment on the relative proportions of controlled and uncontrolled heroin users in the UK. Indeed, given the nature of their survey it was not even possible to focus the research solely on UK residents. It was also not possible in this research to check the accuracy of individuals' reported heroin use. It was possible in this research, however, to carry out qualitative interviews with 51 of the survey respondents.

With regard to the onset of their heroin use, the sample of individuals interviewed tended to be older than the more traditional samples of problematic heroin users more often included within research. The average age at which heroin use had begun for the interviewees in this study was 20 although the range was between 12 and 60 years of age. The circumstances in which individuals' heroin use had occurred varied considerably. The majority of interviewees appeared to have encountered heroin by chance rather than as a result of deliberately having sought out the drug. One of the common ways in which this occurred was through meeting a new partner who had used heroin previously, or linking into a new social group that included individuals who were using heroin. In terms of the individuals' reasons for using heroin, the principal reason cited had to do with curiosity or 'a sheer hedonistic approach to drug taking'. Some individuals appeared to be using heroin as form of self-medication to assist in 'coming down' from other drugs they had used. It was evident though that some individuals had simply started to use heroin as a result of the drug having become a

normal or normalised part of their social world – surrounded by individuals who were using the drug even if only on an occasional basis produced a strong inclination at some point to try the drug out.

The researchers in this study caution against the view of a single trajectory of heroin use progressing from intermittent occasional use, to regular more chaotic use. What they found, even among the relatively small number of users interviewed, were marked differences in the style and frequency of heroin use. Forty-four per cent of interviewees said that they used heroin less than once a month, 31 per cent said that they used the drug a few times a month, 15 per cent said that they used the drug a few times a week and 11 per cent said that they used the drug on a daily basis. What was further striking was the fact that many of these individuals had been using heroin over many years including with sustained periods of abstinence. There appeared to be considerable fluidity in the pattern of heroin use within the sample and it certainly was not the case that those individuals who appeared to have developed a pattern of controlled use (whether dependent or not) were simply individuals at an early stage in their drug use. The occasional, non-dependent heroin users in this study had been using heroin for between six months and 13 years. These individuals tended to place strict limits on the amount of money they were prepared to spend on the drug at any one time, ranging from under £5 to £40. Frequent non-dependent users within the study also placed limits on the amount of money they would spend and the amount of the drug they would use. Mention was also made among these frequent users of ensuring that they left a significant period of time between the occasions when they used heroin – presumably in order to avoid building up a tolerance to the drug thereby needing to increase the quantities of the drug they were using. Among the controlled dependent users, many of whom were consuming the drug on a daily basis, there again seemed a capacity to limit the quantity of the drug they were using to between 0.1 and 1 grams per day. Clearly, these individuals were at greatest risk of seeing their drug use escalate, however even among these individuals there was an evident ability to control their heroin consumption.

The obvious question following on from these accounts of controlled heroin use is how were these individuals able to avoid becoming chaotic dependent users? On the basis of their analysis of the interview data, the researchers identified a range of factors that seemed to be key:

- the pattern of heroin use and the environment in which the drug was used;
- the application of using rules;
- the nature of the individual's life and their commitments;
- the individual's access to heroin;
- the individual's attitudes towards their drug use;
- the individual's expectations regarding their drug use;
- the individual's previous experiences of using heroin;
- the influence of any external pressures upon their use.

In relation to the pattern of heroin use and the environment in which the drug was used, the researchers noted that their controlled users tended to limit the amounts of the drug they used, and they tended to use the drug in a routinised way in a regular situation at a regular time. The sorts of rules individuals used to control their heroin use could encompass such things as not buying heroin if they could not afford the drug, not using the drug for more than two consecutive days, buying a set amount of the drug rather than allowing the amounts they were purchasing to increase, and not injecting the drug. With regard to the individual's social situation and commitments, this could encompass demands arising from their employment or living circumstances. One of the individuals interviewed in this study commented, for example, that:

I work. I've got a flat to maintain and all the rest of it. I enjoy going out, I like to go out for meals and stuff, I like the nicer things in life and you can't do that if you're a full-time heroin addict.

(Non-dependent user; Warburton *et al.*, 2005b, p 35)

Another individual commented:

The life I've got at the moment, the job I'm doing, the career opportunities I've got, I won't mess it up, and the life I've got at home with my daughter ... I won't mess it up for anything.

(Non-dependent user, previously dependent; Warburton *et al.*, 2005b, p 35)

On the basis of these comments, there is the possibility that the individual's belief that their life circumstances will protect them from developing a pattern of chaotic heroin use may be somewhat over-optimistic. Nevertheless, there were clear indications that these individuals had been able to sustain a pattern of controlled use over a significant period of time.

A further element of these individuals' attempts at limiting their drug use involved ensuring that they kept their distance from their heroin supply. While addictive users often ensured that they had ready access to heroin in their immediate environment, the controlled users by contrast sought the opposite, often ensuring that they would need to travel considerable distances to source the heroin they were buying:

I make it as hard as possible ... I mean I have to make a couple of phone calls and then drive for an hour, so it puts out of my range. I don't want to know people in that scene on my front doorstep because that would make it all the harder for me ... so I try and keep it as far away as possible.

(Non-dependent user; Warburton *et al.*, 2005b, p 37)

It was also evident from the interviews that the individual's awareness of how heroin had affected the lives of others was a powerful corrective against their own inclination or otherwise to develop a pattern of more chaotic use:

I knew a couple of people who had died and stuff. .. I was always a little bit wary, I suppose I saw Phil [a friend with whom he used occasionally a number of years previously] in decline, a real huge decline. He got back into it and kind of disappeared off the scene and that's something that really sucks with me. I saw him a year and a half later and he was a right mess.

(Non-dependent user; Warburton *et al.*, 2005b, p 38)

The individuals participating in this study were asked about how they saw their own drug use. For the most part, respondents did not see their drug use as problematic. Some of the interviewees stressed, for example, that their drug use was not causing harm to those around them (they were not funding their drug use through crime). This did not mean that interviewees viewed their drug use as being entirely problem free. Over a third of respondents said that they felt that there were at least some occasions when their heroin use had caused them a problem. The sorts of problems mentioned tended to centre around the potential for their drug use to start to have a broader impact on their lives:

Being invited to go away with friends and not being able to do it because you need drugs or you need to inject.

(Non-dependent user, previously dependent; Warburton *et al.*, 2005b, p 47)

If you wake up in the morning and it's the first thing you think about.

(Non-dependent user, previously dependent; Warburton *et al.*, 2005b, p 47)

If the drug starts using me rather than me using it.

(Controlled dependent user; Warburton *et al.*, 2005b, p 47)

However, the researchers caution against viewing their findings as making the case that heroin is not a dangerous drug. Rather, they stress that the aim of their research was to flesh out our understanding of the impact of heroin on individuals' lives, recognising that the stereotype of the heroin

addict as someone whose entire life is focused on accessing and using the drug is just that – a stereotype.

In looking at the implications of their study, the researchers consider the possibility that drug treatment services might seek to encourage some heroin users to develop a pattern of more controlled heroin use. Parallels are drawn with the alcohol literature in which the concept of controlled drinking on the part of those who had been formerly dependent on alcohol has attained a certain prominence within the alcohol treatment world. The suggestion here is that individuals who are dependent on heroin, and who feel that it is impossible to become drug free, may be encouraged to develop a pattern of controlled heroin use as a more achievable goal. At the present time, it is not possible to say whether drug treatment services would be able to take up the challenge of working with even small numbers of dependent drug users and assisting them in establishing a pattern of more controlled heroin use. It is possible that such a treatment regime would require a level of monitoring that is beyond the scope of most community-based drug treatment services.

The study by Warburton and colleagues is challenging and innovative. Perhaps the key question the research gives rise to is whether, if interviewed at a later date, the respondents would have shown signs that their drug use was indeed starting to escalate and become more problematic? The importance of answering this question led the team to revisit as many of their original respondents as they could around two years after they had been initially interviewed. The researchers were able to successfully re-interview 32 of the original sample of 51 interviewees and found that most of those re-contacted had actually reduced, rather than escalated, their drug use: 14 respondents had ceased their heroin use entirely in the intervening period, seven had reduced their drug use, six had increased their drug use and five had maintained the same level of heroin use as they reported in the initial study.

In the case of those whose heroin use increased, the most common reason for this was the need to cope with personal difficulties in their life. One of the respondents outlined the increasing

stress associated with his troubled personal life with his partner:

I was having nightmares with her through that whole year and I just was literally, totally dependent on that, I just need to be off my face, It was as simple as that! You could draw a chart each day the amount that I've taken and then actually write my life, and my work life whatever, it would absolutely totally tally.

(Controlled dependent user; McSweeney Turbull (2007), p 7)

Other individuals described how their heroin use had increased as a result of the pattern of their drug use having moved from something they did as an occasional treat to something that they saw as functional within their overall life. In this sense, the drug had moved from something that occurred at the margins of these individuals' lives to become something that was much more central to what they were doing:

My use had increased because essentially I'm not getting the same kick I was when I first started. So I'm basically using heroin to function, to become normal. Just to get through everyday activities.... I do a lot of crack and then I become very nervous and I just don't feel comfortable and obviously to come down I use heroin.

(Controlled dependent user; McSweeney Turbull (2007), p 8)

With regard to those whose heroin use had reduced or ceased, the authors of this study identified three elements as being key within that process. These were reinterpreting the drug-using lifestyle, reconstructing a sense of self, and key events that had an impact on the individual's drug use. In terms of reinterpreting the drug-using lifestyle, one of the respondents described how she had simply become increasingly bored with drugs:

I just got really, really bored as well. It was just the same thing every day, went to work came home and started smoking basically and went to bed, got up again the next day

and nothing ever changed and I just got utterly fed up and really, really bored.

(Abstainer following a period of use;
McSweeney Turbull (2007), p 9)

Other respondents described a process of reconstructing their sense of self in which they felt they had matured out of their drug use. One respondent commented: "I think that I have come through some form of maturing process, which has been going on for a long time". Another respondent commented:

I suppose you could say just about the whole thing – I've matured. I'm getting older, I'm thinking about, to me, joining society. There's still that I don't want to, but I figure you've got to. So I've started a couple of college course, so it feels like I'm actually moving on.

(Abstainer following a period of use;
McSweeney Turbull (2007), p 11)

Aside from the cognitive changes in how individuals saw themselves and their drug use, it was also evident that changes in the individual's circumstances could also have a dramatic impact on their heroin use:

I had to fly back from Paris on the Tuesday, feeling like absolute crap and I'm supposedly across there as a consultant and it just kind of 'this isn't conducive' well you're supposed to be a consultant whose been flown across here at great expense and is getting paid for x amount of days, as time goes on, your job or whatever, gets more demanding or you've got more things to your life.

(Occasional user after a period of regular use; McSweeney Turbull (2007), p 12)

I've got a chance of a job in a couple of weeks time so I'm trying to do things to occupy my time. ... We're building a new life. That's what we're doing, I don't want to slip up. I don't want to. Not now I really don't.

(Abstainer after a period of use; McSweeney Turbull (2007), p 13)

It is clear from the users' accounts in this research that the pattern of their heroin use neither was fixed nor entailed a steady increase in the amounts of the drug they were using. Indeed, the reverse appeared to have been the case for many of those interviewed. But how did these individuals structure their drug use so as to avoid steadily increasing the amounts of heroin they were using as their tolerance began to build up?

The chief strategy through which this was achieved involved avoiding using heroin over two or three consecutive days, coupled with ensuring that the amounts of the drug used on those days did not increase:

*It will only always be the weekend.
Like a Saturday or a Sunday.*

(Frequent, non-dependent user; McSweeney Turbull (2007), p 17)

We tend to keep it to sort of infrequent and small amounts.

(Occasional non-dependent user; McSweeney Turbull (2007), p 18)

Other strategies for avoiding escalating their drug use involved ensuring their detachment from the local drug scene or drug contacts, thereby making their own access to heroin more difficult than it might otherwise be:

I have made it so that it's had to be a little bit difficult to get. And then if I've had the offer of a phone number, I've not taken it. Or in fact I remember a guy saying 'here's my phone number'. I put it into my phone and then immediately deleted it.

(Occasional non-dependent user; McSweeney Turbull (2007), p 18)

Some respondents described how having a stable job, or a stable set of non-drug-using friends, served to insulate them from the drug-using lifestyle and through that same process of insulation, enabled them to reduce the likelihood of their drug use escalating and becoming an increasingly central element of their life.

In setting out the various strategies by which these individuals sought to limit their heroin use,

the question immediately surfaces as to how vulnerable they remained even in the face of these various strategies. It is difficult to assess this on the basis of the relatively limited data collected in this study but what is evident is that none of the strategies employed by these individuals could ensure their immunity from developing a pattern of more frequent, non-controlled heroin use. Indeed, from the follow-up data, what is evident is the sheer volatility in individuals' drug-using lifestyles.

If one were to view these individuals (including those who had been using heroin in a controlled way for many years) as being in some sense vulnerable, to what extent are there services available that might reduce that vulnerability? The answer to that question takes one into the potential role of drug treatment services. Presently within the UK, drug abuse treatment services are principally focused on those who have developed a heroin habit and who are seeking treatment for their drug dependency (often along with a whole host of other problems). To the extent that many of the individuals in this study were not dependent on the drug and did not conform to the stereotype of the 'heroin addict', there is a real sense that they were simply outside of the experiential realm of most drug treatment services within the UK. It is perhaps understandable that many of the individuals interviewed in both the original study, and the follow-up study, were deeply mistrustful of the role of addiction services. They were concerned about compromising their anonymity in the event that they contacted services and they were acutely aware of the stigma that was often associated with those drug users who were in contact with support and treatment services. Commenting on why she would not even consider contacting treatment or support services, one of the respondents explained that for her:

It's just too risky for me to do that. I feel that the information could be used in a way that might not be beneficial to me: professionally, as a mother; in lots of different ways. I'm just very aware of how information is used having worked in that industry as well.

(Non-dependent user; McSweeney Turbull (2007), p 25)

Other drug users recounted past contacts with drug treatment and support services that had left them in no doubt that these were not services that they were intending to contact in the future:

They treat you like a child if you go and say you've got a problem with drugs. It's been a bad experience of mine, it's a very dehumanising experience basically.

(Occasional non-dependent user; McSweeney Turbull (2007), p 26)

The downsides of these perceptions are many and varied. First, for the individual there is the real possibility that they might not contact services at a point where their drug use is starting to get out of control. As a result, they may wait longer before contacting services, and witness significant growth in their drug use, before feeling that the time is right for them to make contact with such services. Equally, to the extent that drug treatment services are only contacted by individuals who have a well-developed dependency, the staff of those services will tend to have experience of working with long-term addicts and may fail to appreciate that there are alternative patterns and styles of heroin use and of recovery. Drug treatment and support services might be reduced in their effectiveness to the extent that the only individuals they see are those whose drug use has already become chaotic and dependent.

In the next section of this chapter we shift focus considerably from the world of controlled heroin use to address the question of heroin and cocaine users' contact with the police. This is a topic which, like controlled heroin use, has received remarkably little attention from researchers. As a result, relatively little is known about the experience of street policing in relation to problem drug use from the perspective of either the police or the drug users themselves. This area, however, was a focus of one of the key studies within the JRF Drugs Research Programme.

Street policing of problem drug users

Policing and enforcement have been key elements of the UK drug strategy from its inception. Within

both the current and previous drug strategies, the role of the police goes well beyond enforcement of the drug laws. There is a clear expectation within the drug strategy, for example, that the police have a role in enabling drug users to access treatment. As the authors of the JRF report on policing problem drug users point out (Lister *et al.*, 2008), this means that the police are often operating under somewhat contradictory requirements, that is, the requirement to both 'police' drug users and to ensure the provision of the necessary support to drug users. The research by Lister *et al.* from the University of Leeds demonstrated the tension between these two sets of expectations.

The research involved work in three contrasting police force areas with 45 police personnel and 62 problem drug users (mainly those using heroin and or crack cocaine) being interviewed. In addition, focus group interviews were carried out in each of the three sites with neighbourhood wardens and street wardens. Observational work was undertaken in each force area with a member of the research team accompanying police as they went about their work. The research team looked at such topics as the structure of drugs policing across the three areas, the nature of police encounters with drug users, and the views of officers and drug users of those encounters.

From the interviews with the police officers the research team were able to identify a number of distinct types of encounters between police officers and problem drug users at a street level. These encounters varied in terms of the degree of their planning, their formality and the extent to which they related to past offences or current offences committed by the individual. Informal, unplanned encounters between police officers and problem drug users were a regular occurrence within each of the study areas. Because of the rather static nature of both populations (police officers and drug users) within a local area, even the unplanned encounters had a rather well-worn and familiar feel to them. As one of the police officers interviewed explained:

These drug users, they're not suddenly in your life one day and gone and never to be seen again, they're there for years generally because they've nowhere to go.

So you get a bit of rapport with them: it makes my life easier and their life easier.

(Lister *et al.*, 2008, p 19)

As a result of the frequency with which officers were engaging with the same drug users over time, and building up a relationship with them, there was a clear concern on the part of the police officers to ensure that this did not result in a reduction of their perceived authority over the drug users. Police officers interviewed in this study were well aware of the potential dangers of building up too close a relationship with the drug users in their area while recognising at the same time that the successful policing of those areas necessitated some level of ongoing relationships with local drug users.

Other encounters between police officers and problem drug users on the streets, while informal and to an extent unplanned, often had a specific intelligence-gathering focus in which police officers and drug users would engage in a kind of informal negotiation over any current minor transgression in favour of information the individual might supply in regard to more serious offending taking place within the area. Equally, there were other encounters between police officers and drug users that were both more planned and more formal including 'stop-and-search' encounters.

With regard to the various encounters between police officers and problem drug users, it was important to draw a distinction between whether the individual was being interviewed informally (perhaps on the street) or whether the individual had been formally arrested and removed to the police station. According to the researchers on this study, it would be very unusual for an individual found to be carrying Class A drugs not to be arrested. The police officers explained the increased likelihood of arrest within such circumstances as involving both a concern that a perceived serious criminal offence had taken place (Class A drug possession), but also a concern that the individual involved might commit further offences. There was also a recognition that by arresting the individual they could then be directed towards treatment. Finally, there was also a clear sense that arresting an individual found in possession of Class A drugs was seen as a way of reassuring the wider community that drug abuse was being taken seriously:

You're under pressure from the public because it's getting more so that they know it's going on. They're getting told it's going on and they're seeing signs that it's going on so you have to be seen to be dealing with it.

(Frontline police officer, Lister *et al.*, 2008, p 23)

According to the research team, only a minority of police officers dissented from this view although many officers recognised that once the individual had been arrested they had much greater discretion as to what actually happened to the drug user, for example whether the individual was formally charged, cautioned or dealt with in an alternative way. One of the most common circumstances where such discretion was used had to do with situations where individuals had been found to be in possession of drug-related paraphernalia but where no drugs were found on the individual's person. At such times, police officers often felt that relatively little could be gained from formally arresting the individual.

It was clear from the interviews with the police that the nature of policing had changed in ways that had a direct bearing on police encounters with problem drug users. Increasing attention, for example, was being given to being seen to manage the local area. The police were routinely engaged in monitoring who was present within particular areas, what activities were deemed acceptable or not within those areas, and whether individuals needed to be moved on from one area to the next as a deliberate policing tactic. Observational work undertaken with the police demonstrated such an approach towards neighbourhood policing in action:

The officer decided to follow a white male in his early thirties who he identified as a known prolific shoplifter and drug user. The officer thought he may have come into the city to get his prescription and we pursued him from a distance for several minutes as he made his way across the city centre. We followed him until he reached the edge of the city centre, at which point the officer said 'when he leaves the city centre he can do what he wants'.

(Lister *et al.*, 2008, p 33)

As a result of the move towards policing territories, and local areas, Lister and colleagues suggest that rather less emphasis has been placed on either enforcement of the law or the reduction of drug-related harm. Instead, the police focus has switched to managing behaviours and populations in general within a fixed area. In managing the ecology of the local population, particular attention would be directed at those who were seen as involved in selling or using drugs within a given local area. These individuals would either be arrested or moved on depending on the situational priorities that applied at any one time.

If these were the views and experiences of serving police officers in the three areas studied, the views of the drug users themselves could hardly have been more different. In the main, drug users saw their dealings with the police in negative terms. As the researchers point out:

A few of the sample did relay stories about receiving help from the police, for example, where they had been encouraged to stop using drugs or put in touch with support agencies. But mostly they gained their experiences of street policing from encounters that they did not initiate and in which they were unwilling recipients of authority, whether covert or overt surveillance, cursory questioning or, more intrusively, the formal use of police powers. This meant that their experiences of policing were largely patterned by the coercive use of authority. As a consequence their interactions with police not only reflected a power imbalance but they were also usually framed by adversarial relations.

(Lister *et al.*, 2008, p 40)

As an example of the coercive exercise of police powers, drug users recounted how they were continually under the threat of surveillance. Sometimes this took the form of overtly watching what drug users were doing. At other times it involved directly confronting drug users about their activities, who they were seeing, what they were doing, where they were going and what they were carrying on their person. The two extremes of surveillance are evident in the examples below:

When I was using heavily you'd see them every day, they'd drive past dead slow, depending on the traffic. They eyeball you up, do you know what I mean, that might be their way of just saying we're here and we've got our eye on you.
(Lister et al., 2008, p 41)

'You'. 'Yeah' come over here, got anything on you?' 'No'. 'Any sharps on you?' 'No'. 'Can you empty your pockets?' This is in the street, you know everyday moving up and down, empty your pockets and onto the bonnet of the car or the sidewalk if they're walking. You know, they do a search. Where you been, who you been with, where have you just come from, where are you going. Questions like that 'When was the last time you used? Who are you scoring off?'
(Lister et al., 2008, p 41)

Many of the drug users who the research team interviewed felt that the intention of the police who they were in contact with was often to shame them by exposing their drug use to others. This was felt to be particularly evident in relation to the use of stop-and-search powers that tended to be used in public spaces in the full view of anybody who happened to be in the vicinity when the drug user was stopped. The drug users frequently felt a sense of grievance at what they saw as the tendency of the police to interact with them solely in terms of their drug use:

They look down at you and that, you're dirty, you're scum. A lot of coppers think you're scum and that. That's from my experience anyway through what I think anyway, through what I've been through with the police and that. And just you're scum if you've been on the gear or if you're on the gear.
(Lister et al., 2008, p 47)

Although problem drug users were considerably discomforted by the activities of the police, and felt threatened in some of the encounters with the police, this did not mean that they necessarily saw such encounters as a reason to stop using drugs. Rather, most of those who were interviewed viewed their difficult relations with the police as an occupational hazard of their drug use.

There are various ways, it is suggested, that encounters between the police and problem drug users could be enhanced. First, it is suggested that a greater proportion of these encounters could be used as opportunities for the police to pass on information that may be of assistance to drug users; for example, police could provide drug users with information on state benefits, housing issues and employment matters. It is not clear from the researchers' report how this greater 'pastoral' responsibility would be combined with the more traditional law enforcement role of the police. One imagines that for some officers such an extension of their role would be received with less than wholehearted enthusiasm. Second, it is suggested that within a context in which increasing emphasis is being placed on 'moving drug users on', greater attention could be directed at providing places where drug users could be moved on to. These might take the form of shelters or some other form of provision or indeed may encompass the provision of areas where drug users could use their drugs under some level of medical supervision (drug consumption rooms – see Chapter 5). Third, it is suggested that the increasing use of summary powers, whereby police officers can issue an on-the-spot fine to offenders, may well reduce the likelihood of drug users being referred for treatment as a result of the fact that such initiatives have been designed to reduce the depth of the individual's engagement with the criminal justice system.

Conclusion

In this chapter we have concentrated on the research within the JRF Drugs Research Programme focused specifically on problematic drug use. We have seen that studies within that programme have outlined the adverse impact of problem drug use on the individual, the family and the community. On the basis of the studies reviewed, there is no doubt as to the negative impact of Class A drug use at each of these levels. However, research within the programme has also shown that the problems often associated with Class A drug use may not be an inevitable outcome of the drug use itself. In particular, the research on controlled heroin use has shown that for some individuals it is possible to use heroin for a

protracted period of time (years) without necessarily progressing to a pattern of chaotic, dependent use. Finally, the research has shown something of the difficult relationship between the police and Class A drug users; a relationship in which the drug users are often seen as the source of multiple problems even when it is recognised that they are themselves on many occasions the recipients of those problems.

Class A drug users represent a challenge to society, however they are also individuals in great need of help and support. At present it is often not at all clear whether the thrust of services provided to problematic drug users is about helping the individuals involved or furthering their marginalisation from society. This is a tension that is perhaps more evident in the relationship between Class A drug users and the police but is by no means confined to the area of enforcement.

4 Impact on families and communities

Neil McKeganey

Introduction

For much of the last 40 years, the principal focus of political and public attention in relation to the UK drug problem has been on the individual drug user. During this time there has been a veritable explosion of policies, services and programmes aimed at supporting, treating, rehabilitating and punishing drug users as if these individuals existed within a state of near total isolation from the wider social context. Within the last few years, however, there has been a growing realisation that problem drug use and problem drug users can have a deep and enduring effect on a wide range of relationships. The policy journey from little or no awareness of the impact of drugs on families and communities to these issues becoming central concerns is perhaps most clearly illustrated in the two most recent UK national drug strategies. In the first of these, *Tackling Drugs to Build a Better Britain* (HM Government, 1998), there is not a single mention of the impact of parental drug use on parents or siblings and no commitment to either addressing the needs of children living within drug-dependent households or meeting the needs of drug-dependent parents. While the ‘community’ was identified as one of the four key pillars of the drug strategy (along with treatment, young people and enforcement), the key target set out under the community pillar was to reduce repeat offending. There was, then, very little understanding within the drug strategy of the multiple ways in which drug problems can impact on communities or indeed of the various ways in which communities themselves may respond to their local drug problems. By contrast, the awareness of the impact of drugs on families and communities and the need to target these areas could not have been clearer in the 2008 strategy. Their importance is clear from its title: *Drugs: Protecting Families and*

Communities (HM Government, 2008), which powerfully illustrates that drug policy within the UK has awoken to the realisation of the impact of illegal drug use beyond the individual drug user and on his or her wider family and social network. In her preface to the new drug strategy, the Home Secretary identifies the various ways in which the new strategy represents a development from the previous drug strategy. The new drug strategy she emphasises will:

focus more on families, addressing the needs of parents and children as individuals, as well as working with whole families to prevent drug use, reduce risk, and get people into treatment.
(HM Government, 2008, p 5)

The new strategy will also give:

a stronger role for communities, protecting them from the damage that drugs cause through strong enforcement action, using all available powers, sanctions and lever, giving them a voice and listening to their concerns.
(HM Government, 2008, p 5)

Exploring how relationships within the family and the community can be affected by problematic drug use, and how those relationships can in turn impact on the individual drug user, has been a strong theme within the JRF Drugs Research Programme. To this end, research has been undertaken on the impact of young people’s drug use on parents and siblings, on the impact of parental drug use on children and on the ways in which local communities can be influenced by their drug problems. In this chapter we look at each of these areas in turn.

The impact of drugs on the family

In 2003, the ACMD undertook the single, most detailed review ever carried out in the UK into the impact of parental drug use on children (ACMD, 2003). That review summarised a wealth of research on what is known about the ways in which drug-using parents can have an adverse impact on the lives of their children. The ACMD estimated that there may be between 205,300 and 298,900 children in England and Wales with a dependent drug-using parent. Large as that number is, the authors of the report point out that 'In the light of the assumptions we have made, we believe these are very conservative estimates and the true figure may well be higher (ACMD, 2003, p 25).

But what do we know about the impact of drug dependence on parenting and child welfare? We know that babies born to drug-dependent parents tend to be premature, to have a lower birth weight and to have a smaller head size (Abdel-Latif *et al.*, 2007). We know that as parents' drug use escalates, their capacity to parent young children reduces (Kandel, 1990), and we know that attachment, so crucial in children's development, can be adversely affected by parental drug dependency (Goodman *et al.*, 1999; Quinlivan and Evans, 2005; Savonlahti *et al.*, 2005; Eiden *et al.*, 2006). We know that children of drug-dependent parents are likely to be the subject of child protection proceedings (Street *et al.*, 2008), that children growing up in drug-dependent households are at increased risk of starting to use illegal drugs themselves (Biederman *et al.*, 2000, McKeganey *et al.*, 2004b). They are more likely than their peers to experience depression and other psychiatric and behavioural problems including Attention Deficit Hyperactivity Disorder (ADHD) at an early age (Linares *et al.*, 2006; Weissman *et al.*, 1999), to feel isolated and alone (Barnard and Barlow, 2003; Barnard, 2006) and to perform less well in school (Kolar *et al.*, 1994; Hogan and Higgins, 2001).

As the Hidden Harm report from the ACMD and other publications (Barnard and McKeganey, 2004) make clear, most of the research in this area relates to the US and concerns the impact of maternal drug use on children. As a result, we know much less about the impact of fathers' drug use or about the impact on children of having a drug-using

sibling. We also know very little about the relative impact of either leaving a child within a family where a parent is dependent on illegal drugs or removing the child to live with a relative or to be placed in care. Despite the serious gaps in our knowledge, social workers and other key staff each and every day of the year are making life-changing decisions as they seek to respond to the circumstances of increasing numbers of children growing up within drug-dependent households.

Exploring the impact of drug use on families was a key part of two of the studies undertaken within the JRF Drugs Research Programme. Through research undertaken by Marina Barnard at the University of Glasgow, and by Angus Bancroft and colleagues at the University of Edinburgh, it is possible to gain a detailed understanding of the profound impact of problematic drug use on families. In Barnard's (2005) case, her work involved interviewing both the parents of dependent drug users and the siblings of dependent drug users. The focus in this study was on the immediate impact of young people's drug use on parents and siblings. In the work of Angus Bancroft and colleagues, the focus was on young adults whose past childhoods had been disrupted as a result of their parent's drug and alcohol problems (Bancroft *et al.*, 2004). The key questions in this study were to do with how the young people had managed to cope with the impact of their parent's drug use and whether their childhood exposure to their parent's drug use was still having an impact on their adult life.

Together, these studies have shown that when problematic drug use occurs within families it can have a profound impact on all of those who are closely involved, straining relationships between parents and children and between siblings to breaking point and beyond:

Families were almost universally thrown into disarray by the discovery that one (or more) of their children had developed a problem with drugs. It is hard to overstate the shock and profound dismay that characterised the parents' and siblings' descriptions of this discovery. For most, if not all, families it was an event of such

deep significance that it completely and forever changed the family and its sense of itself.

(Barnard, 2005, p 7)

The initial reaction on the part of parents on finding out that their child had a serious drug problem was often to try to confine this new knowledge to the immediate family and to deal with the problem as an 'internal family matter'. The feelings of anger, sorrow, fear and guilt, however, were often so acute that it became evident to all concerned that they could simply not cope on their own with their child's drug use.

What was often evident in Barnard's interviews with parents was how little they actually knew or understood about the nature of their child's drug use or the driving compulsion that was associated with a well-developed heroin habit. The limits to parents' understanding was often very evident as they sought to tackle their child's drug use by limiting their freedom – even going so far, on occasion, as locking their child within the family home. At such times, the driving force of their child's drug dependency could become shatteringly evident to parents in the lengths their child would go to, to access the drugs they needed. One of the parents in Barnard's study described just such a situation:

She would smash up the room an all this to get out. One time we said 'Right we're gonnae lock the front door'. We should'nae need to do that. No mother should need to lock the front door on their kid but we were desperate.... And the next minute a lassie is shouting up 'Sonia, Sonia Mary has fell from the windae' She had got to one up and had fallen and she cracked a bit of her spine. She was in the hospital for about three or four weeks and then she was in crutches for another three or four weeks. She was very lucky and I could'nae get how she was dying to get out. This compulsion, she had, she wanted out that door.

(Barnard, 2005, p 8)

Although Barnard's research was a small qualitative study involving 24 problem drug users, 20 parents and 20 siblings, it was evident from this sample that the reactions of mothers and fathers to the

knowledge of their child's drug use could be very different, and further, that the difference in their reaction could severely strain relationships between parents:

The wife was wanting to keep them in and I was wanting tae fling them oot, ye know and me and her wid end up arguing. She wid stick up for them and I would be slaughterin them and saying naw they're no ye know and things were steadily going missing out the house....

(Barnard, 2005, p 6)

While many of the mothers in the Barnard study sought to try and keep their family intact, in many cases it seemed as if they were on a downward spiral, leading inevitably to family breakdown. Parents drew particular attention to the unimaginable strain of their child constantly stealing household items and personal possessions to pay for the drugs they needed. The parents also spoke about the pain of watching the physical changes in their child associated with their drug habit and the stress of having to cope with the violent mood swings that would often accompany drug withdrawal:

It wis terrible 'Watch her there, she's away in the room' I actually bought a double lock and put in on the room door and anything that was of real value ... I mean I was sitting one day and saying 'There's something different in this living room' and she stole ma big clock fae the mantelpiece. Do you know what ah mean? Everything went, all their games and all that. Bedding, curtains.

(Barnard, 2005, p 13)

Like she'd start screaming at you, you know, and calling you. I mean she said some very horrible names abusive things to you that you could hardly believe came out of her, you know things like 'I hope you die of cancer' and 'I hope you've got this or I hope you've got that'.

(Barnard, 2005, p 13)

I'm a prisoner in my own house. I'm frightened to go out in case he appears because he would knock ma door in to get in. I mean he's done it. Three of them it took to pull him away from

may door. One day he was determined he was getting in and I was trying to hold the door shut.
(Barnard, 2005, p 16)

Parents talked at length about how upsetting they found the constant badgering for money from their child and the fact that any money given to their child would inevitably be spent on drugs. Parents with more than one child gradually became aware of how much of their time and attention was being taken up with the drug-using child and how little they were engaging with their other children. This was a further source of anxiety underpinned by the fear that in the face of such neglect, one or more of their other children might also start to use drugs.

In Barnard's research, a number of the families had reached the point where their own survival in the face of their child's drug use could only be maintained by excluding the child from the family home. Parents spoke of that decision, when taken, as being a key moment in the history of their family's drug problem:

So he comes up the next night with Anna [girlfriend]. He comes up and the rain was pouring down and I mean absolutely pouring. He comes up to me about quarter to one in the morning, chapped us up out of our beds. I open the door and he goes to come in. I went 'you're no coming in'. Anna is about four months pregnant. 'I went you're not getting back in this house again'. I says 'I've got Donna and Dean (younger children) these two, their nerves are shattered', I says for the age of them and that was my turning point with Richard. See when I sent him away when I went to the window, the rain was pouring, Shane (my partner), he starts getting ready and gets his boots and he says 'I'm off to get him'. Because of the state I was in because I turned him away and I went 'Don't just leave him leave him'. And that's when I sort of gained respect from Richard.
(Barnard, 2005, p 16)

In reality, such exclusions tended to be more temporary than permanent as individuals sought to renegotiate the terms of their return to the family, often accompanying such negotiations with the promise to cease the drug use that had caused

the rift in the first place. Predictably, such promises would often come to be broken as the individual's drug habit resurfaced, leading to further anger and deeply felt recriminations on the part of those involved. In listening to the parents interviewed in Barnard's study, the overwhelming sense one has is of individuals struggling to cope with something that is simply beyond their emotional, financial, physical and spiritual capacity:

Me and Shona [wife] for ten years our life got kind of taken away from us. I felt that we were in a big hole, hanging on to the sides, and I think it was the helpless and the powerless stuff you know. I was powerless. In my whole life I was never fucking powerless. I was never powerless or helpless to deal with anything that came my way. One way or other I could deal with it. But I could'nae deal with this. I could'nae change it. I could'nae make it better.
(Barnard, 2005, p 9)

If the emotional impact of a child's drug use on a parent was often painfully clear in the interviews Barnard undertook for her research, the impact on any siblings was barely less evident. Traditionally, as Barnard has pointed out, siblings do not carry the same sense of responsibility for their brother or sister that is felt by parents. Nevertheless, in Barnard's study it was evident that siblings themselves paid an enormous price as a result of their brother or sister's drug use.

Many of the young people Barnard interviewed had a clear sense of what they regarded as a 'normal' brother and sister relationship and how far their relationship with their drug-using sibling had departed from that ideal. Young people spoke about their expectation that brothers and sisters would be interested in each other, that older siblings would look out for their younger brother or sister and would 'be there' for them. The siblings in Barnard's study spoke at length about the various ways in which they felt their relationship with their sibling had suffered as a result of the drug use. One of the sources of friction that surfaced repeatedly between siblings had to do with the constant theft of items from the family home:

There was a time I was going to Blackpool and I took all my money out. I was up and I got ready and all of my stuff was packed and ready to walk out the door and I went to get my money where I had hid it and it was gone! I was like ... and I'm in the car and all my friends are 'I'll give you money' I was like 'I can't go. So just go without me' And I searched this whole town and I couldn't find him but the time I did find him I had calmed down by then and I was like 'Look just stay out my face'.

(Barnard, 2005, p 13)

Even more upsetting than the theft of everyday items, money, clothes, food and decorations from the family home was the sense that their sibling was somehow no longer 'there for them' and interested in them. In their view, the sibling's drug use had robbed them of a relationship that in other circumstances would have been of enormous importance to them:

I just wish she would be like ... just be like a normal sister, an older sister. I'd like to have been able to go tae her with problems but I cannae dae it for some reason. I don't know how ... I think it's because really that Angela has got problem with the drugs and that and I don't want to hit her with other problem when she's got a problem of her own. I think it's that, I cannae be too sure.

(Barnard, 2005, p 20)

Some of the siblings interviewed in Barnard's study spoke at how upset they were at witnessing the impact of their drug-using brother and sister on their parents:

He was just total evil and he thought he was always right ... once an argument started he would never back down from it. Like even when my mum had ... he would go to my mum 'Shut up' and then it would get to the stage he would actually lose it shout and bawl. If my mum went like that 'Right just get oot the house' he would be 'ya fucking bitch' and know name calling and whatever.

(Barnard, 2005, p 20)

As traumatic as it clearly was for a parent to have a child develop a serious drug problem, it was evident from other research carried out within the programme that when the drug user was the parent, the problems could be even more acute. While within the UK over the last few years there has been greater attention directed at the impact of parental drug use on children (fuelled by the *Hidden Harm* report from the ACMD [2003] and the *Getting Our Priorities Right* report from the Scottish Executive [2003]), the bulk of the research that has been carried out on the impact of parental drug use on children relates to the US. Most of this research is focused on the impact of maternal drug use on children. As a result, we know much less about the impact of fathers' drug use on children or about the impact on children of living in homes where both parents have a drug dependency problem.

Within the JRF Drugs Research Programme, the longer-term impact of parental drug use on children was explored through research carried out by Angus Bancroft and colleagues in the Centre for Research on Families and Relationships at the University of Edinburgh (Bancroft *et al.*, 2004). In their qualitative study, Bancroft *et al.* interviewed 37 young people aged 15 to 27 about what they felt had been the impact of having had a drug-dependent parent for much of their early childhood and in particular whether they felt that this experience had influenced their lives well into and in some cases beyond their teenage years. The researchers on this study were particularly interested in what the young people had to say about how they had coped with the trauma of having a parent dependent on drugs or alcohol.

It was evident from the interviews with the young people that all of them had found the experience of living with a parent with a substance dependency problem to be enormously upsetting. They spoke at length about how they felt their own childhoods had been affected as a result of their parent's drug use. There were accounts from the children of serious neglect, of violence and of children having to take on quasi adult roles in looking after younger siblings:

My dad was injecting, that eh and he used tae batter my mum. He used tae batter me. My brother it was just at the time me and my

wee brother and we used tae get battered. And there was a time my dad battered me and battered my mum and I actually took tae go to court. But I cannae remember because when I was younger my dad was intae drugs and he used to beat us. He used tae batter us, beat us up whatever you want take call it.

(Child of a heroin-dependent father; Bancroft *et al.*, 2004, p 8)

It was clear from the interviews that the young people were often anxious about how people outside of their family might react to the knowledge that their mother or father had a serious drug problem. They talked about trying to limit other people's knowledge of what was happening within their family and of the embarrassment they would feel when such knowledge leaked out:

When people see her in the street and she's out her head and that. That embarrasses me, people thinking, 'Well his mums a junkie.' You know because they're like that.

(Bancroft *et al.*, 2004, p 11)

Some of the young people interviewed had sought to tackle their parents' drug use head on, for example by challenging the parent to cease their drug use or even going so far as to dispose of their parents' drugs. It was clear from what they said, however, that such tactics could seriously backfire on the young person:

And he was that 'Where's my bag of kit (heroin)?' and a that. And I says 'It's down the toilet. And he says 'Right I'm gonna batter' He battered me for doing that.

(Bancroft *et al.*, 2004, p 16)

The young people interviewed in Bancroft's study often found themselves protecting their younger siblings from the trauma and, on occasion, the violence associated with their parents' drug use:

I need to keep (younger sister) out of the way. I kept her in the bedroom, put a video on and things like that.

(Bancroft *et al.*, 2004, p 18)

Protecting younger children from the effects of their parents' drug use was often part of a wider blurring of responsibilities within the family as the young person took on a broader caring role in order to compensate for the neglect of their drug-using parent. This could involve feeding and generally looking after younger siblings:

It's like I'm used tae doing all the tidying and the cooking and like telling [siblings] when to be in and who no tae hang about with and where not to go. And my mum's started doing that and it's like a kind of conflict between us now because she like saying 'you're 17 and I'm the mum'.

(Bancroft *et al.*, 2004, p 10)

Although school could offer some sort of temporary respite from the chaos of their home lives, it was evident that on many occasions what was happening in the young person's family home could severely disrupt their education – with absences from school, failure to complete homework, and disciplinary problems all combining to make the experience of school a far from positive one. Among the young men in particular there were accounts of suspensions and exclusions revealing a tale of highly troubled times in school.

In some ways, the failure of schools to consistently support young people growing up within a family where one or both parents had a serious drug problem was part of a wider failure on the part of services to consistently support these young people. Perhaps in part as a result of having to cope on their own, it was evident that many young people had experienced difficulty in building up longer-term, supportive relationships with others. There were, for example, clear signs that many of the young people interviewed in the Edinburgh study had found it difficult to tell other people about their disrupted childhood, not knowing how these others would react to that knowledge:

Like if I've got a problem and I'm depressed my youth worker will come up and say 'Are you alright', 'Aye whats the matter?' 'Do you want to talk about it' And I'll say 'Nah right now, Bye' and that's the end of it.

(Bancroft *et al.*, 2004, p 23)

For many of these young people, there was a sense that they had had to cope on their own with the stresses and strains of living with a parent with a drug problem. Respite from those difficulties would often only come about once the young person had left the family home. One of the respondents in the Bancroft study spoke about the level of calm he was able to experience once he had his own flat:

I've got my own space and no one around, no one banging on my door like at the hostel asking me if I want drugs. So I can sit in my flat and no-one can come in and pester me.

(Bancroft *et al.*, 2004, p 30)

As Bancroft and colleagues point out, building an independent life was no easy matter for many of the young people interviewed in their study. These were relationships that often carried the imprint of their early childhood exposure to parental drug use well into their own teens and beyond into their early adult life. It was evident from the Bancroft study that services often struggled to identify let alone support these young people.

On the basis of both the Barnard study and the Bancroft *et al.* study, there is clear evidence that drug use can have a profound effect on families, indeed the repercussions of an individual's drug use reverberate throughout the entire family rather than being confined to the individual drug user. And yet for the most part, services have largely ignored that wider impact in focusing attention on the individual with the drug problem. In relation to providing support to the siblings, there was often very little that services had to offer:

Siblings were not, however, prominent in their (service provider's) concerns. Where they were considered at all it was most likely to be in terms of the supportive role they could play.

(Barnard, 2005, p 36)

Typically, where drug service professionals spoke about the wider family, in the interviews which Barnard undertook, it tended to be in terms of the family providing support rather than actually needing support in and of itself. This view of the family, which Barnard saw as being widely held among professional workers, contrasted with the

view of those staff working within family support groups. Within these groups the predominant focus tended to be on the family itself as being in need of support. Such groups tended to involve mothers rather than fathers and were often contacted by family members at the point at which relatives had reached the end of the road with regard to their own attempts to cope with the drug problem within their family. While such groups were able to provide parents with some level of support, even that was largely not available for siblings. Indeed, very few of the services that Barnard contacted had even considered the possibility that siblings might be in need of support. As Barnard points out, one of the difficulties faced by families coping with a member's drug use is the opportunity of being able to access support without publicly identifying the fact of their family member's drug use. In the case of siblings, there was the added complexity of the need to find a way of supporting siblings without requiring those siblings to publicly state that they were being adversely affected by their relative's drug use. The answer to this conundrum seemed to lie in the potential of more generic than specialist services which could be accessed by siblings without their feeling labelled as being 'in need' as a result. Although family support groups were one of the services that Barnard felt might potentially be more widely used, she was cautious in recommending this on the basis of how little is actually known about the operation of such groups, what their potential uses might be, what kind of support they can provide and where their weaknesses might lie.

While there was very little indication of siblings being identified by service providers as being in need of support, this was not the case in relation to those drug users who were parents and whose drug use was undermining their parenting role. Over the last few years there has been a growing awareness of the impact of parental drug use on children and the need to ensure that drug-using parents can access appropriate support services. Again, however, there has been much less of a development of services for the children of drug-dependent parents. Nevertheless, it is clear that a wide range of services could potentially help young people in these circumstances. In the case of schools, for example, Bancroft and colleagues found that many of the young

people enjoyed playing sport and taking part in various the activities associated with the school. School provided the young people both with an opportunity for developing relationships with their peer group as well as some respite from the difficult circumstances within which they were living. Among some of the young men interviewed in this study, however, it was evident that they had found it difficult leaving their home life behind when they were in school and that their school work and involvement in school-based activities had suffered as a result of their home life. This would suggest then that schools could perhaps do more by way of supporting young people whose parents have a drug problem. Again, however, the danger of labelling some young people as living within difficult families would have to be stressed. Schools, as other services, need to find a way of helping such young people without their having to publicly declare their home circumstances.

In the case of social workers, there was a feeling among some of the young people interviewed that it was important for the staff to take the time to build up a relationship of trust with the young people and not to force them to speak about their home circumstances before they were ready. What was evident from the Bancroft study was the fact that the impact of family drug use is likely to persist well beyond the teenage years and after the young person may have left the parental home. As Bancroft *et al.* point out:

Building an independent life was no easy trajectory for most of these young people, and their accounts suggest no sense of a gradual transition to adulthood, many had experienced a foreshortened childhood through the taking on of caring responsibilities and learning to look after themselves. Role reversal between parent and child itself was sometimes described as making the transition to independent living difficult as concern was still felt for the parent left behind.

(Bancroft *et al.*, 2004, p 36)

It is important that services become more aware of the impact of parental drug use on children and the needs of those children. Equally, it is important that services listen to young people as

they articulate their needs rather than assume that these are already sufficiently well understood to confidently frame interventions of various different kinds. Moreover, it is important that services are able to work with the wider kinship network surrounding young people especially where these are already providing a supportive structure for the young person involved. Beyond the existing kin relationships there is a need for services to enable young people to develop supportive relationships outside of the family home with youth cafes and carers' groups being particularly valued by the young people.

The impact of drugs on the wider community

Although it was clear from the research undertaken by Barnard and by Bancroft and colleagues that drug problems could have a dramatic and lasting impact on the wider set of family relationships, it was clear from other research undertaken as part of the JRF Drugs Research Programme that illegal drug use could also have a dramatic impact on the wider set of relationships throughout a local community. The impact of drug problems on local communities, and the ways in which local communities could respond to drug problems, was a topic explored both by Tiggey May and colleagues (May *et al.*, 2005) and by Mike Shiner and colleagues (Shiner *et al.*, 2004).

The principal aim of the study undertaken by May and colleagues was to explore the nature of drug dealing within communities and to examine the impact of such dealing on communities. As the authors of this study point out:

Retail markets for illicit drugs can create intense problems for communities. They can contribute to a pervasive sense of insecurity, and may trigger spirals of social and economic decline in deprived areas that already enjoy limited social capital.

(May *et al.*, 2005, p 11)

As May and colleagues point out, the relationship between local drug dealing markets and the surrounding community has been rarely studied. While there is a predominant view that drug dealing

is carried out by people external to a community, May and colleagues found that drug markets and drug-dealing activities differed greatly in the degree to which they were embedded within local communities. The research undertaken by May and colleagues was carried out within four, contrasting, locations where drug dealing was occurring and involved a combination of face-to-face interviews with 68 people who were involved in drug selling, 60 police officers and 64 other professionals, and 800 street interviews spread across the four locations. Among other things, the research looked at the relationship between local communities and their local drug-dealing markets. The diversity in the relationship between the drug-dealing markets and their surrounding community is very evident within the following two contrasting examples taken from the research:

Drug selling in Byrne Valley was based around clusters of structured top down hierarchies controlled by small handfuls of wholesale suppliers. Most respondents stated that selling was controlled by local families and friendship groups and generally reflected the wider social community. The market was described by some as a 'closed shop' in terms of setting up to sell. Outsiders were not welcome and undoubtedly would either be asked to stop selling or else made to sell probably as a runner for the established sellers. Although four of our (drug selling) respondents had lived in the area for less than five years, there was a general perception from interviewees that all drug sellers were born and bred in the area.

(May et al., 2005, p 11)

The description of this drug-dealing market was very different to one of the other areas the research team studied, in which the market:

appeared to operate along the lines of free market principles – anyone could come into the market and sell, as long as they followed the unwritten etiquette of dealing. Both the professional respondents and the sellers we spoke to stated that, with the introduction of new sellers, market dynamics had changed considerably. The new

sellers were viewed as more business like in their approach. Their style of selling was reported, by some, to be more aggressive and open compared to the local dealers.

(May et al., 2005, p 14)

Many of the drug dealers interviewed had experienced troubled childhoods, with over half having spent time within a children's home, a foster family or a secure unit. Over half had been excluded from school and half had left school with no formal qualifications. Many of the dealers had spent time within a Young Offenders Institution. When these drug dealers were asked why they had started to sell drugs, it was explained that in many instances the opportunity had arisen from either a close family member or friend. In this sense, one of the dynamics associated with drug selling was not a million miles from the impact of drug use within some families:

My dad was fed up of me hanging around the house doing nothing so I had to start dropping (delivering drugs) for him.

(May et al., 2005, p 19)

My partner was selling it first and I started helping him out. Then I took it on full time.

(May et al., 2005, p 19)

While individual's routes into drug selling were often seen to be through existing close relationships, the reasons why individuals persisted in such selling had much more to do with the limited opportunities to secure alternative employment or to make anything like the same amount of money from legitimate employment that they could make from drug dealing. One of the adverse effects of a local drug market was the opportunity that it opened up of attracting young people into a lifestyle that was cash rich and offered access to a level of personal purchasing that was beyond anything else they might otherwise have access to. In this respect, it is perhaps not surprising that in the areas May and colleagues studied there were many young people who were actively seeking to get involved in the world of drug dealing even to the point of offering their services for free in the hope that this would deliver them a substantial income in due course:

I have contact with a 12-year-old. It's better to have a 12-year-old running than a 17-year-old. The police won't do anything to a youngster. Young people are begging to work with some of the Yardies.

(May et al., 2005, p 23)

There's quite a few 14 and upwards involved in selling, they all work shifts. They are doing it when they should be at school. I don't know if they've been kicked out or skipping but there's a lot of them.

(May et al., 2005, p 23)

A lot of them see the money. You know if you come from a single parent background and can't afford very much because you have six brothers and sisters and you can get an extra £150 a week you wouldn't say no you would probably say no to school. They're the runners.

(May et al., 2005, p 23)

The negative impact of local drug markets on local communities went well beyond the attractions of earning large amounts of cash. Many of the residents May and colleagues interviewed, described the experience of living close to areas that were being used for drug dealing. As well as feeling personally intimidated by the proximity of drug dealers, there were also feelings that such markets undermined the perceived quality of the area itself:

Drugs cause the decay of the area, with crime, prostitution and street robbery. The potential to commit crime increases.

(May et al., 2005, p 2)

They deal drugs outside my house.

(May et al., 2005, p 27)

They come to the doors selling things for drugs. They are always prowling for drugs.

(May et al., 2005, p 27)

Although the image contained within such quotes is of an external threat associated with the drugs trade, in fact, as May and colleagues were able to show, some of the drug-dealing markets were

very much part of the local community – involving people who had lived within the local community for many years. Other drug markets in other areas involved individuals who had no connection to the wider community and whose activities were seen as threatening the local area. While May and colleagues point to the various negative impacts of local drug-selling activities on the wider community, they also point out that such markets could be seen as having a positive impact on the surrounding community. For example, the presence of a drug-dealing market could mean the influx of substantial cash that would otherwise not occur as local drug dealers spent the money earned from their drug-selling activities. Similarly, it was claimed by some of those interviewed that the presence of a drug-dealing market could result in lower levels of other crimes as the drug sellers themselves sought to reduce the activities of other criminals that might attract unwanted police attention. Finally, the presence of a drug market could sustain a thriving market in stolen goods being transacted as a way of supporting a drug habit, one of the results of this being that local people had access to a level of consumer products at reduced prices that they might otherwise never be able to afford.

Aside from the claimed benefits associated with a local drug market, on the whole the sense across the various markets studied was one of the adverse impact associated with drug-selling activities. Key here in some areas was the propensity for violence that was often associated with drug selling:

[R]esidents in Midson Vale ... were to a large extent cowed by their concerns about violence. They felt particularly vulnerable to intimidation from drug sellers. Living near one of the dealing houses coupled with the threat of violence from sellers created a collective sense of powerlessness among the residents.

(May et al., 2005, p 38)

While May and colleagues observe that tough enforcement initiatives have a role to play in tackling local drug markets, they are at pains to point out that this is unlikely to be a long-term solution and may be associated itself with a number of unwelcome unintended consequences:

We have seen how action against the well embedded market ... succeeded in removing a cohort of local sellers. The vacuum thus created was filled by a new group of sellers who had fewer attachments to the area and who were less regulated by local pressures. They were more ready to take risks than their predecessors including the risks associated with the use of violence. And as the latter started returning to the area on release from prison, tensions between the two groups grew. At this point the costs to the community of the enforcement strategy seemed to some residents to have outweighed any benefits. Sellers who were locally known and were to some extent responsive to local pressures had been replaced by more violent more criminally entrenched risk takers with little or no attachment to the area; and the two groups were now engaged in a turf war.

(May *et al.*, 2005, p 44)

In preference to tough enforcement tactics, May and colleagues favour a range of more holistic approaches that are aimed at increasing the social capital within an area and trying, through those means, to break the link that may have evolved between a community and the local drug market. Key within such initiatives is likely to be a process of genuine community consultation, including input from local housing management, to ensure that areas are able to develop a diverse range of accommodation rather than a proliferation of one- and two-bedroom properties. It is also important to ensure that properties are appropriately maintained along with innovative schemes aimed at helping drug sellers identify and realise other legitimate ways of earning an income.

Aside from the types of responses to local drug selling that May and colleagues propose, the broader topic of how and to what extent communities can respond to local drug problems was explored by Shiner and colleagues (2004). In their study, Shiner and colleagues surveyed a range of service providers about their views of community involvement and examined a number of community-based initiatives aimed at tackling local drug problems. As they point out, while the term 'community' has become something of a buzzword

in recent drug and alcohol policy, in fact there is considerable uncertainty in relation to almost every aspect of the term. For example, in discussing community responses to drug problems, there are a range of questions that come immediately to the fore, for example, how is a community to be defined, which sections of a community may be most engaged, what are the processes by which some sections of a community become engaged and how much power do community groups actually possess? To address some of these questions, Shiner and colleagues surveyed 155 professionals across 34 Drug Action Team areas in England. In addition, the research team studied specific community initiatives across four case study areas to see how those initiatives had developed and what enabled them to function.

From the survey of Drug Action Team professionals, it was evident that there were widely differing views as to the nature and impact of community-based initiatives. In terms of community consultation, for example, there was a widely held view among professionals that this was a valuable thing to do – an acceptance that communities should be consulted as to the sorts of schemes that may be implemented in their area. Aside from accepting the principle of community consultation however, professionals expressed concerns about the extent to which such consultation exercises truly reflected local opinions. There was a feeling that specific interest groups within the community could often exercise a disproportionate impact on such a consultation process:

A lot of the stuff on community involvement assumes that communities always want to do the right thing. A few people who stand up in a meeting and say we represent the community and I've seen this a lot with black groups and the more you think about it the more you think well who do you represent other than yourself – what is your constituency.

(Drug and alcohol service manager, quoted in Shiner *et al.*, 2004, p 9)

It was not only in terms of the representativeness of different voices that professionals expressed concern regarding community consultation initiatives. There was also a feeling that on occasion

communities could call for ineffective and punitive initiatives that reflected rather more their frustration with local problems than offered a credible way of tackling those problems. Vigilantism and the promotion of schemes that professionals knew from their own knowledge base would simply not work were both elements of the process of community consultation that needed to be avoided while at the same time retaining the good will and active involvement of community members:

I've had experiences where they've said this is definitely what we want and I know from experience and research that it's a really shite idea. The example was a group that wanted a drug rehab in the area for black and minority ethnic users but they wouldn't use it because they don't want to be seen as drug users and don't want to be known in their area. I'm for consultation and it shouldn't just ask and ignore what people say which happens a lot but there can be difficulties with it.

(Drug and alcohol service manager, quoted in Shiner *et al.*, 2004, p 9)

Professionals surveyed by Shiner and colleagues also differed markedly in their views as to the sorts of areas within which community initiatives might be most appropriate. For example, fundraising was typically seen by professionals as not something that should be the responsibility of the state, but rather something that overly involved community groups. By contrast managing and commissioning local services was seen as something that local services could have an intermediate role in shaping whereas local consultation was seen as the key area ripe for community involvement. Enforcement was also seen as an area that could contain particular problems for community groups given the risk that some groups' interest in involving themselves in enforcement initiatives could translate into a kind of vigilantism while other groups who in some circumstances could be seen to usefully act as the eyes and ears of the police could at the same time be seen by some member of their local community as being too close to the police.

On the basis of their case study work, Shiner and colleagues were able to identify a number

of typical roles that professionals were seen to occupy in working with and facilitating community initiatives. These included the role of 'ideas broker', 'nurturer' and 'sponsor'. However, irrespective of the types of role that professionals came to occupy, Shiner and colleagues were able to show that key to the success of community initiatives was a dynamic of trust and risk:

Issues of risk and trust are central to partnerships between professionals and the community. Power relations lie at the heart of these risks for both groups. Professionals risk losing power and influence, while communities risk being involved in ways which do not grant them power and influence (i.e. in ways that are tokenistic).

(Shiner *et al.*, 2004, p 44)

As a result of this dynamic, community initiatives are, according to Shiner and colleagues, a process of near-constant negotiation and review within which the success of an initiative depends almost entirely on the ability to successfully manage a range of competing and to some extent conflicting priorities. The important implications of Shiner and colleagues' analysis relate both to the process of community involvement and to its content. Accordingly, they suggest that the current criminal justice focus of much community involvement work is misplaced given that enforcement is one of the areas where there is least support for community-based responses. As an alternative, Shiner and colleagues suggest that the community pillar of the drug strategy should focus on developing initiatives aimed at increasing social cohesion and social integration. One such scheme would be to explore the possible use of restorative justice initiatives in which:

Those who are hurt by substance use are given a chance to explain their hurts and discuss the problems they would like to see solved. They are triggered when substance use becomes serious enough to cause real crime such as burglary, assault or drink-driving. Crimes that have a victim provide an opportunity for loved ones to confront the substance user's victimisation of themselves and the collateral

victimisation of their family. In other words a restorative strategy exploits criminalisation to challenge both the harms that results from substance use and the substance use itself.

(Shiner *et al.*, 2004, p 51)

At the present time, while it is clear that communities are both negatively impacted on by local drug markets, and can impact on those markets, much less is known about the kinds of community-type initiatives that need to be developed with an eye to enhancing local community resources. Shiner and colleagues caution that the rhetoric of community involvement can all too easily be taken up without any clear sense of how much one can expect a local community to achieve by way of tackling a local drug problem.

Conclusions

The research we have outlined here has been a strong part of the JRF Drug and Alcohol Research Programme in showing how drug problems can have a profound impact on families and local communities. While the UK drug strategy has a number of pillars – one of which relates to the community – in fact much of the attention to date has been on the individual drug user. As a result, there are relatively few services in the UK provided for the parents of dependent drug users, the siblings of dependent drug users or the children of dependent drug users. This represents a major gap in services, resulting in many instances of the parents, siblings and children of dependent drug users having to cope on their own with the impact of drug problems on their family. Similarly, there are very few schemes that are directed at tackling drug dealing in a holistic way, seeking to involve local communities in creating circumstances within which drug-selling activities can be separated off from their local community, or which seek to provide those involved in drug dealing with alternative sources of legitimate income. These are areas which in the future will need to be addressed if the drug problem itself is to be effectively tackled within the UK.

5 Innovative responses

Neil McKeganey and Charlie Lloyd

A key motivation behind the funding of the JRF Drugs Research Programme was the perceived need for independent research on drug issues. For that reason, it was decided to focus resources on some of the more controversial approaches to addressing drug problems that might otherwise not attract research attention. Literature reviews were funded on heroin prescription and drug testing in schools; and working groups were set up on drug testing in the workplace and drug consumption rooms. In this chapter, we look at the results from those reviews and enquiries.

Heroin prescription

Policy context

A range of treatment approaches exist for dependent heroin users, including detoxification, residential rehabilitation and substitute prescribing. The most commonly prescribed substitute drug in the UK is methadone, but alternatives include buprenorphine, dihydrocodeine and diamorphine (pharmaceutical heroin).

As the JRF review points out, the UK is internationally exceptional in including heroin prescription as one of a range of legally sanctioned treatments for opiate dependence (Stimson and Metrebian, 2003); and for having a long history of heroin prescribing going back to the 1920s. However, despite this history, heroin prescribing in the UK is rare, with only 448 users receiving a heroin prescription in 2000 (Metrebian *et al.*, 2002). Only doctors with a Home Office license are able to prescribe heroin and of those who do hold such a license, many are reluctant to prescribe. Heroin prescription has grown in a haphazard way: Stimson and Metrebian, writing in 2003, described the resulting situation as ‘inconsistent and arbitrary’.

In recent times, there have been attempts to revivify heroin prescribing in the UK. The Labour Government’s main drug policy thrust has been to reduce drug-related crime through treatment

delivered within – or through - the criminal justice system. As Stimson and Metrebian (2003, p 3) point out, ‘in the UK, prescribing heroin is seen – at least by the government – more as a way of reducing drug-related crime than as a public health strategy’. Providing dependent heroin users with the drug that they are committing crimes to pay for undoubtedly seemed a good way to short-cut the drug–crime circle. Four months after taking over from Jack Straw as Home Secretary in 2001, David Blunkett informed the Home Affairs Select Committee (2001) that the Department of Health and the Home Office ‘will be developing an expert group to advise us on an action plan which will include ... whether we should engage in highly structured heroin prescribing’. Shortly after this, the Home Affairs Committee began its inquiry into the government’s drug policy. The resulting report recommended that ‘a proper evaluation is conducted of diamorphine prescribing for heroin addiction in the UK ... as compared with methadone prescribing regimes’ (Home Affairs Select Committee, 2002, p 43).

The government response to this recommendation illustrated how heroin prescription had, by this stage, become a high priority, at least for the Home Office with its focus on crime reduction:

The Government is committed to ensuring that all those who could benefit from diamorphine on prescription will have access to it in the future. We do not believe the possibility of future research into the effectiveness or cost-effectiveness of diamorphine prescribing in the UK should delay availability of this as a treatment option now.

(UK Government, 2002, p 19)

However, there have been obstacles in the way of the Home Office’s mission to rapidly expand heroin prescription. As Stimson and Metrebian explain in their review, there was no great desire among the

medical profession to prescribe heroin. The Royal College of General Practitioners in its evidence to the Home Affairs Select Committee had stated its view that 'there would be no added value from general practitioners prescribing heroin to their patients' (Home Affairs Select Committee, 2002, vol iii, appendix II, paragraph 15). Moreover, the government's insistence that heroin prescription be available for all those who could benefit from it begged the question of who these people were.

As a result, the National Treatment Agency was charged with setting up an expert group to consider when and how heroin and other injectable substitutes should be used in the management of opioid dependence. The resulting guidance (National Treatment Agency, 2003) stated that prescription of injectables 'may be beneficial for a minority of heroin misusers' (p 3) and set out eight principles that should underlie such prescription, including that it 'must be supported by locally commissioned and provided mechanisms for supervised consumption' (p 4) and that it should be delivered by specialist doctors. This sets the bar very high and as Luty (2005, p 125) has pointed out, 'mainstream drug treatment services would find it very difficult to create an injectable service in line with current guidelines even if they wished to – which most do not'.

The guidance also included an implementation plan, which referred to national pilots for new types of injectable maintenance treatment that would be set up in accordance with the guidance. In 2005, the Randomised Injecting Opioid Treatment Trial (RIOTT) was initiated, which compares outcomes for heroin injectors randomly assigned to three conditions: prescribed heroin injection, methadone injection and optimised oral methadone (Lintzeris *et al.*, 2006). At time of writing, this study is still under way but the recent UK drug strategy *Drugs: Protecting Families and Communities* (HM Government, 2008) includes a government commitment to rolling out the prescription of injectable heroin and injectable methadone to those drug users who are not succeeding on other forms of drug abuse treatment, provided that the findings from the RIOTT trial support this (HM Government, 2008, p 30).

Effectiveness

Heroin prescription trials have been initiated in six countries – Canada, Germany, the Netherlands, Spain, Switzerland and the UK – and evaluations have been published in four of these countries (Fischer *et al.*, 2007). Reviews of the evidence (Stimson and Metrebian, 2003; Fischer *et al.*, 2007) have concluded that, while the evidence base is still quite weak, heroin prescription appears to be feasible and safe; successful in retaining high-risk heroin addicts who have previously failed to respond to conventional treatments; and associated with positive outcomes in terms of improvements in health and decreases in illicit drug use and crime. Recent research from the German trial has shown how improvements in mental and physical health, criminal activity and social integration have continued after two years of treatment (Verthein *et al.*, 2008) However, as Fischer *et al.* point out, each of the evaluations has had different methodologies, often reflecting the different treatment systems and policy environments in those countries. Thus, a judgement of the place and effectiveness of heroin prescription in the UK context must await the results of the RIOTT trial.

Issues

It is clear that prescribing heroin to dependent drug users is, and perhaps always will be, controversial. A number of the key doctors who have prescribed heroin in the past, for example, have faced General Medical Council inquiries into their prescribing behaviour. Indeed, one of the most significant individuals in the UK history of heroin prescribing was the London-based psychiatrist Lady Frankau who, in a single year, prescribed in excess of 300,000 diamorphine tablets to her private patients and was described by the Home Office Inspector Bing Spear as having contributed virtually single-handedly to creating London's heroin problem in the 1960s (Interdepartmental Committee on Drug Addiction, 1965). Other doctors within the UK have found that their decision to prescribe opiates has brought them unwelcome regulatory attention (for example, Dr Anne Daly had numerous brushes with the medical establishment over her views as to the benefits of prescribing heroin to patients; Dyer, 1987).

One of the key issues here relates to whether prescribing heroin to a heroin addict actually amounts to treatment in the normal sense of the word (McKeganey, 2008). It is perhaps understandable that the medical profession has not generally accepted the idea with open arms: it is hard to think of any other circumstances where doctors prescribe to their patients the very toxic substance that has led to their condition. However, as with other harm reduction approaches, such as needle and syringe exchange, which do not sit easily under the rubric of 'treatment', the central aim of heroin prescription is to reduce the harms and dangers surrounding drug use, rather than to cease the substance use itself.

Nevertheless, even if the immediate aims of heroin prescription are to reduce individual and social harms, many would have problems with the idea of permanently parking drug users on heroin prescriptions, whatever the harm reduction benefits. Such concerns about heroin prescription parallel those increasingly expressed about methadone maintenance. Around two-thirds of the 201,830 drug users in treatment in England are currently prescribed the drug (NTA, 2008b). Although research has shown that methadone prescription is an effective approach to reducing illegal opioid use, HIV risk, drug-related deaths and crime (NICE, 2007), concern has been growing in recent years as to whether methadone is a route to eventual abstinence or a lifelong medication. Much the same anxiety may be felt in relation to heroin prescribing – particularly as, unlike in the case of methadone, those prescribed heroin are being given their drug of choice rather than a frequently unpopular substitute.

What does the evidence show on users' ability to kick their prescribed heroin habits? The only long-term follow-up of users prescribed heroin has shown that, after six years, 12 per cent of a sample of 366 Swiss users were dead, 40 per cent were either still in heroin-assisted treatment (HAT) or back in HAT after a period not in HAT and 38 per cent had left HAT (Güttinger *et al.*, 2003). Of those successfully followed up in the last of these groups, 18 (16 per cent) reported themselves to be abstinent of opioids and cocaine. Thus, of the 244 users for whom there was information, just over 7 per cent were free of opioids and cocaine

six years after entering treatment. It is very difficult to compare these outcomes with other treatment approaches: researchers have rarely followed users up over a six-year period and the target group for the Swiss projects were undoubtedly high risk, being 'long-term opioid addicts who so far could not be integrated into other treatment programs....' (Güttinger *et al.*, 2003). As Fischer *et al.* (2007) point out, there is a need here for more long-term findings from the other trials.

An important, related question here is the degree to which heroin prescription can stabilise and reintegrate users into society. Abstinence from opioids is more likely to be achieved if a user has good health, a place to live, a job and relationships with a non-using partner and friends. There is some evidence that heroin prescription can lead to improvements in these factors (Güttinger *et al.*, 2003; Verthein *et al.*, 2008) but more evidence is needed here – including, critically, the results of the RIOTT trial.

There clearly does need to be some caution generally with regard to the policy of prescribing a highly addictive drug to individuals who have already demonstrated that they are dependent on the drug. The widespread prescribing of benzodiazepines in the 1970s in the UK was undertaken at the time with considerable reassurance on the part of the medical establishment that such an approach would not result in increasing levels of drug dependency. In due course, however, the widespread prescribing of benzodiazepines came to be seen as having contributed itself to the problem of benzodiazepine dependency in the UK and the reassurances from the medical establishment came to be seen as at best rather hollow (Lader, 1991).

There are other gaps in the available evidence in relation to heroin prescribing which in themselves are likely to lead to a degree of caution in the extent to which medical practitioners take up the political enthusiasm for heroin prescribing. For example, we still know relatively little about which drug users may benefit most from prescribing heroin. At the present time, the conventional thinking around heroin prescribing is that there may be around 5 per cent of drug users who would benefit from heroin prescribing as a result of their evident failure to respond positively to other forms of drug abuse

treatment. However, it is not at all clear what the 5 per cent figure itself is based on, given that research has shown that a much higher percentage of drug users being prescribed methadone are combining their medication with illicitly obtained street heroin (Bloor *et al.*, 2008). Targeting heroin prescribing on those who are failing to respond to methadone would conceivably then take one to a much larger group of drug users than the 5 per cent figure would suggest.

In addition to the uncertainties as to which drug users may benefit most from heroin prescribing, there may also be concerns that the wider acceptance of heroin prescribing might, in due course, lead to calls for other drugs of abuse to be provided to dependent drug users. At the present time, for example, there have been hardly any calls within the UK for doctors to prescribe cocaine to cocaine addicts. Nevertheless, there have been calls in other countries to develop cocaine prescribing schemes along similar lines to the heroin prescribing programmes. Such calls have recently been made in Switzerland although there is no sign at present that the Swiss government has accepted the case for cocaine prescribing programmes to be developed (Foulkes, 2004).

Conclusion

Heroin prescription represents a contentious approach to treatment. Many would question whether giving users the drug that they are addicted to constitutes 'treatment' in the normal sense of the word. As with any form of substitution therapy, there is also the question of whether users can be moved on from their drug use – perhaps the fact that users are being prescribed their drug of choice (rather than a frequently unpopular alternative) may mean that users will find it even more difficult to move on to abstinence. There is insufficient evidence to answer this latter concern. However, what the evidence base does indicate is that, in the short term, heroin prescription appears to be an effective way to retain users in treatment who have a history of failing in other treatment settings, with consequent benefits in terms of reduced drug use, crime and social reintegration.

Drug consumption rooms

Drug consumption rooms (DCRs) represent one of the most controversial responses to drug problems, providing a space for drug users to use illicitly obtained drugs in a supervised, hygienic environment. This distinguishes them from informal spaces for drug use, such as 'crack houses' and 'shooting galleries', where drugs may be purchased and used in an unsupervised and often unhygienic environment.

While it is difficult to be precise, there are around 65 DCRs operating worldwide. DCRs have been set up in Australia, Canada, Germany, Holland, Luxembourg, Norway, Spain and Switzerland. However, there are no DCRs operating in the UK.

Policy context

As well as recommending heroin prescription pilots, the Home Affairs Select Committee (2002) report on the government's drug policy also recommended that 'an evaluated pilot programme of safe injecting houses for [illicit] heroin users is established without delay and that if, as we expect, this is successful, the programme is extended across the country' (Home Affairs Select Committee, 2002, vol 1, p 44). However, this recommendation was rejected by the government on a number of grounds, including lack of evaluation evidence, cost, negative media reactions and dealing/public order problems in the vicinity of a DCR.

Given the increasing amount of evaluation evidence, including a major review from the European Monitoring Centre for Drugs and Drug Addiction, it was decided to set up an Independent Working Group (IWG) to consider the evidence and make recommendations on whether or not pilot projects should be set up in the UK. The IWG was chaired by Ruth Runciman and included among its members the-then chair of the ACPO Subcommittee on Drugs, three senior professors and a practising barrister. The group reviewed the evidence, commissioned new research where it was required, visited DCRs abroad and heard evidence from witnesses. In its report, which was published in 2006, the IWG concurred with the Home Affairs Select Committee report in

recommending the setting up of pilot DCRs. Moreover, the IWG recommended that, should government support not be forthcoming for the idea, projects could still be set up on the basis of local accords between the key agencies involved (IWG, 2006).

The IWG's report received considerable attention in the British media. Support for the IWG's recommendations was expressed from a number of quarters, including an editorial in *The Lancet*, referring to the first recommendation from the Home Affairs Select Committee: 'After 4 years, and thousands of needless drug-related deaths, a thorough trial of DCRs is a requirement the Government cannot afford to refuse a second time' (*The Lancet*, 2006, p 1792). However, the UK Government did refuse at the second time of asking. Referring to the earlier rejection of the Home Affairs Select Committee recommendation, Vernon Coaker, Parliamentary Under Secretary at the Home Office, responded thus on live television: 'The reasons for rejecting it in 2002 are as valid today – the risk of an increase in localised dealing, anti-social behaviour and acquisitive crime'. In fact, acquisitive crime had not been one of the grounds for rejecting the idea in 2002 and this hurried response may well reflect the particularly troubled times at the Home Office.

The IWG report came out at a very inauspicious time. The Labour Party had recently suffered heavy losses in local elections, the prisoner deportation scandal was at its zenith and the newly arrived Home Secretary, John Reid, had already described some parts of the Home Office as 'not fit for purpose'. So the timing of the IWG's report could not have been worse with regard to getting a considered response from the government on a very sensitive issue. Nevertheless, while obtaining the support of government for pilots was the IWG's preferred option, it also recommended that, should such support not be forthcoming, DCRs could be set up through local accords between the key local agencies (including the police). Since the IWG report's publication, there have been a number of local initiatives to set up DCRs in this way. To date, none of these initiatives has actually resulted in a pilot project but developments continue.

Another important recommendation from the IWG report was that a set of minimum standards

should be drawn up governing the behaviour of users and staff within a DCR. The IWG was concerned that, having made the recommendation that local projects could be set up through local accords and given the legal and physical safety issues surrounding such projects, local areas should be given guidance on how to set up a DCR safely. This guidance has now been published (Hunt, 2008).

Effectiveness

Evidence of effectiveness comes, inevitably, from abroad. The evaluation literature was reviewed in detail by the IWG (IWG, 2006) and the conclusions are only briefly referred to here, together with one or two further pieces of evidence.

The IWG concluded that some of the serious harms associated with drug use in the UK, such as public injecting (and discarded needles), drug-related deaths, blood-borne viruses and injection-related infections, could be addressed by DCRs, were they to be effective. Furthermore, the available evidence suggested that well-run DCRs had proved effective in reducing these problems in the towns and cities where they had been set up. Since the publication of the report, there has also been further evidence that DCRs can be a successful gateway to treatment (Wood *et al.*, 2007) and reduce ambulance call-outs for drug overdoses (Salmon *et al.*, 2010).

Heroin prescription vs DCRs

It is interesting to compare the policy contexts with regard to these two approaches – both of which have been attacked in the British media and, to some extent, confused with one another. Over the past eight years, heroin prescription has been seen by a number of key people within government as an important way to decrease drug-related crime, the assumption being that if you can provide the pharmaceutical drug for free, there will be no need for users to commit offences in order to pay for their illicit drugs. However, the Home Office-led desire to expand such provision has hit the buffers of a medical establishment that is sceptical of the worth and practicability of this approach. While heroin prescription promises much with regard to tackling heroin dependence as a social problem, it may

offer less as a cost-effective way to tackle heroin dependence as a medical problem.

By contrast, DCRs do not hold the same attraction for a government intent on reducing drug-related crime. Their impacts are primarily on the health side: in terms of reducing drug-related deaths and blood-borne viruses, improving the health of users and getting users into treatment. There is no immediate crime impact in terms of reducing the need for users to commit crime to pay for their drugs. DCRs therefore appeal to those looking at drug dependence through the lens of public health.

Given this, it is unsurprising that heroin prescription has been embraced within a drug policy environment where the Home Office has held sway (see Chapter 1); and unsurprising too, that DCRs have not found favour.

Competing approaches?

Supervised consumption is a shared feature of DCRs, and heroin prescription as envisaged by the NTA (2003) guidance. However, the client group is likely to be very different. While DCRs are primarily focused on excluded users who are often homeless and out of contact with treatment services, injectable heroin/methadone is recommended for those who have failed to respond to optimised oral methadone and are willing to comply with certain conditions such as regular supervision and monitoring and avoidance of injecting in high-risk areas such as the neck or groin.

In cities where both DCRs and heroin prescription are provided (such as Frankfurt and Rotterdam), there appears to be a clear differentiation between client groups. Users are expected to reach a certain level of stability before they can be considered for a heroin prescription.

The future

The current English drug strategy (*Drugs: Protecting Families and Communities*; HM Government, 2008) undertakes to roll out the prescription of injectable heroin and methadone to clients who do not respond to other forms of treatment, subject to the RIOTT findings. A potential stumbling block here will be resources. Given the high cost of diamorphine and supervised consumption, it is difficult to

envisage widespread take-up without additional money.

The IWG's recommendations on DCRs have been supported by a number of bodies and inquiries, including the Royal Society for the encouragement of Arts, Manufactures and Commerce (RSA) drug policy report (RSA, 2007). However, the Home Office continues to resist calls for nationally supported DCR pilots. The most likely development is therefore for one or more local areas to set up pilot projects on the basis of local accords between the key agencies.

Random drug testing at work and at school

For the most part, our knowledge of the extent of illegal drug use within the UK (and elsewhere) consists in asking people in various different contexts whether they have used a number of listed drugs and then reporting, in aggregate form, the answers they provided. That simple question-and-answer model in a nutshell sums up our accumulated knowledge of the extent of drug use among school pupils, college students, employees and other social groups. Within the last few years, however, the reliance on 'self-report' to understand the extent of illegal drug use has changed dramatically with the proliferation of various methods of drug testing. At the present time, along with blood and urine, it is possible to analyse hair, sweat, oral fluid and nail clippings for empirical evidence of drug consumption over the last few hours, days, weeks or, in the case of hair samples, months.

The testing of bodily matter for the presence of banned substances has become commonplace in the field of elite sport, with cases of high-profile sporting stars failing a drug test becoming a staple of the tabloid press. If there is one thing that such 'sports star fails drug test' stories tell us it is that drug testing is a long way from being a simple, straightforward and uncontested process. Within the last few years, drug testing has moved from the sports arena into the workplace, with an increasing number of employers now using, or considering using, drug testing as a way of establishing whether members of their workforce have used illegal drugs.

Drug testing at work

As part of the JRF Drugs Research Programme, an independent inquiry was set up to consider in detail the issue of workplace drug testing. The inquiry ran over a two-year period and represents the most detailed investigation of drug testing in the workplace ever undertaken within the UK. In addition to reviewing a wide range of official documents, the inquiry examined a wealth of written and verbal evidence, initiated a number of reviews in key areas and supported small-scale research projects aimed at clarifying how widespread drug testing was among employers. The inquiry team involved individuals from the worlds of occupational health, business, academia, medicine, drug treatment, civil liberties and public policy. The aims of the inquiry were:

- to examine the nature and extent of workplace drug testing;
- to consider the science of drug testing;
- to look at the consequences and implications of drug testing in the workplace;
- to look at the legal and statutory framework surrounding drug testing;
- to make recommendations regarding the use of workplace drug testing.

While there is little information on the extent of workforce drug testing in the UK, there are indications that drug testing has increased significantly over the last few years. To get some measure of the breadth of workplace drug testing, the inquiry team initiated two small-scale studies. First, a MORI poll of over 200 companies undertaken for the inquiry identified that 4 per cent of the firms surveyed were currently drug testing employees and 9 per cent were considering introducing drug testing over the next year. On the basis of this survey, drug testing of employees would appear to involve only a minority of firms. It is important to stress though that even if only 9 per cent of firms in the UK were to move towards drug testing their employees, that small percentage would still mean that hundreds of thousands of

employees were being drug tested on at least an occasional basis. The findings of this survey, however, were somewhat overshadowed by the findings of a second smaller survey distributed by the CBI to its Health and Safety panel. This survey found that nearly one-third (30 per cent) of companies were drug testing their staff and a further 12 per cent reported that they were considering introducing drug testing in the next year. In the light of these two small-scale studies, it is difficult to establish with any clarity just how extensive drug testing of employees actually is within the UK although what is beyond doubt is the fact that such testing has now extended well beyond the safety-critical areas of employment in which it began.

In considering the evidence for and against drug testing, the inquiry drew attention to the influence of the commercial sector in shaping views as to the worth of drug testing employees. Those companies that provide drug testing services have, as the inquiry pointed out, a clear vested interest in promoting the idea that drug testing itself is an important tool in reducing the adverse impact of drug use on task (work) performance. While it is difficult to get a sense of the scale of the financial interest on the part of drug testing companies, the inquiry reports that one drug testing company has an estimated annual turnover of around £50 million conducting in excess of 175,000 workplace drug tests a year. In considering the broader value of drug testing, the inquiry drew attention to the distinction between testing whether an individual has used a particular substance and testing whether the individual's performance at work has been impaired as a result of that drug use. The inquiry underlined the importance of avoiding drawing a simple equation between drug consumption and reduced performance at work. While drug testing can, with increasing accuracy, report what drugs an individual has consumed over a given time period, it cannot presently reveal the extent of the impairment associated with that level of drug consumption. A naïve user of cannabis, for example, experiences a greater effect associated with a small dose of the drug than an experienced user consuming the same amount of the drug. Most of the drug tests that are presently available (with the exception of hair

testing) would not be able to distinguish whether the individual had used cannabis on many occasions over a protracted period or whether the cannabis had been consumed recently but rarely. Further, while the drug testing companies have cited the growing level of drug use in society as one of the reasons for testing employees, in fact there may be greater levels of impairment associated with alcohol consumption than the consumption of illegal drugs. In summing up the evidence on the impact of drug testing on individual's drug use for the Independent Inquiry, Coomber noted that:

The evidence for clear-cut deleterious effects of drug use on business is equivocal. What is less so is the belief by the business sector of the harm that drug use and alcohol consumption in particular causes to the British industry.

(Coomber, quoted in JRF, 2004)

The inquiry team looked in detail at such areas as the accuracy of drug testing, the cost of drug testing and the practicalities of testing. They also considered some of the legal and ethical difficulties associated with drug testing. With regard to the accuracy of drug testing, the inquiry noted the potential for both false positive and false negative test results. In relation to the former, an individual could test positive for a particular substance without in fact having used the drug in question. In the case of an opiate screen, for example, there are some over-the-counter remedies that can produce a positive test result. Similarly, there will be occasions when a negative test result will be produced even though the individual has indeed used one of the drugs being tested for. In this instance, the false negative may occur as a result of the individual using another substance that can limit the capacity of the drug test to identify the full range of substances an individual may have consumed. Although there is little information on the use of such masking agents, the internet has seen a growth both in the availability of these substances and in the sharing of information on how such drug tests may be circumvented.

Drug testing employees gives rise to many more problems than those to do with the nature of the drug test itself. It is far from clear whether employers have the right to use testing to enquire

into an individual's private life. The inquiry team cautions employers over taking on a quasi 'police role' in relation to obtaining information on how their employees spend their free time. Certainly, drug testing has the capacity to break down the barrier between private life and work-related life that many of us hold to be very important. With regard to the law surrounding the drug testing of employees, the inquiry also found that this was not at all clear cut. The inquiry team accepted, for example, that an employer dismissing a member of staff who tested positive for illegal drug use would probably not have that judgement overturned in the event that the individual sought redress through an industrial tribunal. At the same time, the inquiry pointed out that it is not at all clear that employee drug testing is congruent with the European Human Rights legislation, particularly as this relates to the importance of protecting an individual's privacy:

What is clear is that drug testing raises fundamental issues for law and ethics ... this is a legally and ethically controversial area, which is likely to generate many future cases for the consideration of employment tribunals and law courts because of the tensions between the interests of employers and employees.

(JRF, 2004, p 17/18)

While the inquiry team could see a role for employee drug testing within safety-critical areas (although even here they were far from convinced that such drug testing was effective), there was deep scepticism as to the value of such testing more broadly. Indeed, the inquiry team noted that 'For the most part, it is unclear that anything can be achieved through drug and alcohol testing that could not be done better through other managerial and supervisory processes' (JRF, 2004, p 70).

In conclusion, the inquiry expressed considerable concern at the use of drug testing within the UK and recommended that drug testing should only occur where there is a demonstrable benefit associated with testing. The inquiry team also stressed that drug testing should never be imposed on employees.

Drug testing at school

In February 2004, Prime Minister Tony Blair, in an interview with the *News of the World*, announced his support for randomly drug testing pupils in UK schools: 'We cannot force them to do it but if heads believe they have a problem in their schools then they should be able to use random drug testing'. That statement echoed similar support for drug testing from the US President George W. Bush who, in his 2004 State of the Union address, allocated in excess of 23 million dollars to support drug testing within US schools.

To complement the inquiry on drug testing in the workplace, the JRF funded a review of the evidence for and against drug testing UK schoolchildren (McKeganey, 2005). The review looked in detail at the UK guidance on drug testing from the Department of Education, at the assumptions underpinning drug testing, at the ethics of testing schoolchildren and at the practicalities of such testing.

Despite the level of prime ministerial support for drug testing, the guidance on such testing from the Department of Education is very cautious (DfES, 2004). In advance of developing testing programmes, for example, head teachers are encouraged to consider whether such testing is consistent with the pastoral responsibility on the part of staff to create a supportive environment for young people. They are also urged to consider whether such testing is culturally sensitive, whether it may lead to labelling certain pupils, whether they will be able to provide the necessary support to pupils that test positive and whether it is an effective use of school resources. In addition to the caution that the Department of Education clearly expressed around the whole issue of drug testing, it is noteworthy that within the UK, in contrast to the US, there is no central government funding for developing testing programmes. Perhaps it is as much for this reason as any other that while being frequently discussed in the media relatively few schools within the UK state sector have developed drug testing programmes.

Underpinning drug testing programmes are a number of assumptions about the determinants of human behaviour. For example, there is the assumption that socially deviant behaviours are less likely to occur in circumstances where people

are closely monitored. In this case the assumption is that young people will be less likely to use illegal drugs in circumstances where their drug use stands a high chance of being revealed through a testing programme. Although that assumption may seem straightforward, in fact the impact of a drug testing programme is likely to be influenced by a range of factors including the perceived likelihood that one might be selected for drug testing within a school, the consequences of providing a positive drug test, and the degree to which young people are concerned about their drug use being revealed. In a situation where young people thought that the chances of their being selected for drug testing were low, or where the consequences of testing positive were seen as insignificant or trivial it is easy to see how the testing programme itself may have relatively little impact on levels of drug use among pupils. Perhaps of greater concern, however, is the possibility that some pupils may perceive failing a drug test as carrying a certain cache among friends.

Although substantial funding in the US has been provided to develop drug testing programmes, the evidence base as to the effectiveness of those programmes is far from conclusive or comprehensive. One of the first schools in the US to develop drug testing programmes was Hunterdon High, whose principal, Lisa Brady, has been a strong advocate of the benefits of drug testing (Edwards and the Student Drug-Testing Coalition, 2004). Brady oversaw a series of surveys undertaken within her school during a period in which a drug testing programme was implemented, then suspended (as a result of legal challenge), then resumed. At its simplest, the results of the surveys showed that levels of drug use fell on introduction of the drug testing programme, increased during the period when the programme was suspended and reduced again when the testing programme resumed. Although this study has been widely cited, in fact it would be incorrect to say that the research meets the minimum requirements for scientific research. For example, the research report, although published, was not peer reviewed, there is no information provided on the number of absentees on the days of data collection within the participating school, there is no information provided on the circumstances within which

the data were collected, including whether the questionnaires were completed by pupils under the supervision of the class teacher, and there was no inclusion within the surveys of a comparison or control group.

In another widely quoted study, McKinney (2004) reports the results of having sought the views of school principals on whether they felt drug testing had been effective in reducing teenage drug use. For the most part, principals were positive of the benefits of drug testing, leading McKinney (2004, p 4) to conclude that 'Random drug testing policies appear to provide a strong tool for schools to use in the battle to reduce alcohol and drug usage amongst teens'.

The fact that school principals may view drug testing as an effective tool in drug prevention is not, of course, the same thing as saying that research has proven the efficacy of such testing. By contrast, one of the largest and one of the methodologically strongest studies reporting on drug testing has questioned whether there is a clear drug prevention effect associated with testing pupils. In this study, Yamaguchi and colleagues analysed the results of the large-scale US 'Monitoring the Future' survey of young people to identify whether there was any clear pattern between levels of teenage drug use (as revealed in this survey) and the presence of a drug testing programme within local schools. The authors report that 'among the eighth, 10th and 12th grade students surveyed in this study school drug testing was not associated with either the prevalence or the frequency of student marijuana use or of other illicit drug use' (Yamaguchi *et al.*, 2003, p 164). In the light of their findings, the authors conclude that:

[D]rug testing in schools may not provide a panacea for reducing drug use that some (including some on the Supreme Court) had hoped. Research has shown that the strongest predictor of student drug use is students' attitudes towards drug use and perceptions of peers. To prevent harmful student behaviours such as drug use school policies that address these key values, attitudes, and perceptions may prove more important in drug prevention than drug testing.
(Yamaguchi *et al.*, 2003, p 164)

DuPont (DuPont *et al.*, 2003, p 3) has called for a controlled evaluation of drug testing recognising that it will only be as a result of such research that it will be possible to determine whether student drug testing does indeed have a significant drug prevention effect. Regrettably, nearly five years after DuPont's call and following the allocation of tens of millions of dollars of government funding to support drug testing, that research has not been undertaken.

In addition to drawing attention to the limited evidence base in support of drug testing, the review undertaken by McKeganey (2005) also identified a range of ethical and practical difficulties associated with testing pupils. The issue of false positive and false negative test results has already been mentioned in relation to drug testing in the workplace and it is sufficient to note here that a false positive drug test from a school pupil could have serious consequences for the individual concerned within both the school and the home environment. Concern has been expressed that drug testing pupils, in preference to relying on pupil's self-report, could undermine the level of trust between teachers and pupils. There is some indication that this might occur in research that revealed more negative attitudes towards school on the part of those pupils who had participated within a drug testing programme (Goldberg *et al.*, 2003).

As with elite athlete testing, school-based drug testing programmes need to decide how to deal with the young person who refuses to be tested. DuPont has suggested one way of dealing with a situation in which parents or guardians refuse permission for their child to be drug tested: 'If a parent or guardian refuses to allow the test to be administered to his/her child, a disciplinary action will be recommended as if the test were positive' (DuPont *et al.*, 2003, p 43).

While in the field of elite athlete testing the refusal to provide a test specimen is regarded as the equivalent of having submitted a positive drug test, it is not at all clear that this would be judged appropriate in the case of school-based drug testing programmes. Indeed, from a child's rights perspective it would seem entirely appropriate that children's parents and guardians should have the right to withhold permission for their child to be included within a drug testing programme. Equally,

it would seem to be very much against the spirit of a children's rights perspective to suggest that a child who declines to take part in a testing programme should be responded to as if they have in fact failed a drug test.

The issue of how school authorities respond to a positive drug test is also highly problematic. Within the US, the response tends to be a combination of the therapeutic and mildly punitive. Pupils testing positive may be required to undergo a period of counselling to address their drug use as well as having certain privileges suspended, that is, access to car parking facilities or involvement in after-school activities. Although drug testing programmes have not been developed within the UK to the same degree (with the result that we do not have information on how UK schools are dealing with pupils who test positive), it is questionable whether suspending a young person's engagement in after-school activities is appropriate given what may be their already problematic relationship to school in the first place.

Any drug testing programme, whether in the workplace, the school or the athletics field, is likely to lead to the development of concealment techniques aimed at reducing the effectiveness of the testing regime. Within the field of elite athlete drug testing, various substances have been identified that can mask the individual's ingestion of banned substances. Although these techniques and substances do not appear to have been widely used within schools, nevertheless there is the concern that the further proliferation of school-based drug testing might in due course see school pupils starting to access and use various masking agents. Clearly, this would be a regrettable development. Related to this issue is the concern that as a result of the fact that different drugs are metabolised at different rates within the body (resulting in some drugs being identified over a longer period than others), there may be a tendency on the part of some young people to switch their drug use from those substances such as cannabis that can be identified between ten to fourteen days after use to other substances, such as heroin, that can be identified for only a few days following use.

Both the independent inquiry into drug testing in the workplace and McKeganey's (2005) review of drug testing within schools have expressed

concern about the extension of such testing within the UK. It is difficult to know whether, in the period since the independent inquiry and the review were carried out, drug testing has increased, decreased or remained at the same level. In relation to school-based drug testing, there is a sense (perhaps no more than that) of things having moved on such that relatively few schools are now actively considering drug testing. Within Kent, where the first state school to report the results of drug testing pupils is based, there was a proposal to extend the testing programme to other schools in the county. In reality it appears that insufficient schools within the area indicated a willingness to develop such programmes and as a result no further testing appears to be taking place. The situation in relation to workplace drug testing is rather less clear cut in that it is entirely possible that increasing numbers of employees will find themselves being drug tested in regimes imposed on their workplace by employers. That, as the inquiry team made clear, would be a regrettable development.

6 Conclusions and implications

Charlie Lloyd and Neil McKeganey

It is often said that drug abuse represents one of the major challenges to our society. To take one example, David Blunkett in his forward to the *Updated Drug Strategy* in 2002 stated that: 'If there is one single change which has affected the wellbeing of individuals, families and the wider community over the last 30 years, it is the substantial growth in the use of drugs, and the hard drugs that kill in particular' (HM Government, 2002, p 3).

It is perhaps ironic then, that so little attention has been given to research in exploring the nature of that problem and how we are seeking to tackle it. Until very recently, neither the Economic and Social Research Council nor the Medical Research Council (the two main research funding councils in the UK) had funded a major research programme of work on the use of illegal drugs. Nor has there been significant sustained funding for research from the charitable sector, barring one-off, individual research projects. While over the past ten years there has been a significant amount of government money devoted to drug research, the majority has been expended on large-scale surveys, monitoring and evaluations, rather than more descriptive or exploratory research designed to fill the gaps in our understanding. The highly contentious nature of the drugs field means that much of it is off-limits for government research. This is perfectly understandable: why would the Home Office wish to fund research on cannabis, for example, knowing that virtually whatever was published, the media would use the 'Home Office's own research' to scaremonger and put pressure on ministers? Furthermore, it is also understandable that, while the term 'evidence-based policy' has been on everyone's lips, the focus has been on evaluating new initiatives and setting up costly surveys by which to measure Public Service Agreement (PSA) targets. However, while these

pressures are understandable, it begs the question of whether research on illicit drugs is actually best conducted and managed within the political hot-houses of the Home Office and Department of Health. If evaluations are to be impartial and if we want government-supported research to contribute to our wider understanding of drug issues, it may be best conducted elsewhere in an arm's-length organisation that recognises and responds to the needs of policy-makers but also prioritises the need for us to understand more about drug-related problems in the UK and what the most effective responses may be.

One positive development is the strategic objective in the recent drug strategy *Drugs: Protecting Families and Communities*, (HM Government, 2008) to 'improve the drugs evidence base'. There is also reference to a greater prioritisation for research on addiction, led by the Medical Research Council (MRC). This new interdisciplinary addictions research programme is now being taken forward.

We think that the JRF Drugs and Alcohol Research Programme shows how even a relatively modest investment of independent money can have a significant impact. The programme was funded to the tune of £1.5 million over five years and 24 projects were carried out over this period (see Appendix). In some cases these studies have broken new ground, representing the first detailed research in their area. For example, the research on policing cannabis and Class A drug use, on cannabis cultivation and on heavy cannabis users were the first studies undertaken in these areas in the UK. Similarly, the research on non-problematic heroin use, on the impact of drugs on the family and on drug users' involvement in treatment decisions were among the earliest studies in these areas. This research has therefore taken forward knowledge in these areas and contributed to policy and practice

development. The programme also supported two detailed inquiries on highly controversial topics: drug consumption rooms (DCRs) and drug testing in the workplace, which brought the international research together as part of the process. Finally, the research programme provided key reviews of existing knowledge within specific areas: for example, the review of random drug testing within schools.

However, inevitably, large and fundamental gaps in our understanding remain. It was described in Chapter 2 how our research and information system had been unable to track the dramatic changes in cannabis use that have occurred over the past 20 years: we still know very little about cannabis use and a user survey is needed. We also know very little about enforcement: given that ‘the bulk of expenditure on drug policy in the UK is still devoted to the enforcement of the drug laws’ (Reuter and Stevens, 2007, p 84), there is a real need for further research in this area (Reuter and Stevens, 2007; Reuter, 2009). The studies of the policing of cannabis and Class A drugs in this programme have made a contribution here. Following the second reclassification of cannabis back to a B drug, there is now a pressing need to evaluate how this change is impacting on policing. With regard to problem drug use, it is only recently that research has been undertaken to provide national and local estimates of the scale of problematic drug use within the UK over three consecutive years (Hay *et al.*, 2008b). It is imperative that this initiative is continued and becomes a standard part of our knowledge base. We lack a good understanding of the routes both into and out of problematic drug use and we also lack research on the long-term impact of drug use on families, by which to inform social workers making difficult decisions about the placement of children. We know very little about drug injectors’ reactions to finding out that they are Hepatitis C positive – this gap in our knowledge is all the more troubling given that around 40 per cent of injecting drug users within the UK are known to be Hepatitis C positive. Similarly, despite mounting concern about the prevalence of drug-related deaths in the UK, there have been remarkably few studies undertaken looking at how services can reduce such deaths. This list of research gaps is merely

the tip of an iceberg of things that we ought to now know but on which we have undertaken precious little research.

Where we do have knowledge, it is not always applied. This is, of course, a problem in all areas of policy-relevant research. However, it may be a particular problem in the drugs field, where policy is so severely constrained by political trepidation. The role of evidence is clearly limited when decisions are made about the classification of cannabis that ignore the explicit advice of experts selected to advise government on such issues. Likewise, the conclusion of the Independent Working Group on DCRs was that the level of positive evidence of effectiveness from abroad demanded that we pilot the approach in this country. The government decision not to support such a trial was inevitably driven, at least in part, by the controversial nature of ‘shooting galleries’, as they were described in many newspapers. To support pilot DCRs would have been to court instant attacks from some quarters and risk many years of negative reporting as the pilots were set up. It is easy to understand why this may not have seemed like a risk worth taking but again, the evidence took a back seat.

While evidence will often struggle to make itself heard at the national policy level, that is by no means the only way in which it can have an impact on policy and practice. There is a need to ensure that research is disseminated to – and has an impact on – policy-makers and practitioners. The implications of research have to be clearly drawn out and made accessible to those outside the research community. And policy-makers, practitioners and service commissioners need to be supported – and in some cases challenged – to respond to this evidence. Having said these things, we are aware that research findings are often equivocal and ambiguous – and in many cases contested. Research reviews are therefore crucial in this field. It should be recognised that over the course of the last decade, considerable advances have been made in this area through the guidance provided by the National Institute for Health and Clinical Excellence (NICE) and the National Treatment Agency (NTA); but also the accessible summary of research produced in Drug and Alcohol Findings (www.findings.org.uk). However,

there is certainly further scope to bring evidence to bear – especially on practice.

Social vs medical science

The majority of the work funded under the JRF programme has been social scientific research, focusing on issues like policing and the effectiveness of drug testing, rather than medical research focusing on treatment effectiveness. This reflects the wider remit of the Foundation, with its focus on social problems. However, there are broader issues about the way in which drug problems have been studied and understood within the UK. The major research centres are mostly clinical or epidemiological in nature. Reflecting this, the majority of senior academics come from medical disciplines. Our purpose here is not to detract from the importance – or indeed the very high standards – of work conducted in these fields. However, it might be questioned whether we have got the balance right. The large majority of drug use is essentially a social activity with social impacts. The risk factors for problem drug use, while partly genetic, are probably predominantly social in character and, for most people in society, the impacts of problem drug use lie in the social, rather than health, realm: that is, drug-related crime and nuisance. Furthermore, there is a growing awareness, reflected in the recent drug strategies in the UK (HM Government, 2008; Scottish Government, 2008; Welsh Assembly Government, 2008) and in debates elsewhere (Roberts, 2009; Wardle, 2009), that we need to look beyond medical interventions in order to socially reintegrate users and move them on to recovery. Despite this, there are only two relatively small research centres in the UK (in Glasgow and London) that are predominantly undertaking social science research on the drugs problem.

In conclusion, and returning to our original theme, drugs are a highly emotive topic and one that has touched many people's lives in a host of different ways. This makes the drugs field a vital and fascinating one; but also one that is full of hyperbole, controversy and political sensitivity. In such a field, the role of evidence is particularly important and our hope is that over the next decade, government, funding agencies and

charities will increasingly recognise this and make a greater contribution to our understanding of drug use, drug problems and responses to them.

Notes

- 1 Following the 1984 Police and Criminal Evidence Act, only offences for which the maximum penalty on indictment at the Crown Court was five years or more counted as an 'arrestable offence'. Offences attracting lower sentencing maxima could only result in arrest in particular circumstances, such as the address of the suspect being uncertain. While cannabis was a Class B drug, possession of the drug remained an arrestable offence as it attracted a maximum sentence of five years' imprisonment but if it became a Class C drug, the offence would cease to be arrestable because the sentencing maximum would have reduced to two years' imprisonment.
- 2 Unfortunately, trends in sentencing for cannabis offences cannot be readily analysed because criminal statistics do not distinguish between drugs within a particular class (and thus sentencing for cannabis offences cannot be differentiated from sentencing for other Class B or Class C drugs).
- 3 The 2007 PSA Delivery Agreement 24 includes a similar goal.
- 4 Skunk is a term usually applied to describe herbal cannabis or 'grass' with a high level of the main psychoactive ingredient, Tetrahydrocannabinol (THC).
- 5 A bong is a type of cannabis-smoking device with a chamber between the burning cannabis and the mouthpiece.
- 6 Helping friends to gain access to cannabis without taking a financial profit.
- 7 Interviewees could name more than one type of cannabis.

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Appendix

Reports published under the Drugs and Alcohol Research Programme

2002

- *Times They Are A-Changing: Policing of cannabis*
Tiggey May, Hamish Warburton, Paul J. Turnbull and Mike Hough

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Gerry V. Stimson and Nicky Metrebian
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- *The Report of the Independent Working Group on Drug Consumption Rooms*
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- *The Impact of Heavy Cannabis Use on Young People's Lives*
Margaret Melrose with Penny Turner, John Pitts and David Barrett

2008

- *Cannabis Supply and Young People*
Martin Duffy, Nadine Schafer, Ross Coomber,
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- *Street Policing of Problem Drug Users*
Stuart Lister, Toby Seddon, Emma
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- *Guidance on Standards for the
Establishment and Operation of Drug
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Neil Hunt

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