
Breakthrough Britain

Briefing Paper 4

ADDICTIONS

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This is the Executive Summary of the Addictions volume of the Social Justice Policy Group's *Breakthrough Britain* report. For further information, or to download the full report please visit www.povertydebate.com

1.1 Introduction

Over the last ten years the British government has spent more on its 'war on drugs' than on its combined operations in Iraq and Afghanistan.¹ UK spending is relatively generous and reflects the scale of the problem we face – one of the largest in Europe. Even so, we are spending less per head than those countries (such as Sweden and Holland) that are today more successfully facing the problems of drug abuse.²

Yet this spending is often wasteful, unwise and misdirected. For example, to meet the 'Janus faced' requirements of centralised 'treatment' targets and devolved administration, bureaucracy has grown dramatically. National Treatment Agency staffing has gone from 30 to 150 employees in five years, matched by burgeoning local Drugs Action Team administrations. Spending on prescribed methadone alone has reached £111 million per annum.

Nearly every reform of policy requires some up-front investment; all the more so when the underlying problems are getting worse. Under this administration, while alcohol harms have gone up, the gulf between treatment and need has widened. Yet spending on alcohol treatment currently runs at only 6 per cent of the drugs budget.³

It is likely that spending on drugs and alcohol addiction treatment may have to more than double from the current £400 million per annum in order to get people into recovery and to bring us to Swedish and Dutch levels of success.⁴ This, however, is a modest investment, against the **£39 billion that drug and alcohol abuse is estimated to cost society every year** – or by comparison with the £13 billion a year derived by the Exchequer from alcohol duty alone.⁵



1 The Today Programme, BBC Radio Four, 12th May 2007. Gordon Brown cited £6 billion for the combined operations. Ian Martin, Head of the Drug Strategy Unit, Home Office has cited £7 billion, 13th March 2007.

2 The budget for a problem drug user in the UK is €2,300, compared to €20,000 in Sweden and €4,500 in the Netherlands.

3 Figures obtained by David Burrowes MP under the Freedom of Information Act showed PCTs spent an average of £256,315 on alcohol treatment compared to £4, 118,164 for drug treatment.

4 The National Treatment Budget for 2007/08 is £398 million, but this does not include all available funding from other sources

Investment of this nature is clearly required to break the socially destructive and economically costly cycle of addiction; and is justified by the moral, social and financial necessity of reform.

The depth of the problem

The statistics are now well known: with 327,000 problem drug users of opiates and cocaine alone we have a significantly higher percentage of the population addicted than any of our immediate neighbours. Our mean alcohol consumption is higher than theirs too, costing the nation some £23 billion as the outcome of alcohol harm.



Poly-substance abuse is one of the chief characteristics of dependency today. Three quarters of problematic drug users use two or more of the main illicit target drugs and more than half use psycho-stimulants (mostly crack cocaine). Many have highly problematic patterns of drinking.⁶

While heroin use has 'plateaued', cocaine use has grown dramatically, with 5 per cent of 15-39 year olds using the drug.

The age of initiation has consistently fallen.

Care leavers, the homeless and young offenders have disproportionately higher levels of problematic drug and alcohol use than the rest of the population. A reasonable estimate is that **half of the UK's near 80,000 prison population are problem drug users.** Drugs are now a rural as well as an urban problem.

Some **350,000 children have drug addicted parents and one million have alcohol addicted parents.** Of the 77,928 drug dependent parents surveyed for the 'Hidden Harm Report', 54 per cent had children living elsewhere.⁷

The most widely used drug, cannabis, is now known to involve significant mental health risks - the risks of psychosis are higher for those who initiate earlier - and to affect cognitive

“ It's often seen as parents losing their children, but if you are a child care worker, I am sorry, but it is the child losing a parent ”

Tom O'Loughlin, Bolton 360 service

“ I went from having no money to having a wage every Friday. So then, I started buying cannabis in bulk, and I started selling it to my friends. This was at the age of 16. I smoked cannabis daily; I was smoking twenty joints a day, every day. ”

Eddie, recovering addict at the Maxie Richards Foundation, Glasgow

functioning. Last year use by 10 and 11 year old boys grew by one per cent. There is no evidence base about mean consumption or any longitudinal health data. Testimonies of recovering addicts suggest high and intense consumption of cannabis in their teens, possibly mirroring the evidence for alcohol consumption amongst

5 The additional benefit of reducing consumption and therefore harm is detailed in 3.1.1

6 Gossop, Marsden, Stewart, NTORS, *Changes in Substance Use, health and criminal behaviour during the five years after intake*, National Addiction Centre, 2001

7 *The Hidden Harm Report*, ACMD, Home Office 2003

adolescents that 'more alcohol is going down fewer throats'.⁸

Young people's drugs services and drugs education programmes remain premised on a philosophy of harm reduction, though there is little evidence of this being a safe or effective approach to the prevention of substance abuse.⁹

The collateral damage of addiction in all layers of society was set out in our interim report.⁹ Though more concentrated and cyclical amongst those with the fewest 'safety nets' for whom dependency cements deprivation and exclusion, our research and evidence showed addiction to be a societal condition or problem. The view, still held by influential policy opinion formers, that the use of drugs in this country is predominantly harmless, is, we believe, unsustainable.¹⁰ Their argument that alcohol harms are 'greater' than drugs harms in this context is also misleading. These harms may be absolutely greater, reflecting the numbers using alcohol. Nevertheless, drugs harms are relatively greater.

1.2 Reasons for the failed government strategy

Drugs Policy

The failure of the Government's drugs harm reduction strategies to positively impact on this damage, despite unprecedented 'treatment' investment, is not the mystery that the recent UK Drugs Policy Commission report would seem to suggest.¹¹ **The conclusion of our policy review is that the Government has failed to address drug and alcohol problems, either in terms of breaking the cycle of addiction, or in terms of recovery.**

The philosophy, purpose and practice of drugs policy, particularly in the treatment

domain, historically has been dominated by an ethos of management and maintenance. Ignoring the issue of addiction and the challenges associated with its treatment, has over the years, contributed to the growth of the problem rather than lessened it.

Under the ten years of Labour's drugs strategy, policy itself has become an intrinsic part of the problem. It has been a costly investment in failure.

“ We need to challenge the hegemony of harm reduction over other models and reflect on its philosophical and ideological undercurrents. It has been argued, for example, that provision of lifelong methadone or injectable heroin would help reduce crime, especially crimes against people. I often wondered what message this gives to young people with addiction: "We don't really care about what would happen to you, as long as you do not kill or mug anybody. You may go along and shoot yourself to oblivion in our Heroin Galleries and live in the land of your bliss as long as you like" Harm reduction has a place in treatment. But it should open many other doors including the path towards abstinence.”

Dr Mirza, Senior Lecturer and Consultant Adolescent Psychiatrist at Institute of Psychiatry

8 Poulin, C "Harm reduction policies and programs for youth" in Harm Reduction For Special Populations In Canada Addictions, Dalhousie University, August 2006

9 Breakdown Britain Interim Report Volume 3

10 RSA Commission on Illegal Drugs, Communities and Public Policy, March 2007

11 The Today Programme, BBC Radio Four 18th April 2007, The Launch of the UK Drugs Policy Commission.

The combination of centralised targets and a ‘medical management’ approach to treatment has further entrenched addiction, adding to intergenerational cycles of substance dependency which are particularly damaging for children.

“Addiction is a progressive disease, which means the drugs that keep me happy today won't keep me happy in a week's time or a month's time so I need to continue to take more and more. It's not only the physical addiction that gets (progressively) worse, but it's a sort of emotional crisis that is being pushed away. My belief is it's a spiritual crisis that is being batted away by taking drugs. And the trouble is, the more drugs you give an addict, the more drugs an addict needs.”

Former addict and repeat offender

Chances of recovery and rehabilitation from drugs, challenging in any circumstances, are seriously undermined in this misguided system of social control.

Maintenance methadone prescribing which perpetuates addiction and dependency has been promoted under current policy while rehabilitation treatment has been marginalised and crucial family residential services run down.

A ‘colonisation’ of the voluntary sector as the third arm of the state in ‘harm reduction’ drugs service provision has stifled innovation and holistic services.

The response to the crisis in adolescent drug and alcohol use is a plethora of unaccountable, and adult oriented ‘services’ rather than robust treatment intervention or prevention.

The same system of counterproductive targets and maintenance ‘treatment’ undermine the efficacy of criminal justice treatment interventions. The gulf between need and treatment in the prison service, which houses the largest addict population in the country, remains unbridged.

The Government's commitment to controlling the supply of drugs and to middle-level police enforcement appears weak.

The preferred harm reduction approach to drugs education in schools, promoted by government though lacking a sound evidence base, could be doing as much harm as good.

Alcohol Strategy

By contrast with its highly interventionist approach to drugs policy, the Government's approach to the ‘alcohol problem’ has been remarkably *laissez faire*. Whilst willing to legislate on alcohol to liberalise licensing laws, it has given no signal that it views alcohol as a potentially dangerous commodity.

From a public health perspective this is disturbing: under the Labour Government we have seen increasing levels of harm due to alcohol, and a growing culture of drinking especially amongst young people. Yet there has been no equivalent government spend on, or policy commitment to, either the treatment of alcohol dependency or to the control of its harms.

The alcohol strategy exists on paper only. Many health areas across the country have no alcohol treatment provision at all.¹² Yet neither the NHS, nor the statutory social work services use Alcoholics Anonymous as effectively as America does, if at all.¹³

12 Suffolk (Ipswich) is a case in point. Evidence from Dr Nadir Omara

13 AA operates a ‘twenty four hour, seven day a week ‘free’ service with 3500 meetings across the country a week.

Further, there has been little attempt by government to control supply or availability of alcohol. Government policy has, perversely, been to work with the alcohol industry relying on its promises of self regulation while liberalising the main drivers of consumption: the regulation and taxation of alcohol. Yet the rising levels of alcohol misuse in recent years, the state's power to sanction the manufacture and sale of alcohol, its potential for controlling the availability and price of alcohol, give government the responsibility to minimise the harm it causes – not least because of its cost to the public purse.

“ My GP was aware of what I was doing, how much I was drinking. There were times that I was on my diazepam prescription too. I didn't want to stop at the time, you know. There are many people who don't want to stop, and there are many people who wouldn't find out treatment centres - and, more to the point, there's many people who won't know they suffer from a disease, of addiction, and they'll die from it. ”

Former addict and repeat offender

“ Political leadership of a kind willing to connect the main issues around alcohol related harm and to invest both political and financial capital into undermining the main drivers of that harm is patently lacking and urgently required. ”

Srabani Sen, Chief Executive of Alcohol Concern

Inadequate explanations

The view that the high level of 'problem' drug use in the UK is due to prohibition, is in our view one dimensional and incorrect. Countries with broadly similar legislative frameworks which spend far more on the control of supply and on enforcement have far less of a problem.¹⁴ In general we found that the significance attached to the Misuse of Drugs Act by some, whether as a cause of or as a solution to the drugs problem, to be overemphasized. Nor did we find either view to dominate or reflect the concerns of those most afflicted – the families of those who have died.

The importance of the law is primarily as a marker for those behaviours which as a society we countenance. In light of the multiple and growing evidence of harms of drug use we ignore this at our peril. Drug use is a disproportionately damaging activity in which a minority (even amongst young people where the levels of use are the highest) not the majority, is engaged.¹⁵ We therefore believe the law needs simplification to enable its more effective communication. In addition, within the current framework, the law needs to make a strong statement about cannabis, through its reclassification to Class B.

However an over preoccupation with reform of the Misuse of Drugs Act risks diverting attention from the prime need – expressed to us by parents, practitioners and addicts in recovery alike – for a societal and political commitment to understanding, addressing addiction and its treatment. The moral and practical case is compelling. Government must prioritise this and focus on recovery as the goal of policy.

14 The UK spends just 28% of its overall drugs budget on control of supply and enforcement. This is far less than either Holland (75%) or Sweden (54%). Section 4 A perspective on comparative Drug Policies and Implementation in the Netherlands, Sweden and the UK

15 'Last month' prevalence any drug use for 16 -24 year olds was 17.2% BCS 2003/4

1.3 Policy Proposals

The task we have ahead to reform the system is ‘herculean’ and involves treatment reform, harm prevention and child protection.

“ Evidence from neuroscience is loud and clear. A period of abstinence is often essential for recovery from the subtle, structural changes brought about by chronic substance misuse to the hard wiring of brain!! ”

Dr Mirza, Senior Lecturer and Consultant Adolescent Psychiatrist at Institute of Psychiatry

Treatment Reform

There is no point in advocating the need for more residential rehabilitation without an understanding of how radical a reform of treatment is needed towards holistic and abstinence-based approaches. It is about

facing the fact that abstinence is the most effective method of treatment, and the only appropriate one for many addictions.

To redress the acute and chronic imbalance in treatment provision and to break the cycle of addiction we propose:

- An **integrated addiction policy** to replace the separate drugs and alcohol treatment, led by a National Addiction Trust responsible to a Cabinet Office Second Chance Unit and in charge of a Treatment Trust Fund
- A **devolved responsibility to local Addiction Action Centres** for identifying local need, working alongside One Stop (treatment) Shops ensuring client’s progress to supported abstinence treatment and an improved response to clinical and public health needs.
- An **expansion of third sector proven provision of ‘holistic’, value added, abstinence-based treatment**, both day treatment and residential, prioritising much needed family residential centres and adolescent residential development.
- A new method of **‘reward’ driven funding by personal abstinence treatment vouchers** deriving from the Treatment Trust Fund will ‘incentivise’ both system change and client change.

Criminal Justice Interventions have an important role to play in breaking the cycles of addiction. We propose:

- **The further development of experimental, dedicated drugs courts**, raising their treatment threshold and provision requirements.
- **Replicating the highly successful abstinence programmes run by RAPT and Phoenix Futures amongst others aiming for a dedicated wing in every prison across the estate.**

Harm prevention

The best way to reduce harm is to prevent it in the first place through policies aimed at an overall reduction in consumption of both alcohol and drugs.

The relationship between the affordability of alcohol and the level of consumption provides government with an effective tool for controlling levels of consumption within society through the levying of a tax on the product. This tax would in turn provide the funding needed to meet the social and economic costs of alcohol related harm, such as police enforcement measures resulting from binge drinking and violence, health service costs and treatment for addicts.

We also propose a renewed commitment to the control of supply of drugs by providing a more transparent record of seizures and interceptions, by plugging the gap left by SOCA and by proper local level drugs teams enforcement.

Finally we recommend further implementation of innovative third sector interventions for stopping drugs trafficking.

Protecting children and confronting cannabis

Neither addiction treatment or harm prevention will work without addressing the

need to mend families, and to set boundaries to protect children and give them something to live positively for.

Our most widely used illegal drug should not be in the category which conveys the impression to parents or children that we need to be less concerned with it than the other drugs classified. The government should be giving out a clear message that cannabis use is regarded as a serious matter – one that should be actively discouraged and certainly not seen as something that is rather a fruitless waste of police time.

As stated above we propose

- the reclassification of Cannabis from Class C to B as part of a **national action plan** to discourage cannabis use.
- a radical reassessment of appropriate responses to adolescent substance misuse. This requires first a **formal assessment of adolescent needs** – not just for their substance abuse problems but also for associated mental health, family and social issues, and secondly a **general adolescent ‘services’ review in view of their diverse development under this government**.
- the development of **residential treatment for adolescents** which would should provide the informal setting for **juvenile drugs courts**, as being experimented in Sweden (see next).
- the introduction of **Juvenile Treatment Orders for drugs offences which would be totally expunged after a five year period of clean record**.

The efficacy of random or other modes of **drug testing in schools** has never been properly trialled and researched in the UK. We believe that government should tender for well designed systematic experimental trials to be conducted in different parts of the country and across different school settings. In this context we also propose the **trailing of effective addiction education** in schools, again inviting well designed research applications

Together these reforms will result in a dramatic improvement in the quality of treatment and access to treatment for recovery. They will introduce financial efficiencies, simplify budgets and create the right incentives for

“ Drugs cannot be dealt with on one level only. Firstly we believe that those who are addicted need support. Not a methadone programme within the community - this only replaces one drug with another and methadone itself is unsatisfactory. It needs to be long term support with continuity and in many cases needs to be residential rehab. Secondly, are the icons that young people wish to emulate. Whilst the media and big business support known drug users and they appear to be 'cool' young people will continue to experiment. Thirdly, children and adults alike need to be educated in the dangers of addiction, the type of drugs, and the dangers they provide. Most importantly of all they need to know what the condition 'addiction' means. Fourthly, cannabis should be re-classified as Class A. The strength of the drug today can cause permanent schizophrenia.”

Marilyn Shaw, The Luke and Marcus Trust

holistic, committed and integrated care. Furthermore by applying more stringent standards, these reforms will promote public health, reducing death and infection, and prevent drug use and criminal involvement.

ADDICTIONS WORKING GROUP

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David Burrowes MP (Deputy Chairman) Member for Enfield Southgate since 2005 General Election

Professor Chris Cook, Consultant psychiatrist specialising in alcohol misuse with Tees, Esk and Wear Valleys NHS Trust.

David Partington, Director of the International Substance Abuse & Addiction Coalition

Camila Batmanghelidjh, 'Woman of the Year' 2006, founded and runs Kids Company

Andy Horwood, Director of Doyle Training & Consultancy Ltd

Shaun Bailey, Director of 'My Generation' a youth community initiative on the North Kensington estates

Rebecca Smith, Parliamentary Assistant to David Burrowes

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ABOUT THE SJPG

The Social Justice Policy Group was commissioned by Rt Hon David Cameron MP, Leader of Her Majesty's Opposition, in January 2006 to make policy recommendations to the Conservative Party on issues of social justice.

The Policy Group is chaired by the Rt Hon Iain Duncan Smith MP, former leader of the Conservative Party and Chairman of the Centre for Social Justice, and its Deputy Chairman is Debbie Scott, Chief Executive of Tomorrow's People. The Policy Group's Secretariat is hosted by the Centre for Social Justice.

The work has been done through six working groups, which have examined key "pathways to poverty": family breakdown, educational failure, economic dependency, indebtedness and addictions. A sixth group has studied how the third sector might be supported to do more to give vulnerable people second chances and help them escape poverty.

For further information, or to download the full report of the Social Justice Policy Group, *Breakthrough Britain*, please visit www.poverty.debate.com

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