AMBITIOUS FOR RECOVERY

Tackling drug and alcohol addiction in the UK

August 2014

THE CENTRE FOR SOCIAL JUSTICE

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Ambitious for Recovery: Tackling drug and alcohol addiction in the UK
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About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British politics. Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities. We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Director: Christian Guy

Director's preface

For ten years the Centre for Social Justice (CSJ) has witnessed the destruction drug and alcohol addiction can cause, but we have also seen the potential for full rehabilitation in the lives of addicts. Through research, data and close working with numerous people affected by addiction we have shown how our country can become considerably more ambitious for people locked into substance abuse. For years full recovery has been the preserve of the wealthy – closed off to the poorest people and to those with problems who need to rely on a public system. We want to break this injustice wide open.

In several reports, including this one, we have demonstrated how addiction causes and entrenches poverty. Whilst in the context of our total population the number of people affected is a clear minority, the problem runs deep. As we revealed in our *No Quick Fix* report last year: 1.6 million people are dependent on alcohol in England alone; one in seven children under the age of one live with a substance-abusing parent; and more than one in five (2.6 million) live with a parent who drinks hazardously. 335,000 (one in 37) children live with a parent who is addicted to drugs. This dependency and abuse rips into families, makes communities less safe and generates an enormous bill that UK taxpayers have to foot.

Take Daryl, who we met on a visit to a treatment centre in north London. As a heroin addict he had been on the streets for 15 years and seen his girlfriend die there. He felt of himself as one of the lucky ones, having gained a place at rehab. Three years on, he's still clean and runs his own business.

After significant pressure applied through the CSJ before 2010, some political and policy progress has been made during this Parliament. For example it has been refreshing to work with Government ministers determined to establish greater availability for abstinence, even if progress in local areas has been painfully slow. It has been important that the Government has resisted the naïve and dangerous calls for liberalisation of our drug laws. Such policies would cause even greater harm, however well-intentioned they are in formation. New ambition for drug addicts in the welfare system has also been a positive development.

The CSJ is clear, however, that there is a very long way to go before we can declare our nation's drug and alcohol systems successful. Although a growing number of addicts leave treatment in 'recovery' the truth is, because the official definition of recovery is so weak and misleading, many remain addicted to a number of substances. They just happen to be leaving clear of the recorded addiction they entered treatment with. Rehabilitation centres are

closing at a rapid rate. Local treatment budgets are still heavily dominated by methadone and maintenance rather than abstinence programmes. Prisons are awash with drugs and alcohol. Our rather pathetic 'Talk to Frank' drug education scheme persists. Legal highs are entering the market and causing harm far quicker than our enforcement and regulation systems can adjust – based on trend we predict they may be linked to more deaths than heroin by 2016. JobCentres could become much more effective in spotting and supporting addicts. Alcohol treatment services are woefully inadequate.

In light of the reform we require, this report *Ambitious for Recovery* sets a new course in many of these areas. Based on key objectives for preventing addiction, protecting the vulnerable and achieving full recovery, we recommend a suite of policy changes. They include: raising a Treatment Tax to fund effective rehabilitation programmes; clamping down on legal high head shops; more efficient alcoholism diagnosis in our hospitals; new techniques for finding addicts who are reliant on benefits; changes to local treatment commissioning to secure more abstinence and expanding effective prevention schemes in schools.

In publishing this report my gratitude goes to the review's remarkable Chairman Noreen Oliver MBE, who has led by example in our country, and through the work of her charity BAC O'Connor, has saved countless lives. Noreen is precisely the kind of expert who deserves to shape public policy because for years she has shown what works. The CSJ will be forever in her debt. I would also like to thank our superb working group whose members provided excellent insight and provided a rigorous filter for what emerged. I also appreciate the dedication and passion of the project's lead researcher Rupert Oldham-Reid. Rupert was very well-supported by our Policy Director Alex Burghart, Edward Boyd and others at the CSJ.

It might be tempting for an incoming Government to push these issues to one side. Yet we urge those forming the new administration not to make that mistake. Foundations have been laid for something important – full recovery – but they remain far too weak and wobbly. Full recovery from addiction is possible. Preventing drug abuse is feasible. Protecting communities is crucial. Let us take our opportunity to prove it.

Christian Guy
Director

Members of the CSJ Working Group

Noreen Oliver MBE (Chairman)

Following her own personal experience of addiction to alcohol and her own journey into Recovery, Noreen Oliver MBE, set out to provide a rehabilitation programme in the community in which addiction had developed. This led to Noreen Oliver being recognised by the Daily Mirror People's Justice Award in November 2006, followed by the accolade of MBE by Her Majesty Queen Elizabeth II in June 2009.

Today the BAC O'Connor employs 84 staff from clinicians through to resettlement staff; fifty per cent of the staff are in recovery and have gained qualifications from NVQ's through to Degree level.

In September 2012 The O'Connor Gateway Charitable Trust launched, founded by Noreen Oliver, with a new Social Enterprise called Langan's Tea Rooms and Training Centre, the Social Enterprise was opened by The Rt Hon Iain Duncan Smith MP.

The Recovery Group UK (RGUK) was established by Noreen Oliver in September 2009 to provide a platform for the reform of the UK drug & alcohol treatment system. To remove the polarisation of the system and to bring together a group of experts from across the spectrum of care. Building upon the success of RGUK, The Recovery Partnership was formed in May 2011; Noreen Oliver invited Drugscope and The Skills Consortium to partner with RGUK to provide a new collective voice for the drug and alcohol sector to Ministers and Government.

Noreen was the recipient of a CSJ 'Lifetime Achievement Award' in 2010. She is also a member of the CVLS Honours Committee.

Rupert Oldham-Reid, author and researcher

Rupert joined the CSJ team in January 2012 and has spent time working within the fundraising, policy and events departments. After managing the CSJ's presence at the party conferences and organising the Prime Minister's only major speech on criminal justice, Rupert currently leads the CSJ's research into addictions as part of Breakthrough Britain 2015. He has written for national publications and is the author of *No Quick Fix*.

He has a broad range of experience, working with an addiction rehabilitation centre and an MP's office in Westminster. Rupert read History and Politics at Newcastle University, and went on to gain an LLB at the College of Law. As well as serving with the Royal Naval Reserve, he has won several debating competitions.

Lisa Bryer, Co-founder of Cowboy Films

Lisa Bryer has worked as a film and documentary producer for the last 30 years. She co-founded the independent production company COWBOY FILMS. And is best known for having produced the Oscar and Bafta winning film 'The Last King of Scotland'.

Lisa was addicted to drugs including heroin, for eight years and is still suffering from the effects of Hepatitis C, resulting from her addiction. After a friend recommended that she attend Narcotic Anonymous, she realized that she could break the cycle of drug use, and she eventually managed to overcome her addiction by attending a residential rehabilitation centre in Weston-super-mare.

Today Lisa has not had a drug or a drink for 31 years and spends a lot of her time helping other addicts, either through one-to-one mentoring or as a trustee on various charities. She is the mother of 16 year old twin boys, conceived and parented within her recovery from drugs. She has also been happily married for 18 years.

Huseyin Djemil, Founder and Director of Green Apple Consulting

Huseyin Djemil is the founder and director of Green Apple Consulting, a specialist substance misuse consultancy which works mainly in the UK criminal justice and drug treatment sector. Huseyin has worked in the drug and alcohol misuse field for over 18 years, and was personally addicted to heroin and cocaine for seven years before recovering through a residential rehabilitation programme. In his capacity as the director of Green Apple Consulting he advocates abstinence-based rehabilitation as necessary in all stages of treatment and recovery.

Andrew Griffiths, Member of Parliament for Burton and Uttoxeter

Andrew Griffiths is the Conservative Member of Parliament for Burton and Uttoxeter. He works closely with the Burton Addiction Centre and also serves as the Secretary of the All-Party Parliamentary Group on the Misuse of Drugs.

Dr Chris Longstaff, General Practioner

Chris qualified from Cambridge in 2007 and after completing his training in General Practice, worked with the team at Luther Street Medical Centre to provide primary care to people experiencing homelessness in Oxford. Here he developed a particular interest in finding ways to help people with addiction to prescribed medications move forward with their lives. He now works as a GP at Bassett Road Surgery, in Leighton Buzzard.

James McDermott,
Founder and Chair of Recovery is Out There (R.I.O.T)

James McDermott is the founder and chair of Recovery is Out There (R.I.O.T). R.I.O.T advocates a recovery champion-based model for overcoming addiction through abstinence at all levels of treatment. He also a founding member of the Recovery Champions network, a broad spectrum of service user groups which aims to improve the opportunities for people to move from treatment to recovery. James personally experienced 20 years of substance abuse which he eventually overcame through a residential rehabilitation programme.

Richard Phillips, Director, SMART

Richard Phillips is the director of SMART (Self-Management and Recovery Training) Recovery UK. It works to assist recovery from any type of addictive behaviour and helps people overcome their addictions through peer-led mutual aid groups that advocate self-help as a method of recovery. He has worked in the field of substance misuse for over 20 years and strives to integrate treatment and recovery programmes.

Chip Somers, Chief Executive, Focus12

Chip Somers is the founder of Focus12, an independent charity which provides residential rehabilitation for drug and alcohol abuse. As a former drug addict himself Chip recently appeared before the House of Commons Home Affairs Select Committee, alongside comedian Russell Brand, and advocated abstinence as the best form of long term rehabilitation for those misusing drugs and alcohol.

Advisor to the Working Group

Nick Barton, Chief Executive, Action on Addiction

Nick Barton is the Chief Executive of Action on Addiction, the only charity working across the addiction field in treatment (residential and non-residential), research, prevention professional education and family support. Previously Nick worked in the US as a psychotherapist and family counsellor before becoming involved in the addiction field in the UK in the mid 1980's

Nick was one of the principal architects of the merger of the three charities Clouds, the Chemical Dependency Centre and the former Action on Addiction in 2007. He has been instrumental in developing a variety of interventions to support families and carers affected by substance misuse since 1986. He has championed professional workforce development, and the Charity opened its Centre for Addiction Treatment Studies in 2008.

He has sat on many panels advising government on aspects of treatment delivery, family support and workforce development. He currently sits on the board of Substance Misuse Management in General Practice. He was a member of the Topic Expert Group for NICE standards in drug treatment. He has advised organisations in several countries, taught courses and written numerous articles.

Special thanks

The Centre for Social Justice (CSJ) would like to thank the many people and organisations who kindly gave their time to contribute evidence during the course of this review. Our thanks go to the Working Group for their time and expertise. Particular thanks to Noreen Oliver MBE, the group's Chairman, for her incredible leadership and commitment to the review. Special thanks also go to Alex Burghart, CSJ Director of Policy, for his invaluable help and guidance.

Chairman's foreword

Addiction to drugs and alcohol takes a heavy toll on society. In 17 years running BAC O'Connor I have seen the impact, from crime, worklessness and strains on the NHS, to the price paid by individuals and their families. I have witnessed, however, people overcome their addiction and progress to lead full lives as contributing members of society. Provided with a little support to become drug and alcohol free, I have watched people transform their lives and become productive members of society.

Recent falls in drug and alcohol use in the wider population conceal a rising cost of addiction: more alcohol-related admissions and readmissions, more prescription drugs issued, and, a surge in use of 'legal highs'. This is a social justice issue. Addiction can strike anyone but the harm of this situation is felt most keenly in poorer communities.

Our interim report, *No Quick Fix*, laid bare the costs, extent and changing nature of drug and alcohol addiction in the UK. We outlined how the Government's 2010 Drug Strategy marked a welcome shift from a policy of maintaining addicts on substitute drugs to an ambition to help people lead drug-free lives. We have seen a rise in the use of mutual aid and the rhetoric of recovery now pervades strategy.

Yet while some of the rhetoric has been good, action has been poor. Abstinence from drugs and alcohol, which is key to achieving lasting recovery but is still not the marker by which we measure our success. Equally, rehabs are the most effective route to abstinence for many yet are still the preserve of the wealthy or the lucky few. Making the situation worse, we now have 'legal highs', often more dangerous and addictive than the drugs they seek to imitate, available to buy on high streets across the UK.

Our report lays out a programme for whoever next enters government, to tackle addiction and reduce its costs to society. We argue that priorities for the next Parliament should include: a small treatment tax of a penny on a unit is introduced by the end of the next Parliament to provide proper rehabilitation; reform to the welfare, criminal justice and health services to address the addiction problems which drain resources; and, a proper response to 'legal highs'.

This project has been ably supported throughout by the Addictions Working Group, to which I extend my thanks. We have met regularly since 2012, taking evidence from academics, doctors, treatment professionals, and people with personal experience of addiction and recovery. We have toured the country visiting hospitals, schools, prisons, rehabs, community

treatment centres, courts, Jobcentres, and the countless workplaces where people in recovery are contributing to society.

We know that people can recover from addiction. Our duty is to ensure that everyone is given the chance to recover and prevent people from falling into addiction in the first place. With the economic recovery well underway, we must also see that society recovers with it.

Noreen Oliver MBE
Chairman of the Addictions Working Group

Breakthrough Britain 2015

The Centre for Social Justice shone a light on the shocking levels of deprivation that blight communities across the UK in 2007 in our report *Breakthrough Britain*. The project transformed the British political landscape, reinvigorated a tired debate on how to tackle poverty and was hailed as a definitive research paper on social problems in modern Britain.

This unprecedented diagnosis of deprivation led us to identify five interlinked 'pathways to poverty'. These were:

- Family breakdown;
- Economic dependency and worklessness;
- Educational failure;
- Drug and alcohol addiction; and
- Serious personal debt.

Alongside this, we made recommendations about unlocking the potential of the voluntary sector to reverse social breakdown.

These reports revealed how, despite the longest period of continuous economic growth in modern history – more than 60 quarters – and unparalleled levels of government spending, a large proportion of British society remained cut off from the mainstream. We argued that what was trapping people was not necessarily the economy but their exposure to long-term worklessness, family breakdown, poor education, addiction and serious debt, and that too often government intervention was focussed on trying to alleviate the symptoms of poverty, rather than these causes.

Seven years on, the UK is in a radically different political and economic position – but the need to give a voice to the most disadvantaged people could not be greater. For this reason we have spent the past two years researching *Breakthrough Britain 2015* – a fresh assessment of how the five pathways are continuing to hold people, families and communities back.

Following on from our six 'state of the nation' reports last year, over the coming months we will publish recommendations to all political parties, again showing how people can be

helped back to work, families kept together, educational achievement improved, addiction and personal debt relieved. The work will amount to an exciting and radical programme for any Government in 2015.

These six policy reports are the culmination of an extraordinary process. Our team has travelled tens of thousands of miles around the country, visiting our most deprived communities – from Rhyl to Ramsgate, from Margate to parts of Manchester, from Great Yarmouth to Glasgow – to discover first-hand what is fuelling poverty. We have carried out extensive public polling, conducted several thousand meetings with charities, frontline workers and policy experts, and heard from huge numbers of people struggling to get their lives back on track. For further inspiration we have looked abroad, taking evidence from successful projects around the world including those in Australia, the Netherlands, various parts of the USA, Ireland, and Singapore.

As well as our own committed staff, the CSJ has recruited well-known specialists in each of the six areas to be on working groups who have met regularly to take evidence from those who understand the problems best. These dedicated individuals have used their extensive knowledge and contacts to ensure our research is relevant, focussed and influential.

Throughout this process we have constantly been given heart by the remarkable work people are doing to help rebuild the lives of those who have become trapped in poverty. The practical solutions presented in these reports are grounded in their experiences and they are a call to politicians to ensure that the next government continues the fight against poverty by tackling it at its roots.

Executive summary

Addiction to drugs and alcohol is destroying lives and blighting communities. Today, 300,000 people in England are addicted to opiates and/or crack and 1.6 million are dependent on alcohol.[1] The cost of this is substantial. Every year drugs cost society around £15 billion and alcohol a further £21 billion.[2] The human cost is even greater. Addiction ruins the lives of those it affects, as well as the lives of their families and communities, causing long-term unemployment and crime, and damaging mental health.

It does not have to be this way. There is much that can be done to prevent addiction, and to help those with an existing addiction recover. This paper sets out an ambitious plan to strengthen Britain's fight against addiction and the harm that it causes. We look at:

- How to prevent more people from becoming addicted;
- Ways of tackling the supply of drugs in Britain;
- How to reform our treatment system so that more people recover from addiction and rebuild their lives;
- How interactions with public services can more effectively encourage people into treatment.

Prevention: how to keep children and young people safe

More needs to be done to prevent children becoming addicted to drugs and alcohol. At present:

- One in ten pupils reports being drunk in the last four weeks;[3]
- One in six pupils reports having used an illegal drug at least one;[4]

1 Liverpool John Moores University, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12*, 2014 [accessed via: www.nta.nhs.uk/uploads/estimates-of-the-prevalence-of-opiate-use-and-or-crack-cocaine-use-2011-12.pdf (06.06.14)]; Health and Social Care Information Centre, *Adult psychiatric morbidity in England: results of a household survey, 2007*,2009 [accessed via: https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng- 2007-rep.pdf] and National Institute of Clinical Excellence, *Alcohol-use disorders*, London: The British Psychological Society and The Royal College of Psychiatrists, 2011

2 HM Government, *Drugs Strategy 2010*¸ London: Home Office, 2010; HM Government, Alcohol Strategy 2012, London: *Home Office*, 2010

3 Health and Social Care Information Centre, *Smoking, drinking and drug use among young people in England in 2012*, 2013 [accessed via: www.hscic.gov.uk/catalogue/PUB11334/smok-drin-drug-youn-peop-eng-2012-repo.pdf (07/08/14)]

4 Health and Social Care Information Centre, *Smoking, drinking and drug use among young people in England in 2012*, 2013 [accessed via: www.hscic.gov.uk/catalogue/PUB11334/smok-drin-drug-youn-peop-eng-2012-repo.pdf (07/08/14)]

- The last UN estimate said that the number of young people (15–24) who have taken a 'legal high' in the UK was the highest in Europe;[5]
- Hospital admissions of under-30s with alcohol-related liver disease increased in England by 117 per cent from 2002 to 2012.[6]

We have shown that young people are being let down by a lack of effective prevention programmes:[7]

- The Government's flagship drugs and alcohol prevention programme, FRANK, is shamefully inadequate – a survey conducted by a national treatment provider found that only one in ten children would call the 'FRANK' helpline to talk about drugs;[8]

- Almost two-thirds of schools cover the subject of drugs, alcohol and tobacco only once a year or less between the crucial ages of seven and 11.[9]

We recommend that:

- FRANK should be scrapped and an effective replacement programme developed to inform young people about the dangers of drug and alcohol abuse;

- The Department of Health should develop an information campaign to inform parents and young people about the growing threat of so-called 'legal highs' (or New Psychoactive Substances) which were related to nearly 100 deaths in 2012;[10]

- Because the availability and quality of prevention programmes in schools is often very poor, schools should be able to apply for match-funding from their local Health and Wellbeing Boards to provide approved schemes. These would include those offered by external providers, such as charities, that have been shown to reduce alcohol and drug abuse amongst children. We case study successful programmes from the US that have reduced problematic behaviour like substance abuse by around 29 per cent.[11]

Tackling supply

Restricting the supply of dangerous substances is a crucial component in the battle to reduce the harm that they cause.

5 United Nations Office on Drugs and Crime, *World Drug Report 2013,* Vienna: United Nations, 2013
6 Balance North East, Worrying rise in young people with alcohol-related liver disease, Press Release, 19 March 2013 [accessed via: www.balancenortheast.co.uk/latest-news/worrying-rise-in-young-people-with-alcohol-related-liver-disease 07.08.14)]
7 Centre for Social Justice, *No Quick Fix*, London: CSJ, 2013
8 Addaction, 'One in five young people say they think parents have taken drugs, according to Addaction commissioned survey', October, 2008 [accessed via: www.addaction.org.uk/news.asp?section=253&itemid=297&search (08.08.13)]
9 Formby E, "It's better to learn about your health and things that are going to happen to you than learning things that you just do at school': findings from a mapping study of PSHE education in primary schools in England, Pastoral Care in Education, 29 (3), 2011, 161–173
10 St George's University of London, *Drug-related deaths in UK*, 2013 [accessed via: www.sgul.ac.uk/research/projects/icdp/our-work-programmes/pdfs/drd_ar_2013.pdf (07.08.14)]
11 Hawkins et al, 'Sustained Decreases in Risk Exposure and Youth Problem Behaviors After Installation of the Communities That Care Prevention System in a Randomized Trial, *Archives of Pediatrics and Adolescent Medicine*,163, 2009, pp 789–798 [accessed via: http://archpedi.jamanetwork.com/article.aspx?articleid=1107692]

Getting the police to prioritise tackling supply

Policing in England and Wales is currently failing to constrain the supply and use of illegal substances. Only ten per cent of respondents to the Global Drug Survey found to be in possession of cannabis during a police stop and search were arrested and sent to court.[12]

So that the public can hold their local police force to account, and to encourage Police and Crime Commissioners (PCCs) to prioritise tackling the supply and use of illegal drugs, the CSJ recommends that the Home Office publish annual data for the use of illegal substances, broken down for each police force area.

Tackling online drug dealing

A major and growing concern is the supply of illicit drugs across the internet:

- Illegal websites on the dark web first came to prominence in 2000. There are online marketplaces where customers can purchase drugs from dealers and have them shipped via regular postal services to an address chosen by the buyer;[13]

- Whilst it is difficult to estimate the size of the online drug trade there are indications that it is significant and growing – worldwide there has been a 300 per cent rise in cannabis intercepted through postal services between 2000 and 2011;[14]

- Between 31 to 45 per cent of revenue is from large scale trading, suggesting that dealers are buying in quantity on the internet before distributing locally.[15]

The CSJ has heard that the problem of cybercrime is growing, and that the National Crime Agency (NCA) needs to become more effective in its efforts to disrupt online crime. We welcome the Government's increased focus on cyber crime and security, however we believe that the next Government should make this more of a priority for law enforcement.[16]

- Only £65 million is spent by the Home Office on the four-year Cyber Crime Strategy, out of an annual crime and policing budget of over £6 billion;[17]
- Amongst many other similar comments from people the CSJ heard from a leading academic that '*at the moment the NCA just hasn't got capacity*'.

12 The Guardian and Mixmag, *Global Drug Survey*, 2012 *[accessed via:* https://docs.google.com/spreadsheet/ccc?key=0AonYZs4MzlZbdDdrY2NMeWZpQzZwekxUU19TdWVrc3c#gid=11 (06/08/14)]

13 UNDON, World Drug Report 2014, [accessed via: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (07.08.14)]

14 UNDON, World Drug Report 2014, [accessed via: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (07.08.14)]

15 Judith Aldridge and David Decary-Hetu http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2436643 Meaning kilos worth of marijuana and amounts of MDMA that translated to between 500 and 50,000 doses

16 HM Government, *Drug Strategy 2010*, London, Home Office, 2010

17 Crime and Courts Bill, Factsheet [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/98445/fs-nca-what-how.pdf (06.08.14)]; HM Government, *The UK Cyber Security Strategy*, 2011 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/60961/uk-cyber-security-strategy-final.pdf (06.08.14)]

'We are not on top on this right now, the bad guys are definitely several steps ahead.'
Former Chief Detective Inspector

For this reason, the Government must ensure that the NCA has the resources it needs to tackle the growing threat of the online supply of illegal drugs.

Tackling 'legal highs'

'Legal highs', or New Psychoactive Substances (NPS), are a growing problem in the UK. They are intended to produce similar effects to illegal drugs, such as cocaine, amphetamine, MDMA (ecstasy) or heroin, are often just as dangerous and can be addictive– in 2012, the deaths of nearly 100 people were connected to their use.[18] Because many NPSs are new substances that have not yet been made illegal, they can be sold in 'head shops' on the high street, as well as online.

- Head shops operate on the edge of legality, and are both vague and creative in the descriptions given to products. To circumvent the Medicines Act, or any Food Regulations they are frequently labelled as 'NOT FOR HUMAN CONSUMPTION', and advertised as, for example, plant food or pond cleaner;[19]
- There are an estimated 250 legal-high head shops in the UK.[20]

The CSJ has heard how the Irish Government has had considerable success in reducing the number of head shops:[21]

- The Criminal Justice (Psychoactive Substances) Act was passed in 2010 and – according to the Irish Department of Justice – effectively removed the threat of head shops overnight by making it much easier for the police and courts to close them down if they are thought to be selling psychoactive substances;
- Tracy O'Keefe of the Criminal Law Reform Division, Ministry of Justice (Dublin) told the CSJ:

  'Before this [Act] there were well over 100 [head shops], now there are fewer than 10';

- Hospitals in Ireland we have spoken to saw a noticeable decline in the number of people being admitted because of NPS use.

The CSJ calls on the Government to bring a similar Act to the UK and ensure that the police, regulators, companies and internet service providers (ISPs) work together to disrupt the trade of these harmful substances and protect young people.

18 St George's University of London, *Drug-related deaths in UK*, 2013 [accessed via: www.sgul.ac.uk/research/projects/icdp/our-work-programmes/pdfs/drd_ar_2013.pdf (07.08.14)]
19 Bill Stupples in evidence to CSJ
20 Angelus Foundation in evidence to the CSJ
21 National Advisory Committee on Drugs, *An Overview of New Psychoactive Substances and the Outlets Supplying Them*, Dublin: NACD, 201, p18 [accessed via: www.dit.ie/cser/media/ditcser/documents/Head_Report2011_overview.pdf (06.08.14)]

Reducing alcohol abuse

Whilst overall levels of drinking are declining in the UK, serious alcohol abuse is rising:

- In 2012, there were 6,490 alcohol-related deaths – a 19 per cent increase from 2001;[22]
- Liver disease is the only one of the big five killers that is rising with at least 37 per cent being driven by alcohol abuse;[23]
- Alcohol-related hospital admissions have doubled in a decade are stood at over one million in 2012/13;[24]
- Approximately 190,000 people suffer from Korsakoff's syndrome – which is brought on by brain damage caused by chronic alcohol abuse.[25]

In order to tackle this problem it is essential to improve detection and treatment for alcoholism (as set out below) but it is also necessary to reduce the supply of alcohol to vulnerable people. For this reason we recommend that:

- Police and Crime Commissioners should direct police forces to inform licensed premises of their legal duty not to serve intoxicated people (the number of prosecutions for serving someone who is drunk or below age is low and falling – from 369 to 143 between 2009 and 2013);[26]

- To allow communities to make informed decisions as to how many premises should be able to sell alcohol in their areas, local authorities should be allowed to reject a license application on grounds of protecting or promoting public health.

Reducing overprescribing

The overprescribing of drugs by doctors is also causing increasing harm, especially in poorer communities:

- There are up to 1.5 million people addicted to medication in the UK today;[27]
- In England, data shows that overprescribing particularly occurs in poorer areas. Blackpool, Salford, and Newcastle have, for example, around three times as many antidepressant prescriptions per patient per year than Kensington and Chelsea;[28]

22 Health and Social Care Information Centre, *Statistics on Alcohol – England*, Leeds: HSCIC, 2014,
23 Drinkaware, *Alcohol and Liver Disease*, 2014 [accessed via: www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/effects-on-the-body/alcohol-and-your-liver (06.08.14)]
24 Health and Social Care Information Centre, *Statistics on Alcohol – England*, Leeds: HSCIC, 2014,
25 Alcohol Concern, *Wernicke-Korsakoff's syndrome: Factsheet 6 Summary*, London: Alcohol Concern, 2001 [accessed via: www.alcoholconcern.org.uk/assets/files/Publications/Wernicke-Korsakoff%20Factsheet1.pdf (06.08.14)]
26 Hansard, Written Answers and Statements, Column 388W, 30 June 2014 [accessed via: www.publications.parliament.uk/pa/cm201415/cmhansrd/cm140630/text/140630w0002.htm (06.08.14)]
27 Home Affairs Committee, *Drugs: New Psychoactive Substances and* Prescription Drugs, London: Home Affairs Committee, 2013 [accessed via: www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/819/81906.htm (06.06.14)]
28 Guardian Online, March 2011, [accessed via: https://docs.google.com/spreadsheet/ccc?key=0AonYZs4MzlZbdEhkM0hoaWVieC12Z1Z5VUtNc2tSeGc&hl=en#gid=0 (07.08.14)]

- In parts of the US widespread addiction to prescription drugs has led to a full-blown heroin epidemic as addicts look for alternatives to their prescribed drug.[29]

So that government can get a better handle on levels of prescription addiction (which are not formally recorded) we recommend that detailed prevalence estimates are made. This task could be undertaken by the North West Public Health Observatory who have expertise in estimating the number of people dependent on other drugs and also creating local area profiles.

To help reduce the numbers of people who are overprescribed drugs, we recommend that the Quality Outcomes Framework, which rewards GPs for implementing best practice in their surgeries, be amended to encourage, amongst other things, regular reassessments of whether people need to be on prescriptions for psychoactive drugs and the publishing of prescribing rates of psychoactive drugs by GP clinics.

Reducing demand: treatment, recovery and abstinence

The most effective way to overcome addiction and eliminate its costs is to help people to stop taking drugs and become fully abstinent. Yet as the CSJ has long argued, treatment services have continually failed to support abstinence-based recovery. Despite warm words in its 2010 Drug Strategy, this Government has failed to create the recovery revolution that it promised:

- Far too many heroin addicts – approximately 150,000 – are still prescribed addictive opiate substitutes (normally methadone) effectively replacing one addiction for another (although many users are known to take methadone on top of their heroin);[30]

- The number 'parked' on methadone for four years or more increased by a quarter between 2010–11 and 2012–13, from 39,725 to 48,510;[31]

- Residential rehabilitation, the most effective form of abstinence-based treatment, has been continually decommissioned. CSJ FOI requests revealed last year that 55 per cent of local authorities had reduced funding for residential rehab. Nationally, referrals to rehab have fallen 15 per cent between 2008/09 to 2011/12 compared to an overall reduction of 0.3 per cent for other treatments.[32] This is despite the fact that at the most effective abstinence-based rehabilitation centres over two-thirds of people beat their addiction.[33]

29 Speech by [Governor of Vermont state] Peter Shumlin, *State of the State*, 8 January 2014 [accessed via: http://governor.vermont.gov/newsroom-state-of-state-speech-2013 (06.08.14)]

30 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]

31 National Treatment Agency for Substance Abuse, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use*, 2010/11 [accessed via: www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xlsm (07.08.14)]; Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]

32 *Ibid and* National Treatment Agency, *Drug Statistics from the National Drug Treatment Monitoring System*, 2013[accessed via: www.nta.nhs.uk/uploads/ndtms_annual_report_200809_final.pdf (06.08.14)] (The fall to 2011/12 could be as high as 40 per cent but the methodology has changed and the data sets are no longer comparable)

33 National Treatment Agency, *The Role of Residential Rehab*, 2012, [accessed via: www.nta.nhs.uk/uploads/roleofresi-rehab.pdf (07.07.14)]

As a result of these failings, last year only 11 per cent (21,810) of people in drug treatment became drug-free.[34] One major driver of this is that the incentives for local public health teams to prioritise tackling addiction are weak. The Public Health Outcomes Framework (PHOF) is intended to drive local improvements in public health and yet:

- Only three indicators out of 66 are focused on alcohol and drugs (compared to four devoted to weight/obesity);[35]
- In 2012 over a third of the £2.66 billion public heath grant was ring-fenced for drugs and alcohol. That ring-fence has now been removed and at least a third of local authorities are making plans to cut funds to addiction services.[36]

Holding services to account on abstinence

To ensure that local public health bodies are incentivised to prioritise tackling addiction the CSJ proposes the following reforms:

- Within the context of devolved commissioning of addiction treatment, a Recovery Champion for England should be appointed to ensure services offer people the chance to become drug-free;
- To improve the commissioning of abstinence-based recovery Public Health England should be held to account on how many patients (proportionally and absolutely) leave treatment fully abstinent from drugs to alcohol;
- To drive improvements at a local level, Recovery Champions should be established as statutory members of Health and Wellbeing Boards and hold to account the performance of local authorities with regard to addiction.

Funding a new generation of high quality residential rehab

The treatment sector also currently suffers from chronic underinvestment:

- Germany spends approximately €9,000 per addict a year and Sweden €6,000, while the UK spends approximately €3,000 per addict, with the result being that these two other countries have considerably fewer problem drug users;[37]

34 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]

35 Department of Health, *Improving Outcomes and Supporting Transparency*, London: DH, 2013 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf (15/05/14)]

36 *British Medical Journal*. 'Raiding the public health budget' 27 March 2014 [accessed via: www.bmj.com/content/348/bmj.g2274 (08.08.14)]

37 European Monitoring Centre for Drug and Drug Addiction website [accessed via: www.emcdda.europa.eu//alias.cfm//countries/compare? 07.08.14)]

- In total, we spend just £42 million out of a total treatment budget of £1 billion on residential rehabilitation in England, despite it being by far the most effective abstinence-based method of recovery from addiction.[38]

To fund a new generation of residential rehabilitation centres to permanently reduce levels of addiction the UK, the CSJ recommends that the Government introduce a charge of one pence on every unit of alcohol sold in the UK rby the end of the next Parliament, rising to two pence by 2024, excluding sales in bars and restaurants.[39]

- This would raise around £155 million a year between 2015 and 2017, around £290 million a year between 2018 and 2020, around £410 million a year between 2021 and 2023, and around £520 million a year from 2024 onwards. It would be spent solely on setting up a network of abstinence-based rehabilitation centres and funding sessions within them;

- 330,000 addicts could receive treatment over a decade and create capacity for around 58,000 people to enter residential rehabilitation every year from 2024.

Involving families in treatment

The CSJ has heard how involving families in the treatment process can be extremely helpful in improving rates of recovery, yet currently there is a general lack of engagement with families. To help remedy this:

- Public Health England (PHE) should issue guidance to providers highlighting the value of including families in treatment consultations;

- The National Institute for Health and Clinical Excellence (NICE) should include the impact of treatment on family members/carers in assessments of the cost-effectiveness, benefits and risks of drug treatment programmes.

Responding to addiction

Every time an addict interacts with public services there is an opportunity to help them into recovery. Yet too little is made of these chances and, as a result, many who would benefit from treatment do not receive it. We explore how the most can be made of these opportunities. In particular, we focus on: welfare, criminal justice and health.

38 National Treatment Agency, *The Role of Residential Rehab*, 2012, [accessed via: www.nta.nhs.uk/uploads/roleofresi-rehab.pdf (07.07.14)]; The figure of £42 million is an outdated estimate from 2009/10. Subsequent years have seen a decline in referrals however a change in how data is collected means the latest figures are not directly comparable; Office for National Statistics, Tackling Problem Drug Use, London: ONS, 2010

39 Please see Appendix II for further details of the model

The Welfare System

Addiction and worklessness are inextricably linked:

- Approximately one in fifteen of those claiming welfare benefits have a substance dependency;[40]
- Dependent drinkers are twice as likely to claim benefits than the average citizen.[41]

Identifying addiction

Yet addicts are often not helped into treatment by Jobcentres Plus (JCP).[42] JCP Advisers and addicts told the CSJ that:

- People with an addiction are reticent to reveal their condition to the Jobcentre adviser due to a lack of trust that they would or could help;[43]
- If advisers suspect claimants have an addiction they often ignore the problem and, instead of dealing with it, wait to pass the claimant on to the Work Programme.[44]

To remedy this, we suggest that Jobcentres roll out the Intensive Activity Programme being piloted in Hammersmith, which enables advisers to build relationships with clients to establish the barriers to work they face, including addiction.

We also recommend that claimants are screened for addiction when presenting to JCP using the proven questioning techniques for example CAGE and AUDIT.

Linking benefits to treatment

Our welfare system could play a much more active role in helping addicts turn their lives around. Between 40,000 and 100,000 addicts are receiving benefits but not accessing treatment.[45] Although the last Government's 2009 Welfare Reform Act intended to establish a pilot which would have steered people on benefits with an addiction towards treatment,

40 Radice, R, *Drug and Alcohol DWP Strategy*, 2013 [accessed via: www.ldan.org.uk/PDFs/Rachel%20Radice%20%20welfare%20reform%20&%20JCP%20Offer%202.pdf (07/08/14)]

41 Hay G and Bauld L, Population estimates of alcohol abusers who access DWP benefits, London: DWP, 2010

42 Between 60,000 and 100,000 addicts could be claiming benefits without being in treatment Public Health England (PHE), Drug Statistics from the National Drug Treatment Monitoring System, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]; Prevalence of Opiate Use and/or Crack Cocaine Use, University of Glasgow [accessed via: www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf (06.08.14)]; Drugscope, Welfare Reform Bill 2009 Report Stage Briefing, 2009 [accessed via: www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=131D2BA9-3751-48FE-B5E1-865AFBE43E2D&mode=link&guid=508a2f4ade6f49e1b03f69cc4a98044e (07.08.14)]

43 C, *Evaluation of the Jobcentre Plus Intensive Activity trial for substance misusing customers*, London: DWP, 2011 [accessed via: http://findings.org.uk/count/downloads/download.php?file=Fisher_C_1.txt (07.08.14)]

44 CSJ, *Up to the Job?*, London: CSJ , 2012

45 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]; Prevalence of Opiate Use and/or Crack Cocaine Use, University of Glasgow [accessed via: www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf (06.08.14)]; Drugscope, 'Welfare Reform Bill 2009 Report Stage Briefing', 2009 [accessed via: www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=131D2BA9-3751-48FE-B5E1-865AFBE43E2D&mode=link&guid=508a2f4ade6f49e1b03f69cc4a98044e (07.08.14)]

it was never implemented.[46] Building on this idea, the next government should ensure that the welfare system has a duty to establish whether people need treatment for addiction and then to help them to take it. It should also ensure that people have a responsibility to work towards their own recovery.

In practice, this might mean that once a claimant had been identified as having an addiction, they would be offered abstinence-based treatment. If they accepted this, they would be placed in a suitable benefit category (perhaps Employment and Support Allowance (ESA) 'support group' (£108.15)) and have their conditionality suspended (for example, their job search requirements would be halted).

If a claimant declined the offer of treatment and refused to show willingness to face up to their addiction, they could then be placed on a lower category of benefit (perhaps ESA work-related activity (£101.15) or, in appropriate cases, Jobseekers Allowance (JSA)). They could also be required to take steps towards their own rehabilitation as agreed with their advisers, for example, a treatment awareness programme, educational session or specific interviews. Failure to comply with the agreed terms could result in sanctioning.

These reforms could only be implemented once there was sufficient capacity in the system to allow people to be offered high quality, abstinence-based recovery.

Welfare cards

For those with an entrenched alcohol or drug addiction who refuse treatment, who have not been in employment for a year and who have children, the use of welfare cash cards should be considered. Whilst this alone will not help addicts recover, evidence from similar successful initiatives in Australia has shown that such a scheme can protect addicts and their families by limiting the expenditure of their benefits to basic essentials such as food, clothing, travel etc.[47] Beyond this, it will establish a principle that taxpayers' money should not go directly into the pockets of drug dealers and may restore faith in our welfare system. We recommend piloting the scheme in the first instance.

46 Welfare Reform Act 2009 [accessed via: www.legislation.gov.uk/ukpga/2009/24/schedule/3]

47 Aus Gov Library, Is Income Management Working? 2012 [accessed via: http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/1603602/upload_binary/1603602.pdf (07.08.14)]; Creative Commons, *Cape York Welfare Reform Evaluation*. 2012 [accessed via: www.dss.gov.au/our-responsibilities/indigenous-australians/publications-articles/evaluation-research/cape-york-welfare-reform-cywr-evaluation-report-2012 (07.08.14)]; Proceedings of Australian Senate Finance Committee, 2013, [accessed via: www.aph.gov.au/parliamentary_business/committees/senate/finance_and_public_administration/social_services/report/~/media/Committees/Senate/committee/fapa_ctte/social_services/report/c02.ashx (08.08.14)]

summary

The National Health Service

Whilst overall levels of drinking in the UK are falling, research undertaken by the CSJ challenges the assumption that Britain is getting its drink problem under control:[48]

- Freedom of Information requests by the CSJ reveal that alcohol-related readmissions to hospital rose by 85 per cent in the four years up to 2012/13;
- The number of alcohol-related admissions to hospital has more than doubled since 2002;[49]
- Liver disease is now one of the 'big five killers' alongside heart and lung disease, stroke and cancer and the only one to be rising.[50]

The CSJ believes that no-one admitted to hospital with an alcohol-related condition should be discharged without being offered support and/or treatment. To make this possible, we suggest a number of recommendations, including:

- NICE should review how alcohol-related admissions are handled by hospitals – looking closely at pockets of good practice such as in Queen Alexandra Hospital and the Royal Liverpool;
- Commissioners of healthcare (CCGs) should ensure that alcohol screening is taking place, and readmissions should form part of their funding assessment.

The Criminal Justice System

Because crime and addiction are inextricably linked it is essential that the criminal justice system identifies addicts and helps them find treatment.

- Between one-third and half of new prisoners are estimated to have a severe drug problem in England and Wales and over half of offenders link their crime to their drug problem;[51]
- Half of the victims of violent crime believe their attacker had been drinking.[52]

Drug courts

A potentially successful means of tackling addiction is the use of drug courts:

- One comparison study found that those who passed through drug court were a fifth less likely to be using drugs than those who did not;[53]
- In Australia, those who completed the drug court programme were 37 per cent less likely to reoffend.[54]

48 *The Guardian*, 'Booze Britain Sterotype flagging' 30 May 2014 [accessed via: www.theguardian.com/commentisfree/2014/may/30/booze-britain-stereotype-flagging-alcohol-consumption-down (07.08.14)]
49 NHS Information Centre, Statistics on Alcohol 2011, London: DH, 2012
50 Office for National Statistics, *Age-standardised alcohol-related death rates*, London: ONS, 2013
51 UK Drug Policy Commission, *Reducing drug use, reducing reoffending*, London: UKDPC, 2008; Prison Reform Trust *Bromley Prisons Briefings Factfile*, London: Prison Reform Trust, 2010
52 Flatley J, Kershaw C, Smith K et al, *Crime in England and Wales 2009/10*, London: Home Office, 2010
53 The Multi-Site Adult Drug Court Evaluation, 2011, [accessed via: www.ncjrs.gov/pdffiles1/nij/grants/237108.pdf (07.08.14)]
54 Law Reform Commission of Western Australia, *Court Intervention Programs*, 2009 [accessed via: www.lrc.justice.wa.gov.au/_files/P96-FR.pdf (07.08.14)]

However, previous attempts to introduce drug courts in England and Wales have proven unsuccessful due to failures of implementation:

- The treatment provided has often been a methadone prescription, rather than abstinence-based rehabilitation;
- In only five per cent of cases did offenders see the same sentencer when they returned to work;[55]
- There was also a lack of rigorous evaluation of the pilots.

The CSJ calls on the Ministry of Justice to re-trial drug courts with adherence to all the key factors identified as essential to their success and then evaluate them in full.

Prisons

It is important that the time offenders spend in prison is also used productively to undermine the root causes of their offending – tackling drug and alcohol addictions is a crucial part of this. Yet, far from tackling addiction, prisons are currently awash with drugs and alcohol:

- In 2010–11, 38 per cent of those who entered local prisons had a drug problem and nearly one-third estimate they will leave prison still using drugs;[56]
- 22 per cent of prisoners surveyed reported having an alcohol problem when they entered jail.[57]

The CSJ strongly believes that the Government should seek to ensure that all prisons are drug- and alcohol-free. Further to this, they also need to be places where prisoners receive effective treatment to tackle their addictions:

- Work to ensure all prisons are drug- and alcohol- free;
- Treatment received in prison needs to mirror the level received in abstinence-based rehabilitation which is provided in the community;

To ensure prison treatment services are working towards recovery, the Recovery Champion for England should be able to access prisons, review the treatment services available and the prescribing practices.

55 Ministry of Justice, The Dedicated Drug Courts Pilot Evaluation Process Study, 2011 [accessed via: www.natcen.ac.uk/media/28647/the-dedicated-drug-courts-pilot-evaluation-programme.pdf (07.08.14)]

56 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011

57 Prison Reform Trust, *Bromley Briefings*, 2013 [accessed via: www.prisonreformtrust.org.uk/Portals/0/Documents/Factfile%20autumn%202013.pdf (07.08.14)]

Introduction

Drug and alcohol addiction profoundly weakens British society. 1.6 million people are dependent on alcohol in England alone.[58] One in five children under the age of one lives with a parent who drinks hazardously, and one in 40 with a parent who is addicted to drugs.[59] About 40,000 children have been taken into care because of their parents' substance misuse.[60]

Addiction fuels family breakdown and worklessness, crime and poor mental health, destroying lives and undermining communities. Despite well known solutions, it is a problem that successive governments have failed to resolve in any significant ways.

In 2007, the Centre for Social Justice's *Breakthrough Britain* report shattered a consensus which held little ambition for those with an addiction except that they be 'managed' on substitute drugs. Our work laid bare a failing drug treatment system which left many thousands of addicts trapped in state-sponsored dependency and offered little help to those with other addictions.

We established that addiction to drugs and alcohol was a pathway to poverty and that only the select few could access the help they needed to break free. This argument was accepted by many and now forms a key indicator of the Government's Social Justice Strategy and that drug-free recovery is, for the first time, an objective of the Drugs Strategy.[61]

Unfortunately, it is a mark of the failure of the intervening years that so little has changed on the ground. As our state of nation report, *No Quick Fix*, showed last year, the UK still has the highest level of heroin addiction, the highest level of cocaine and crack cocaine use, and the second highest level of alcohol dependence in Europe.

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58 Liverpool John Moores University, *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12*, 2014 [accessed via: www.nta.nhs.uk/uploads/estimates-of-the-prevalence-of-opiate-use-and-or-crack-cocaine-use-2011-12.pdf; Health and Social Care Information Centre, *Adult psychiatric morbidity in England: results of a household survey, 2007*, 2009 [accessed via: https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng- 2007-rep.pdf (05/05/14)] and National Institute of Clinical Excellence, *Alcohol-use disorders*, London: The British Psychological Society and The Royal College of Psychiatrists, 2011 [accessed via: www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf (01/08/14)]

59 Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in BMC Public Health, 9, 2009

60 Department for Education, Statistical First Release: Children looked after in England (including adoption and care leavers) year ending 31 March 2012, London: Department for Education [accessed on25/06/13 via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/167451/sfr20-2012v2.pdf.pdf (08/08/13)] and Cafcass, Three weeks in November … three weeks on, 2012 [accessed via: www.cafcass.gov.uk/pdf/Cafcass%20Care%20Application%20Study%202012%20FINAL.pdf (22/08/13)]

61 HM Government, *Drug Strategy 2010*, London: Home Office, 2010

On the surface, there appears to have been some progress. The number of heroin users is slightly down, as is the level of day-to-day drinking and the number of people using cannabis.[62] But beneath these basic figures are signs that little has changed. The reduction in heroin use appears to be substantially due to the fact that older addicts are dying off.[63] The reduction in overall national alcohol consumption is overshadowed by the fact that readmissions to hospital for alcohol-related reasons are soaring.[64] The decline in cannabis use is nullified by the dramatic rise in the availability and consumption of New Psychoactive Substances (sometimes known as 'legal highs').[65]

Enduring problems

As a nation we spend a significant amount of money on drugs and alcohol treatment – about £1 billion.[66] Yet the fact that the number of heroin addicts and alcoholics has not fallen substantially suggests that this money is not well spent.[67]

Far too much is still being wasted on interventions that have very poor long-term outcomes for those involved. Of these the most widely used is methadone. Of the 148,423 people on methadone, 66 per cent have been on it for more than a year and 52 per cent have been parked for more than two.[68] That one-third have been in substitute prescribing treatment for four years or more should be a source of national shame.[69]

As this report argues, the reasons for this failure are simple. Success is still not measured by how many people achieve abstinence, so there is little compunction to invest in the most effective forms of treatment, particularly residential rehabilitation, which is only given to less than five per cent of patients.[70]

The consequence of this failure to back abstinence-based programmes is that hundreds of thousands of people are not being given the chance to move on in their lives, often unfit for work, struggling to be of support to their families and severely unwell. These are the people who need assistance to move into recovery.

62 UK Focal Point on Drugs, *UK Drug Situation,* 2013 [accessed via: www.nta.nhs.uk/uploads/24780focalpointreport2013.pdf (06.08.14)]
63 *Ibid*
64 Health and Social Care Information Service, *NHS Statistics on Alcohol*, 2013
65 UNDON, World Drug Report 2014, [accessed via: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (07.08.14)]
66 National Audit Office, Tackling Problem Use, London: The Stationary Office, 2010 [accessed via: www.nao.org.uk/wp-content/uploads/2010/03/0910297.pdf (08/08/13)]
67 UK Focal Point on Drugs, *UK Drug Situation,* 2013 [accessed via: www.nta.nhs.uk/uploads/24780focalpointreport2013.pdf (06.08.14)]
68 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]
69 *Ibid*
70 *Ibid*

New challenges

Alongside these long-term problems, other challenges are emerging. A diverse range of New Psychoactive Substances ('legal highs'), which often mimic the dangerous effects of more established drugs and which are just as harmful and addictive, have appeared on the market. Because many of these are still legal they are easy to acquire and can give users the impression that they are safe.

At the same time, huge numbers of people are becoming addicted to prescription drugs – a problem which, in the US, has ultimately led to an increase in heroin consumption as users turn to more readily available illegal substitutes.

Supply of all drugs has found a new outlet through the internet which is making narcotics more widely available than ever before. Sites such as the Silk Road and its successors allow customers to order any type of drug and have it shipped to their front door. Other websites offer people the chance to mail order 'legal highs'.

Localism, whilst having exciting potential, also present policy challenges. As responsibility for public health has passed to local authorities it has created a less centralised system which makes it harder to drive through cultural change in commissioning. Similarly, the election of the first Police and Crime Commissioners cannot be allowed to force drug enforcement off the agenda in some police areas.

Policy proposals

In this, the final report of the *Breakthrough Britain 2015* Addictions Working Group, we tackle each of these issues and set out how the next government can drive through vital improvements that will permanently reduce the number of people suffering from addiction in our country.

This will require a strong lead from central government in holding local authorities to account for the services they provide, an upfront public investment in the most effective form of rehabilitation services, a determination to identify addicts whenever they come into contact with state services and to signpost them to the best treatment, and a new programme of preventative work to protect children and families from drugs and alcohol.

For too long many individuals, families and communities blighted by addiction have been written off in British politics. This report offers politicians of all parties the opportunity to ensure that they are offered a way out and the next generation is protected.

chapter one
Prevention: Keeping children, young people and families safe

Children and young people in the UK are among the earliest in Europe to try drugs and alcohol. Scotland, Wales and England rank sixth, eighth and ninth respectively in European league tables for early drunkenness.[71] Similarly, the last UN estimate said that the number of young people (15–24) in the UK who have taken a 'legal high' was the highest in Europe.[72]

Yet despite this problem, the CSJ has repeatedly heard that Government is doing too little to discourage young people from using drugs and abusing alcohol. In this section we discuss how young people and their families can be given better information about the dangers of drug and alcohol abuse. Because children who grow up with an addicted parent are seven times more likely to become addicted themselves, in Chapter Three we set out how the Government can substantially reduce levels of addiction in the UK.

Better education and information

Replacing the failing FRANK

In *No Quick Fix* the CSJ highlighted how the Government is letting young people down by a lack of effective prevention programmes.[73] The flagship drugs and alcohol prevention programme, FRANK, which has been running since 2003, is shamefully inadequate. Despite there being a lack of evidence that it has reduced the numbers of young people abusing drugs and alcohol, the Government continues to pump money into it and last year the Crime

71 World Health Organisation, *Status Report on Alcohol and Health in 35 European Countries*, Copenhagen: WHO, 2013 [accessed via: www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf (06.08.14)]

72 United Nations Office on Drugs and Crime, *World Drug Report 2013*, Vienna: United Nations, 2013

73 Centre for Social Justice, *No Quick Fix*, London: CSJ, 2013

Prevention minister reaffirmed this approach: 'the FRANK website … has been updated and re-launched and is widely used as a source of information – particularly … by young people'.[74] Yet a survey conducted by national treatment provider, Addaction, found that only one in ten children would call the 'FRANK' helpline to talk about drugs.[75]

The CSJ has long argued that the messages contained on the FRANK website do not send a strong signal to young people about the risks of experimenting with drugs.[76] For example, the main entry entitled 'Legal Highs', prioritises details on their effects and does not mention any of the known dangers until the fourth and final paragraph.[77]

A reinvigorated and up-to-date national campaign, be it FRANK or an alternative, including a focus on New Psychoactive Substances, would provide a catalyst to reengage school and parents.

Recommendation:

Scrap or reform FRANK and develop an effective replacement programme to inform young people about the dangers of drug and alcohol abuse.

An urgent part of this replacement programme should be an awareness campaign providing information on NPS to young people and parents. There is currently a great deal of misunderstanding about NPS, indeed, the term 'legal highs' may well form part of the problem as the term 'legal' can imply regulation and safety. These drugs are not legal to sell for human consumption but this nuance is lost on some. As treatment centre One North East London told the CSJ:

> *'People come in and they've tried these things and say "it was in a shop, at least you know it's not dodgy."'*

Many parents would like to know more about NPS and are extremely concerned by the uncertainty and availability of 'legal highs'.[78]

> *'These things are so new; parents often have no idea what they are and don't feel able often to discuss them.'*
> Elizabeth Burton-Phillips, Drugfam, in evidence to the CSJ

To date calls for a public health awareness campaign have fallen on deaf ears. Within Whitehall, health officials say that it is up to local authorities to decide what their public health priorities are, whilst local authorities claim a campaign would be too expensive for them to produce and publicise.

74 Hansard, House of Commons debate, 6 June 2013, c287WH [accessed via: www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130606/halltext/130606h0001.htm (08.08.13)]

75 Addaction, Press Release, 'One in five young people say they think parents have taken drugs, according to Addaction commissioned survey', October, 2008 [accessed via: www.addaction.org.uk/news.asp?section=253&itemid=297&search (08.08.13)]

76 Centre for Social Justice, *Green Paper on Criminal Justice and Addiction*, London: CSJ, 2010 [accessed via: http://centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJ_Green_paper_criminal_justice.pdf 05.08.2014]

77 FRANK website [accessed via: www.talktofrank.com/drug/legal-highs (06.08.2014)]

78 Angelus Foundation and Adfam, *Talking to your children about legal highs and club drugs* [accessed via: www.adfam.org.uk/cms/docs/Angelus_Adfam_Parent_ClubDrug_Booklet.pdf 05.08.2014)]

Professor Keith Humphreys, former White House drugs policy adviser, with Noreen Oliver MBE, chairman of the CSJ Addictions Working Group.

> *'No one wants to take ownership of this and as a consequence, young people are doing a lot of harm to themselves.'*
>
> Jeremy Sare, Angelus Foundation, in evidence to the CSJ

Just as authorities gravely underestimated the threat posed by heroin in the 1970s, there is a danger that they are underestimating the threat lurking amongst the various NPS. Some of these substances are highly addictive and life threatening. It was not until 20 years after the increase in heroin use, with addicts committing enough crime for society to notice, that treatment was expanded.[79]

Given the economies of scale that would be derived from a national awareness campaign, and the effectiveness of previous campaigns (such as HIV, seatbelt safety and solvent abuse), the Department of Health should produce a succinct information campaign.[80]

Re-Solv, a prevention charity initially set up 30 years ago to educate young people about solvent abuse, told the CSJ that prevention messages can be effective if part of a wider campaign:

> *'Educating young people, parents, and the public can have an effect, together with clear controls on retailers.'*
>
> Stephen Ream, Director, Re-Solv, in evidence to CSJ

Recommendation:

The Department of Health should produce an information campaign to educate parents and young people about the dangers of NPS.

79 Ian Wardle, Recovery and the UK Treatment System, 2009 [accessed via: www.fead.org.uk/docs/IWRecoveryPaper09-web.pdf (05/08/2013)]

80 Department of the Environment, *Seatbelts*, [accessed via: www.doeni.gov.uk/index/road_users/corporate-road-safety/road-safety-campaign-research/road-safety-campaigns/corporate-road-safety-seatbelts.htm (06.08.14)];The successful HIV campaign of the mid 1980s cost, between 1985–87, approximately £20 million in today's money. A similar campaign should not be as expensive now given the developments in public health infrastructure and the development of the internet and social media.

Prevention in schools

Schools must do more to ensure their pupils are protected from drug and alcohol addiction and abuse. The underdeveloped decision-making and risk-assessing centres of the brain in children mean they must be protected.[81] Programmes to build knowledge and strengthen the resilience of children are therefore paramount.

Whilst the number of 11- to 15-year-olds who drink alcohol each week is declining (from one in four in 2001 to one in ten in 2012[82]), more frequent drinking is rising with the number of young people drinking two days per week increasing by seven percentage points between 1998 and 2012.[83]

The CSJ has heard repeatedly that many schools are not taking seriously their responsibilities to educate pupils about the dangers of alcohol and drugs. Recent studies have shown that the subject of drugs, alcohol and tobacco is covered once a year or less by more than 60 per cent of schools from Key Stages Two to Four (ages 7–11) and 74 per cent of schools covered it once a year or less at Key Stage 1 (ages 5–7).[84]

> *'There are some kids here who I work with, young as 12, who are using drugs. Sometimes people sell [drugs] to them at school … yet the schools say they haven't got a problem. Not all kids are doing drugs, but some are, and they get no help. Schools need to open up.'*
> Caroline, Youth Worker, Stockton, in evidence to the CSJ

> *'A significant majority of the schools we have approached have been delighted to welcome our programme into their school, however where there has been reticence it has been typically led by a belief within a given school hierarchy that it does not have any issues with drugs and alcohol. In these instances we are left concerned by the lack of understanding on the part of the school about how their students' emotional wellbeing can greatly impact on their potential for engaging in problematic substance misuse in later life.'*
> Dominic Ruffy, Amy Winehouse Foundation, in evidence to the CSJ

There are programmes that can be delivered in schools which are known to prevent children abusing substances, as well as providing other behavioural improvements. However, structural arrangements and incentives within the education system hinder their use.

In order to improve prevention in schools, the Government should apply a form of the successful American-model of match funding approved schemes that are shown to reduce

81 John Hopkins Bloomberg School of Public Health, *Effects of Tobacco, Alcohol and Drugs on the Developing Adolescent Brain* [accessed via: www.blueprintsprograms.com/evaluationAbstracts.php?pid=9a3e61b6bcc8abec08f195526c3132d5a4a98cc0 (05.08.2014)]

82 These figures do carry a health warning – the sample size has decreased from 5204 to 3639 [accessed via: www.hscic.gov.uk/searchcatalogue?productid=12096&q=title%3a%22Smoking%2c+Drinking+and+Drug+Use+Among+Young+People+in+England%22&sort=Relevance&size=10&page=1#top (06.08.14)]

83 Health and Social Care Information Centre, *Smoking, Drinking and Drug UseAmong Young People – 2012,* Table 3.8 [accessed via: www.hscic.gov.uk/searchcatalogue?productid=12096&q=title%3a%22Smoking%2c+Drinking+and+Drug+Use+Among+Young+People+in+England%22&sort=Relevance&size=10&page=1#top (05.08.14)]

84 Formby E, 'It's better to learn about your health and things that are going to happen to you than learning things that you just do at school': findings from a mapping study of PSHE education in primary schools in England, Pastoral Care in Education, 29, 2011, pp 161–173

alcohol and drug abuse among children. Such programmes have been found to reduce problematic behaviour like substance abuse and violence by between 25 to 33 per cent.[85]

Communities That Care[86]

Communities That Care (CTC) is a flexible prevention programme that helps communities and officials in the US with the selection and implementation of evidence-based programmes which suit the particular needs of communities. Communities can therefore tailor their response to local challenges be it with teenage drinking, NPS ('legal highs') or gangs.

The Communities That Care programme has been shown to work. It was tested in a randomised controlled trial in 24 communities across seven states. They were paired and randomly assigned to either the programme or as controls and 4,407 students were monitored. By 13 to 14 years old, significantly fewer of the students from the CTC communities had health and behaviour problems than those from the controls.

The Good Behaviour Game

Another example of successful prevention is the 'Good Behaviour Game'. The 'game' aims to teach children how to be better pupils and reduce aggression or disruptive behaviour, which are known to be related to later substance abuse and dependence and antisocial behaviour. Findings represent some of the most substantial effects recorded from a school-based prevention programme. Results show it:[87]

- Halved the proportion of boys who would develop a dependence on alcohol;
- Halved (from 86 to 41 per cent) the rate amongst boys who were identified as likely to development acute problematic behaviour;
- Reduced 'regular' smoking rates from 17 to seven per cent;
- Reduced serious and persisting anti-social behaviour from 25 to 17 per cent.

The programme works by punishing bad behaviour and rewarding good. A review and consideration of the implementation in an English context found that the programme would cost:[88]

'Based on an optimal level of training and coaching support, the cost for one teacher with 25–30 pupils for the initial GBG year is estimated at £3704 … over ten years [the cost] comes down to £43 per pupil.'

Considering the potential benefit (savings up to $96 for every $1 spent), this programme should be prioritised for consideration for eligibility for any match-funding scheme.[89]

85 Hawkins et al, 'Results of a Type 2 Translational Research Trial to Prevent Adolescent Drug Use and Delinquency: A Test of *Communities That Care*', *Archives of Pediatrics and Adolescent Medicine*, 163, 2009, pp 789–798 [accessed via: www.ncbi.nlm.nih.gov/pmc/articles/PMC2740999/ (05/08/14)]; Kuklinski et al, 'Cost-Benefit Analysis of *Communities That Care* Outcomes at Eighth Grade', *Prevention Science*, 13, 2012, pp 150–161 [accessed via: www.ncbi.nlm.nih.gov/pmc/articles/PMC3305832/#R17 (05.08.14)]

86 *Ibid*

87 Kellam et al, 'Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes.' *Drug and Alcohol Dependence*: 2008, 95(suppl. 1), 2008 pp S5–S28 [accessed via: http://findings.org.uk/count/downloads/download.php?file=Kellam_SG_4.txt (05.08.14)]

88 Chan et al, *Improving Child Behaviour Management: An Evaluation of the Good Behaviour Game in UK Primary Schools*, 2012 [accessed via: www.swph.brookes.ac.uk/images/pdfs/research/GBG_UK_Final_Evaluation_Report_Executive_Summary.pdf (05/08/2014)]

89 Kellam et al, 'Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes.' *Drug and Alcohol Dependence:* 2008, 95(suppl. 1), 2008 pp S5–S28 [accessed via: http://findings.org.uk/count/downloads/download.php?file=Kellam_SG_4.txt (05.08.14)]

The Department for Education and the Department of Health (through the auspices of Public Health England) should allow schools to apply for match funding from the Public Health Grant given to local authorities to enable them to implement their favoured prevention schemes. Health and Wellbeing Boards, the branches of Public Health England which sit within local authorities, should supervise this process and award bids on the basis of need within their areas.

Recommendation to expand prevention in schools:

Schools should be able to apply for match funding through local Health and Wellbeing Boards for approved schemes known to reduce drug and alcohol use among children.

Directors of Public Health (DsPH) should ensure that any local needs assessments and Joint Strategic Needs Assessments include NPS use. DsPH should open a dialogue with local schools and parents as to what is occurring among the most vulnerable groups in society.

Conclusion

Addiction is the largest preventable killer in the UK. Through effective intervention in the family setting and at school, we can take action to prevent this condition being developed by future generations saving both resources and lives yet to be lived.

chapter two
Restricting supply

Restricting the supply of dangerous substances is a crucial part of reducing the harm they do. This applies to illegal drugs, new and emerging 'legal highs', as well as the excessive use of alcohol and prescription drugs. In many cases, it is the poorest and the young who are most at risk. Be it in drug- or alcohol- related violence or the impact upon life-chances, these groups bear a disproportionate level of harm.

In this chapter we analyse four areas of concern and suggest reforms to help tackle supply and overuse of:

- Illegal drugs on the street and online;
- 'Legal highs' on the street and online;
- Super cheap, super strong alcohol;
- Prescription drugs.

Tackling the supply of illegal drugs on the street and online

Success at tackling the supply of illegal drugs into the UK requires a two-pronged attack on both the traditional routes through which drugs have been distributed, such as street dealers, and the new supply networks opening up over the internet.

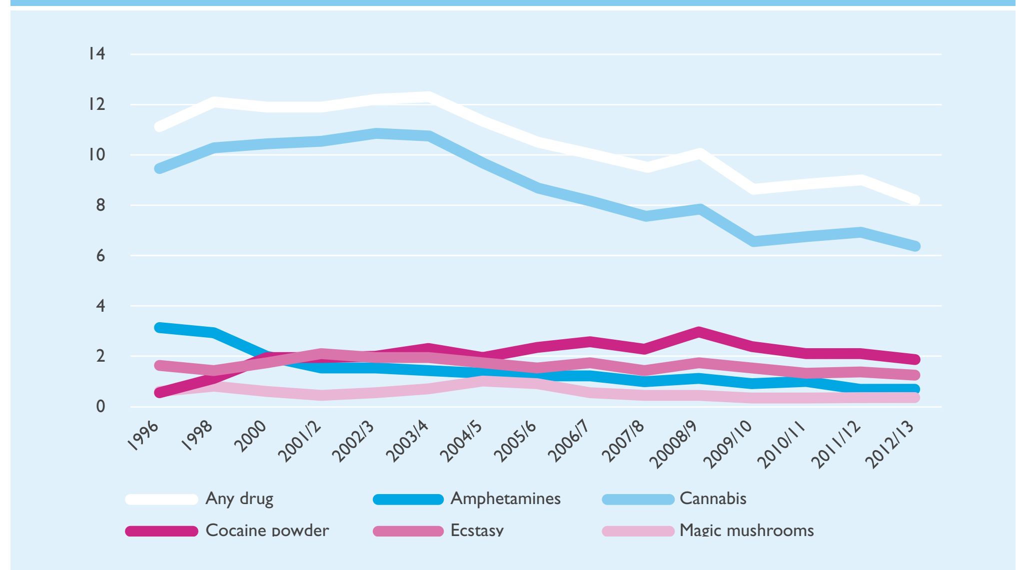
Improving the enforcement of drug laws

In England and Wales policing is currently failing to reduce the use of illegal substances. Over the past ten years drug use has remained largely constant, the only exception being a decline in the use of cannabis (see graph below). Opiates and crack, furthermore, have declined only marginally.[90] At the same time there has been a substantial growth in the use of New Psychoactive Substances (NPS) or 'legal highs'.[91]

90 UK Focal Point on Drugs, *UK Drug Situation,* 2013 [accessed via: www.nta.nhs.uk/uploads/24780focalpointreport2013.pdf (06.08.14)]

91 UN, *World Drug Report 2013,* Press Release, [accessed via: www.unodc.org/unodc/en/press/releases/2013/June/2013-world-drug-report-notes-stability-in-use-of-traditional-drugs-and-points-to-alarming-rise-in-new-psychoactive-substances.html (06.08.14)] NPS are often marketed as 'legal highs'. Many are chemical variant of illegal drugs, some being more dangerous than there illegal cousins. It is also the case that some drugs marked sold as 'legal highs' often contain illegal drugs, but are still sold openly in head shops.

Figure 1: Percentage of adults in England and Wales reporting using drugs to 2012



Drug law enforcement is not a priority in many police force areas. The CSJ has heard that many boroughs no longer have a dedicated drugs officer, with those officers having been drawn into tackling other areas of organised crime. Only ten per cent of respondents to the Global Drug Survey, who are more likely to use drugs than the general population, found to be in possession of drugs during a police stop and search were arrested and sent to court.[93] Bill Stupples, former police officer and drugs lead for the Association of Chief Police Officers confirmed this, telling the CSJ:

> *'Drugs by themselves just aren't a priority, not unless guns are attached.'*

Police and Crime Commissioners (PCCs) need to make tackling the supply and use of illegal drugs a priority in their force area. In order to help the public and media hold PCCs to account it is essential that there is relevant data made available.

At present, figures on drug use are not collected at police force level. We are calling on the Home Office to augment drugs misuse statistics by publishing annual data for the use of the following illegal substances broken down for each police force area:

- Heroin
- Crack
- Methamphetamine
- Cocaine
- Ketamine
- Amphetamines

92 UK Focal Point on Drugs, *UK Drug Situation*, 2012 *[accessed via:* www.cph.org.uk/wp-content/uploads/2013/03/23779-FOCAL-POINT-REPORT-2012-B5.pdf (06/08/14)]

93 The Guardian and Mixmag, *Global Drug Survey*, 2012 *[accessed via:* https://docs.google.com/spreadsheet/ccc?key=0AonYZs4MzlZbdDdrY2NMeWZpQzZwekxUU19TdWVrc3c#gid=11 (06/08/14)]

- Skunk cannabis
- Ecstasy
- Cannabis
- Other drugs controlled under the Misuse of Drugs Act 1971 as deemed appropriate

Regular publication of such data would offer significant progress in helping the public hold PCCs and Chief Constables to account for levels of illegal drug use in their area and should help to ensure that the tackling of drug supply and use does not slip down the list of local policing priorities.

Tackling the online supply of illegal drugs

As we highlighted in our 2013 report on addiction, *No Quick Fix*, the supply of illicit drugs across the internet presents a growing threat. The first online drug sites, such as the Silk Road, appeared in 2000, enabling people to buy all types of illegal drugs utilising the 'dark web'. Customers use online marketplaces and purchase drugs from dealers using the online practically untraceable currency, Bitcoin. The drugs are then shipped via regular postal services to an address chosen by the buyer. Users, including first-time users, now have access to substances they otherwise would not have tried.[94]

The Dark Web

Inaccessible through regular search engines, such as Google, sites like the Silk Road can only be accessed by logging on through a 'web proxy', such as the Tor ('The Onion Router') network. The individual's web 'identity', known as the Internet Protocol (IP) address, is bounced around the world through multiple servers, known as the 'onion skin effect'. The result of this is to render users almost untraceable, making it easier to conduct illicit trades without being caught.

It is extremely difficult to know how big the online drug trade is, but there are indications that it is large and growing – for example, there has been a worldwide 300 per cent rise in cannabis intercepted through postal services from 2000 to 2011.[95] Tellingly, between 31 to 45 per cent of trades are large in scale – e.g. parcels containing kilos of cannabis[96] – suggesting that dealers are shipping in sizeable quantities for resale on the streets. As Tim Bingham, independent drugs researcher, told the CSJ:

> *'Although we're talking about a relatively small part of the dealing, use of the Silk Road has definitely picked up amongst some dealers in the UK. It's definitely growing.'*

94 United Nations Office on Drugs and Crime, *World Drug Report 2014*, Vienna: UNODC, 2014, p18 [accessed via: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (06/08/14)]

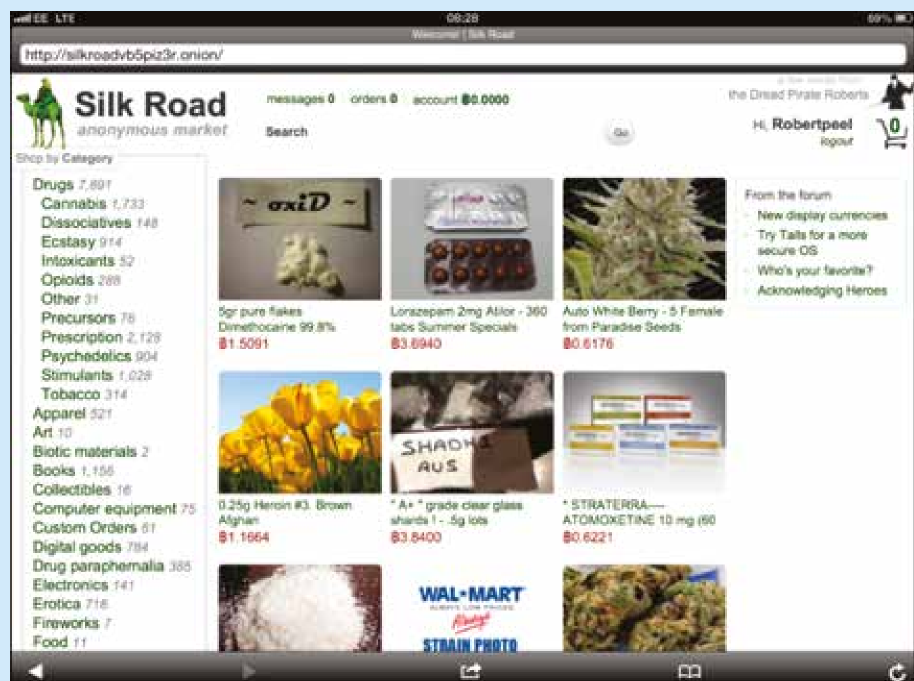
95 United Nations Office on Drugs and Crime, *World Drug Report 2014*, Vienna: UNODC, 2014, p18 [accessed via: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (06/08/14)]

96 Aldridge J, and Decary-Hetu D, 'Not an 'eBay for Drugs': The Cryptomarket "Silk Road" As a Paradigm Shifting Criminal Innovation', 2014 [accessed via: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2436643 (06/08/14)] Meaning kilos worth of cannabis (marijuana) and amounts of MDMA that translated to between 500 and 50,000 doses

Silk Road

With an estimated 200,000 people registered and a revenue of $1.2 billion, the Silk Road was the most infamous of the online, dark web market places. Its three most traded items were 'weed', 'drugs', and 'prescriptions'. Functioning in a similar way to Ebay the site puts buyers in contact with dealers. In 2013 the FBI shut it down, yet within weeks another version (Silk Road 2.0) was up and running.[97] It is thought that around 10 per cent of shipments come from the UK.[98]

Figure 2: A screen shot of the Silk Road, offering heroin for sale.



'We are not on top on this right now, the bad guys are definitely several steps ahead.'

Former Chief Detective Inspector in evidence to the CSJ

Although the Government has rightly stated its commitment to tackling the supply of illicit drugs online, tasking the National Crime Agency (NCA) to lead the fight, the CSJ has heard it will soon need more resources to meet this increasing threat. Only £65 million is spent by the Home Office on the Cyber Crime Strategy, out of a crime and policing budget of over £6 billion.[99] A leading on academic told the CSJ, 'this is big task, the FBI have struggled, at the moment the NCA just hasn't got capacity'.

97 Christin, N, 'Traveling the 'Silk Road': a measurement analysis of a large anonymous online marketplace'

98 Christin, N, 'Traveling the 'Silk Road': a measurement analysis of a large anonymous online marketplace'

99 Crime and Courts Bill, Factsheet [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/98445/fs-nca-what-how.pdf (06.08.14)]; HM Government, *The UK Cyber Security Strategy*, 2011 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/60961/uk-cyber-security-strategy-final.pdf (06.08.14)]

Furthermore, we have heard from international counterparts of the NCA that at present UK enforcement agencies do not have sufficient power to tackle some cyber crime in the most effective manner. For example, we were told that the necessary 'Forfeiture Statute' of the type which the FBI used to bring down the Silk Road, was not available to UK agencies.

While we welcome the increased focus of the Government on cyber crime and security, we believe that the next Government should make this more of a priority for law enforcement.

Although the founder of the Silk Road is due to go on trial in November 2014 there remains far more to do to effectively tackle this problem as there are many copycat sites. The Government must ensure that the NCA has adequate resources to investigate and if necessary close down these blackest of markets.

Recommendations to tackle the supply of illegal drugs online:

The Government should ensure that the NCA has the resources and powers necessary to tackle the growing threat of the online supply of illegal drugs. The next Government should consider legislating to give the NCA similar 'civil forfeiture' powers to those held by the FBI.

Tackling the supply of 'legal highs' on the street and online

The growing menace of NPS requires a robust response by government. These substances can be more harmful than illegal drugs and can be just as addictive. Action is required to ensure that this new and dangerous market does not go unchecked.

Because they are not illegal, NPSs can be sold online or in 'head shops' on the high street. Often these head shops operate on the edge of legality, and are both vague and creative in the descriptions given of their products.[100]

To circumvent the Medicines Act 1968, or any food regulations they are frequently labelled as 'NOT FOR HUMAN CONSUMPTION', and advertised as, for example, research chemicals, plant food, bath salts, room odouriser or pond cleaner. However, they are priced far in excess of what those products would normally be priced (e.g. 'Plant Food' at £20 to £30 per gram as opposed to £3.00 for a kilo in supermarkets).

The number of high street-based head shops in Britain is uncertain but according to the Angelus Foundation which works with those affected by NPS there could be as many as 250 across the UK.[101]

100 Some NPS sold as 'legal highs' have been found to contain illegal drugs. However they are not branded as such and pass unnoticed by police through head shops.

101 Angelus Foundation in evidence to the CSJ

The Irish success story

The Irish Government has had considerable success in reducing the number of head shops.[102] In 2010, growing concern about the availability of drugs in high street shops led to a Bill being passed that has, according to the Department of Justice in Dublin, effectively removed the threat of head shops.[103] The CSJ was told by Tracy O'Keefe of the Criminal Law Reform Division, Ministry of Justice (Dublin): *'before this there were well over 100, now there are fewer than 10'*.[104] Of these, a review found that 'none are selling psychoactive substances and only one… was observed to have hydroponic equipment on display'.[105]

> *'HEAD shops across the country were closed yesterday on day one of a "blanket ban" on mind-altering drugs. Garda sources said reports from 12 Garda divisions across the country at 5pm yesterday indicated that no head stores had opened. Gardaí expect to have a full picture by later today. They said the "vast majority" of head shop owners had indicated before yesterday that they had decided to shut up shop for good. In Dublin, the biggest and most popular head shops had their shutters pulled down with signs saying they had closed.'*
>
> Irish Examiner: Tuesday, 24 August 2010

The CSJ has heard that the result of the closures has been to reduce harm to young people by restricting the availability of these drugs on the high street. We spoke to emergency departments across the Republic of Ireland and heard consistently how the ban had led to a reduction in the number of young people being admitted for ingesting NPSs.

Reduction in admissions following to ban on selling NPS in Ireland

Irish Doctors in evidence to the CSJ

> *'Before they [Irish Parliament] passed this law, you would see five or six admissions to our hospital of people suffering from some NPS consumed each weekend. Since the 2010 law, that figure has gone right down.'*
>
> **Dr Chris Luke, Cork University Hospital**

> *'There was one head shop right in the centre of town, it closed down. It made a huge difference … night and day'.*
>
> **Dr Conor Egleston, Drogheda Hospital**

> *'It was a definite and sudden change, and specifically young people'.*
>
> **Dr John O'Donnell, Galway University Hospital**

> *'Although our numbers were small, we noticed the difference.'*
>
> **Dr Gerry Lane, Letterkenny General Hospital**

102 National Advisory Committee on Drugs, *An Overview of New Psychoactive Substances and the Outlets Supplying Them*, Dublin: NACD, 201, p18 [accessed via: www.dit.ie/cser/media/ditcser/documents/Head_Report2011_overview.pdf (06.08.14)]

103 National Advisory Committee on Drugs, *An Overview of New Psychoactive Substances and the Outlets Supplying Them*, Dublin: NACD, 201, p18 [accessed via: www.dit.ie/cser/media/ditcser/documents/Head_Report2011_overview.pdf (06.08.14)]

104 In evidence to the CSJ

105 Kelleher C, Christie R, Lalor K, Fox J, Bowden M and O'Donnell C, *An overview of psychoactive substances and outlets supplying them*, Dublin: National Advisory Committee on Drugs, 2011 [accessed via: www.drugsandalcohol.ie/15390 (06.08.14)]

This view was confirmed by Tim Bingham, an independent expert of new drugs research in Ireland. He told the CSJ that head shop closures have helped to protect teenagers saying *'it hasn't really affected the older drug users, who use the internet to buy drugs, but there has been a decrease amongst the under-age'*.

The **Criminal Justice (Psychoactive Substances) Act 2010** makes it an offence to sell a psychoactive substance knowing or being reckless as to whether it is being acquired or supplied for human consumption. It also places the burden of proof 'on balance of probabilities', thereby making it easier to prove. We demonstrate briefly below how the Act works in practice (for more details please see Appendix I).

A central provision of the Act is the definition of the term 'psychoactive substance' as a substance, product, preparation, plant, fungus or natural organism which has, when consumed by a person, the capacity to:

a. produce stimulation or depression of the central nervous system of the person, resulting in hallucinations or a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood, or
b. cause a state of dependence, including physical or psychological addiction,

but with exemptions for alcohol, tobacco, food etc..

In Ireland, the law is enacted in the following way:

- A senior officer serves a Prohibition Notice to stop selling a substance he suspects to be psychoactive;
- If the officer believes the Notice has not been complied with, he can apply to court;
- The court can decide to issue a Prohibition Order if it deems the accused to have sold psychoactive substances;
- If the person fails to comply with the Order the court can issue a Closure Order and have their shop closed and they can be banned from operating certain types of businesses for up to five years. Breach of Closure Order or ban constitutes a criminal offence.

A recent review of this legislation has found:

> *'While the operation of the 2010 Act continues to be monitored, it appears that the legislation has achieved its main objective which was to tackle the headshop trade in Ireland and the widespread public availability of unregulated psychoactive substances.'*[106]

This process has also been applied to online outlets of 'legal highs' based in the UK. The police, having identified an online seller of psychoactive substances, would contact them and can begin the process against them.

Given that one estimate says 80 per cent of NPS are sold over the internet, it is important

106 Ministry of Justice, Dublin, in evidence to CSJ

that attention is not solely focused on high street head shops.[107] A combined effort of police, regulators, companies and internet service providers (ISPs) should all be pushed in an attempt to disrupt the trade of these harmful substances online.

The NCA, deploying the skills of the Child Exploitation and Online Protection Centre, should step-up their work to monitor and, if appropriate, disrupt sites offering dangerous chemicals. The NCA is already working with ISPs to tackle access to abuse images online and resources should be made available to the NCA to include work to disrupt the sale of NPS.

However, it must be noted that this will not prevent online sales of 'legal highs' when the website and provider are in a different country and the NCA should further investigate how best to undermine this trade. In Ireland, for example, it has been recommended that a system of cooperation is explored similar to that between the Irish Medicines Board and the customs authorities to monitor the sale of counterfeit medicines.[108]

Recommendations to tackle supply of NPS through head shops:

- The Ministry of Justice should study the Irish experience and seek to affect a similar solution through legal systems of the UK.
- PCCs should direct their local forces to make an assessment of the number and location of local head shops and, following enactment of the above legislation, prioritise eliminating them.

Reducing alcohol abuse

Alcohol is the most commonly abused drug in the UK. In recent decades it has become more available and affordable:

- Alcoholic beverages are 61 per cent more affordable than in 1980;[109]
- The 2003 Licensing Act introduced 24-hour licenses, which have increased year on year – there are now approximately 8,900;[110]
- The number of prosecutions for serving someone a person already intoxicated has fallen from 369 to 143 between 2009 and 2013;[111]
- The number of off-licenses has more than doubled over 50 years, including an increase of 2500 from 2005 to 2011.[112]

107 Jeremy Sare, former Home Office Drugs Official and Angelus Foundation, in evidence to the CSJ.
108 National Advisory Committee on Drugs, *An Overview of New Psychoactive Substances and the Outlets Supplying Them*, Dublin: NACD, 2011[accessed via: www.dit.ie/cser/media/ditcser/documents/Head_Report2011_overview.pdf (06.08.14)]
109 Institute of Alcohol Studies, *Alcohol Affordability*, 2013 [accessed via: www.ias.org.uk/Alcohol-knowledge-centre/Price/Factsheets/Alcohol-affordability.aspx (06.08.14)]
110 Institute of Alcohol Studies, *Alcohol Licences: Statistical Trends*, 2013 [accessed via: www.ias.org.uk/Alcohol-knowledge-centre/Availability-and-licensing/Factsheets/Alcohol-licences-Statistical-trends.aspx (06.08.14)]
111 Hansard, Written Answers and Statements, Column 388W, 30 June 2014 [accessed via: www.publications.parliament.uk/pa/cm201415/cmhansrd/cm140630/text/140630w0002.htm (06.08.14)]
112 Institute of Alcohol Studies, *Alcohol Licences: Statistical Trends*, 2013 [accessed via: www.ias.org.uk/Alcohol-knowledge-centre/Availability-and-licensing/Factsheets/Alcohol-licences-Statistical-trends.aspx (06.08.14)]

two

Whilst for those who drink alcohol in moderation there are generally no lasting negative effects, the damage this has caused for those who abuse alcohol or become dependent upon it is significant:

- In 2012, there were 6,490 alcohol-related deaths – a 19 per cent increase from 2001;[113]
- Liver disease is the only one of the big five killers that is rising with at least 37 per cent being driven by alcohol abuse;[114]
- Alcohol-related hospital admissions have doubled in a decade.[115]

The Government has taken some action to try and tackle problem drinking. The introduction of the late night levy and early morning restriction orders, for example, have given councils useful tools to tackle alcohol abuse.[116]

Similarly, brewers have made some important changes. The drinks industry has agreed to take one billion units out of circulation by gradually lowering the strength of their drinks.[117] Heineken has also ended the production of the branded, strong, low-cost *White Lighting* cider.[118]

Yet these 'solutions' are not fixing the problem, and alcohol abuse and dependency is getting worse in this country. The human misery caused by this failure is alarming. The physical problems of prolonged abuse include brain damage (Korsakoff's syndrome – estimated to effect some 192,000 people in England), as shown by short term memory loss, shuffling of feet and liver damage. [119] As Dave Bell, of homeless charity St Mungos, told the CSJ:

> *'35-year-olds are dying from problems related to drinking super strength lagers and cider. By the time they've died they often have the physical health of someone over retirement age.'*

Despite the damage to individuals and the costs to society, however, prosecutions for the sale of alcohol to intoxicated persons have decreased. The number of prosecutions, already low at 369 in 2009, had more than halved by 2013 to 144.[120]

Police and Crime Commissioners should direct police to raise awareness among both on- and off-trade business about the consequences of selling alcohol to those already intoxicated and, where necessary, increase the policing of this legislation.

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113 Health and Social Care Information Centre, *Statistics on Alcohol – England*, Leeds: HSCIC, 2014, [accessed via: www.hscic.gov.uk/catalogue/PUB14184/alco-eng-2014-rep.pdf (06.08.14)]

114 Drinkaware, *Alcohol and Liver Disease*, 2014 [accessed via: www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/effects-on-the-body/alcohol-and-your-liver (06.08.14)]

115 HSCIC, *Statistics on Alcohol – England*, 2014

116 Late Night Levy allows councils to raise a contribution from premises to help with the cost of policing the night-time economy. Early Morning Restriction Orders allow authorities to restrict alcohol sales from 12 midnight to 6 am.

117 Public Health Directorate, Health and Wellbeing Division, Alcohol and Drugs Branch, *Responsibility Deal Alcohol Network – Pledge to remove 1 billion units of alcohol from the market by 2015 – interim report*, London: Department of Health, 2014 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/306529/RDAN_-_Unit_Reduction_Pledge_-_1st_interim_monitoring_report.pdf (06.08.14)]

118 Marketing Week, *Heineken Withdraws White Lightning*, 15 December 2009 [accessed via www.marketingweek.co.uk/heineken-withdraws-white-lightning/3007903.article (06.08.14)]

119 Alcohol Concern, *Wernicke-Korsakoff's syndrome: Factsheet 6 Summary*, London: Alcohol Concern, 2001[accessed via: www.alcoholconcern.org.uk/assets/files/Publications/Wernicke-Korsakoff%20Factsheet1.pdf (06.08.14)]

120 Hansard, Written Answers and Statements, Column 388W, 30 June 2014 [accessed via: www.publications.parliament.uk/pa/cm201415/cmhansrd/cm140630/text/140630w0002.htm (06.08.14)]

Local action

The CSJ has highlighted how some measures taken by local communities, including local businesses, have had an impact in tackling street drinking. Our report, *Potential for Partnership,* highlighted what can be done if communities work together.[121] Another example is Brighton's *Sensible on Strength Campaign*, which has seen the police, trading standards and local business working together to reduce the alcohol content of certain types of product. The results, according to local GPs, is that:

> *'The homeless report that many people have switched to lower strength alcohol, as the higher strength brands like Tennants and Special Brew become harder to find.'*[122]

To allow communities to make informed decisions as to how many premises should be able to sell alcohol in their areas, they should be permitted to take into account the impact on health of a saturation of licenses. At present in England, there are four grounds upon which a council may object to a license application:

- The prevention of crime and disorder;
- The protection of public safety;
- The prevention of public nuisance;
- The protection of children from harm.[123]

However, they can only do so on the four grounds mentioned above, public health is not a ground for objection. Dr Richard Aspinall, Consultant Hepatologist at Queen Alexandra Portsmouth, told the CSJ:

> *'I would love to use our data to inform council decisions on health grounds, they would see the harm and cost of these parades of bars and clubs.'*

Given the rising cost to the health service, and considering the future unavoidable demands increasingly being placed on the NHS by an ageing population, we must take action to tackle preventable conditions stemming from alcohol abuse.

We therefore recommend that the Government introduce legislation to make promotion and/or protection of health an objective of licensing by amending s4(2) Licensing Act 2003.

Recommendations to tackle the over-supply of alcohol:

- Police and Crime Commissioners should direct police forces to inform licensed premises of their duty not to sell to intoxicated persons and ensure that this legislation is enforced.
- Government should introduce legislation to make promotion and/or protection of health an objective of licensing by amending s4(2) Licensing Act 2003.

121 Centre for Social Justice, *Potential for Partnership: Working to create safer, healthier communities*, London: Centre for Social Justice, 2013 [accessed via: www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/Potential_for_partnership_WEB.pdf (06.08.14)]

122 Equinox Care, *Brighton Street Drinking Audits: 2013 to 2015,* 11 June 2014 [accessed via: www.equinoxcare.org.uk/news/equinox-brighton-street-drinking-audits-2013-to-2015/ (06.08.14)]

123 Scotland has an additional factor of protection of public health

Preventing the overuse of prescription drugs

'What started as an Oxycontin and prescription drug addiction problem in Vermont has now grown into a full-blown heroin crisis.'
Governor of Vermont on the effects of over-prescribing, State of the State Address, January 2014[124]

The over prescribing of drugs is causing increasing harm, especially in poorer communities. Driven by short patient contact time and a system which does too little to encourage non-medical interventions, Britain maybe in danger of following the United States into an epidemic of prescription drug abuse. This epidemic is seeing increasing numbers of young people turn to heroin having become addicted to a medically prescribed opiate.

Official figures on the level of addiction to medication in the UK are not collected but one estimate puts the figures as high as 1.5 million people.[125] Given that the consequences of addiction to prescribed medication are much the same as any other drug – higher chances of workless, family breakdown, crime, an increased burden on the NHS[126] – it is unsurprising that overprescribing is commonly found in poorer areas.[127] Blackpool, Salford, and Newcastle have, for example, approximately around three times as many antidepressant prescriptions per patient per year than Kensington and Chelsea.[128]

The CSJ has heard that poor prescribing practice is one of the main reasons why strong medications are prescribed. Contrary to NICE guidelines, which state that due to the long-term addictive consequences, benzodiazepines should be a limited short-term measure during crises, they are in fact prescribed for far longer in many cases. [129] One locum GP told us:

'I know of cases where people don't check the notes properly, or allow themselves to be bullied, and they rewrite a prescription for another two weeks. If the same thing happens again, the patient is soon developing both tolerance and dependence.'

We have also been told that a consultation of ten minutes or less is not always long enough to get to the root cause of complex psycho-social problems. Prescribing a potentially addictive painkiller, sleeping tablet or sedative can make for a less demanding and quicker consultation.

124 Speech by [Governor of Vermont state] Peter Shumlin, *State of the State*, 8 January 2014 [accessed via: http://governor.vermont.gov/newsroom-state-of-state-speech-2013 (06.08.14)]

125 Home Affairs Committee, *Drugs: New Psychoactive Substances and* Prescription Drugs, London: Home Affairs Committee, 2013 [accessed via: www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/819/81906.htm (06.06.14)]

126 Ashton H, 'The Diagnosis and Management of Benzodiazepine Dependence', *Current Opinion in Psychiatry*, 18, 2005, p249–255 [accessed via: www.benzo.org.uk/amisc/ashdiag.pdf (06/08/14)]

127 Perrot J. letter to the British Association or Psychopharmacology, London: All Parliamentary Group for Involuntary Tranquilliser Addiction, 2013 [accessed via: www.appgita.com/index.php/2013/11/letter-to-the-british-association-for-psychopharmacology-and-to-the-authors-of-the-recently-published-paper-benzodiazepines-risks-and-benefits-a-reconsideration/ (06/08/14)]

128 The Guardian, Datablog, [accessed via: https://docs.google.com/spreadsheet/ccc?key=0AonYZs4MzlZbdEhkM0hoaWVieC12Z1Z5VUtNc2tSeGc&hl=en#gid=0 (06.08.14)]

129 National Institute for Clinical Excellence, 'Summary of guidance relevant to general practice published in January 2011', [accessed via: www.nice.org.uk/usingguidance/implementationtools/howtoguide/January2011SummaryOfGuidance.jsp#osteoporotic on 13 May 2013]; NTA, *Addiction to Medicines*, 2011, [accessed via: www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf (06/08.14)]

In addition, a lack of alternative therapies is leaving doctors feeling as if they have no choice but to prescribe.[130] One GP and CCG lead for substance misuse, told the CSJ:

> *'Talking therapies aren't there. Because GPs want to support someone, they can end up prescribing because there's nothing else to do.'*

We need to ensure that GPs, and the targets they work towards, tackle addiction rather than enable it. As the majority of those addicted to prescribed medication are 'managed' by a GP as opposed to their local drugs and alcohol addiction services, GPs have a key role to play in seeking change and preventing dependence.

A few small changes can go some way to dealing with the overprescribing crisis. The main vehicle at a national level for ensuring that national policy priorities become priorities in the GP consulting room is the Quality Outcome Framework (QOF). NICE is the responsible body for setting the outcomes, in consultation with bodies like PHE.[131]

Quality Outcomes Framework (QOF)[132]

QOF was introduced to improve the quality of general practice. It is now a key tool via which policy is implemented, from central health decisions on best practice down to a GP's consultancy room. QOF rewards GPs for implementing best practice in their surgeries. Participation is voluntary for each practice but for most GPs participate as it is one of the few areas where they can top-up their income.

QOF is a list of different targets – either clinical outcomes (for example, percentage of patients with a blood pressure lower than 140/85), clinical processes (for example, percentage of patients who are given emergency contraception who also receive advice on long-term contraception options) or administrative processes (for example, how well the practice is managed).

To incentivise GPs to work towards QOF, a proportion of practice income (approximately 17 per cent) is linked to the achievement of its targets.[133] It is also seen as a marker of 'good practice' and results are published along with performance breakdowns, so many practices are keen to do well.

There has never been a QOF target for addiction and this is a striking omission, especially considering the levels of dependence of prescribed medication. A huge number of conditions are included, e.g. Mental Health, Diabetes, Cancer, Kidney Failure, Depression, Contraception, Blood Pressure, Thyroid Disease, Asthma, Flu, COPD, Rheumatoid Arthritis, Peripheral Vascular Disease etc., some of which have a much lower prevalence rate than addiction. For

130 Pulse Today, *GP's forced to prescribe as psychological therapy services are 'bursting at the seams'*, 19 June 2014 [accessed via: www.pulsetoday.co.uk/clinical/therapy-areas/mental-health/gps-forced-to-prescribe-as-psychological-therapies-services-are-bursting-at-seams/20007033.article#.U62RPJRdWSo (06/08/2014)]

131 Health and Social Care Information Centre, *Quality and Outcomes Framework: GP Practice Results*, Leeds: HSCIC, 2013 [accessed via: www.qof.hscic.gov.uk/index.asp (06/08/14)]

132 *Ibid*

133 Pulse Today, *Smaller QOF being considered under radical rethink of GP contract by NHS England*, 15 May 2013 [accessed via: www.pulsetoday.co.uk/your-practice/practice-topics/qof/smaller-qof-being-considered-under-radical-rethink-of-gp-contract-by-nhs-england/20002965.article#.U6MAa5RdWSo (06/08/14)]

example, Peripheral Vascular Disease affects a lower proportion of the population than the five per cent who are alcohol dependent.[134]

Recommendations to tackle over-prescribing of medicines:

Until we know the size of the problem, targeting support will remain a challenge. Prevalence estimates should be undertaken to achieve the most accurate estimate possible of the number of people dependent upon prescribed painkillers. This task could be undertaken by the North West Public Health Observatory who have expertise in estimating the number of people dependent on other drugs and also creating local area profiles.[135]

NICE should include an addiction section in QOF with a few reasonable targets. These could include:

- The practice must maintain a list of all patients on opiate substitution therapy (OST), even if this is prescribed externally to the practice. It should be clearly visible in the notes of these patients that they are on OST;
- All patients on OST should have an annual face-to-face review within the practice to include weight, blood pressure, blood born virus screening, discussion of potential relapse triggers and a discussion mapping out the person's recovery journey. (This would mirror the annual health check that is required for patients with mental health problems.);
- Patients initiated on a benzodiazepine or z-drug should be reviewed face-to-face within a month of starting this medication. (This should help to increase awareness of the risk of tolerance, dependence and dose escalation and contribute to a reduction in prescribing);
- All patients receiving benzodiazepines, z-drugs or strong opiate analgesics on an ongoing basis should have a face-to-face review repeated six monthly and receive information from the practice about the risk of tolerance and dependence;
- The rate of prescribing of psychoactive drugs per patient per GP clinic should be published and made easily accessible. This would allow the approach of practices to prescribing to be compared in a demographic context. Some practices will have a higher demand than others but publishing this data will encourage GPs in high prescribing areas to consider whether high levels of methadone, benzodiazepines., Ritalin etc are really in their patients best, long-term interests.[1136] CCGs would also be able to better scrutinize the prescribing habits of practices to ensure value for money.

134 National Institute for Health and Clinical Excellence, *NICE cost impact statement: QOF indicators for peripheral arterial disease,* 2011 [accessed via: www.nice.org.uk/Media/Default/Standards-and-indicators/QOF%20Indicator%20Key%20documents/NM35%20cost%20statement.pdf (06/08/14)

135 See HASC for further recommendation: www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/819/81906.htm

136 Some of this data is already available but is highly inaccessible and spread across three large databases on the Health and Social Care Information Centre website. Publishing the data in an accessible location would allow for more targeted support to break the cycle of dependency.

chapter three
Reducing demand – treatment and recovery

Addiction to drugs and alcohol wrecks lives and is blighting communities. 300,000 people suffer from an opiate and/or crack addiction and 1.6 million are dependent on alcohol in England alone.[137] Beyond the human tragedy is a vast financial cost to society: annually, drugs cost society £15 billion and alcohol £21 billion.[138] The best way of reducing these costs is by helping people fully recover from their addiction.

The CSJ's seminal Addiction Report of 2007 exposed a system of treatment which held heroin addicts in 'managed dependency' on opiate substitutes and did little for other addicts or alcoholics. Access to drug-free rehabilitation was the preserve of the rich, who could afford to pay for residential treatment.

In the wake of this, the last Government's 2008 Drug Strategy belatedly stated that treatment should aim for addicts to become drug-free. The Coalition Government's 2010 Drug Strategy went further, including for the first time the ambition of recovery. This has helped foster the powerful benefits of mutual aid and seen a small amount of capital funding to build up services that nurture and strengthen full recovery.[139]

Yet there is much more to do to ensure that treatment is fully focussed on achieving recovery. The treatment sector is still predominantly concerned with 'managing' addicts rather than promoting abstinence from drugs and alcohol. At present some 148,000 people are on a substitute prescription script, 98,000 of whom have been on it for more than a year. Furthermore, as we showed in our 2013 paper, *No Quick Fix*, referrals to residential rehabilitation centres – by far the most effective form of treatment – are falling.

137 HM Government, *The Government's Alcohol Strategy*, London: HM Government, 2012; HM Government, *Drugs Strategy 2010*, London: HM Government, 2010

138 HM Government, *Drugs Strategy 2010*, London: HM Government, 2010; HM Government, *The Government's Alcohol Strategy*, London: HM Government, 2012

139 HM Government, *Drugs Strategy 2010*, London: HM Government, 2010

This section argues that Government can drive abstinence-based recovery by:

- Establishing more rigorous metrics to hold local authorities' public health strategies to account on how well they are providing recovery;
- Creating a Recovery Champion for England to monitor the effectiveness of local authorities' responses to addiction in their areas;
- Raising a 'treatment tax' on alcohol to fund a new generation of high quality residential rehabs to permanently reverse the level of addiction in the UK.[140]

The importance of abstinence

The most effective way to overcome addiction and eliminate its costs is for the person to become abstinent. At present, however, treatment in England does not sufficiently help enough people recover.[141] One reason for this is the failure of treatment to target and support abstinence, a situation compounded by a sometimes inadequate workforce and a lack of resources.

Despite ambitious strategy documents issued by the Government and a slight improvement on past performance, too few people are leaving treatment drug-free and many are receiving inadequate support to maintain abstinence and build their recovery.[142] Last year, only 11 per cent (21,810) of people in drug treatment became drug-free.[143] Simultaneously, residential rehabilitation, the most effective form of treatment, has been continually decommissioned – CSJ FOI requests revealed last year that 55 per cent of local authorities had reduced funding for residential rehab. Nationally, referrals to rehab have fallen 15 per cent between 2008/09 and 2011/12 compared to an overall reduction of 0.3 per cent for other treatments.[144]

The CSJ has repeatedly heard how treatment that aims for abstinence, with integrated support, is both considerably more effective in the medium to longer term and much better for the patient. A lack of so-called 'gold-standard' research, however, means that pharmacological treatments (drugs used to treat drug addictions) have been better evidenced and approved. Compared to the numerous studies into the efficacy of methadone prescription, there are far fewer which look at long-term results of abstinence-based treatment.[145]

Those that exist, however, are compelling.

140 Treatment is a devolved matter but our recommendation would be for all devolved administrations to invest in abstinence-based rehabilitation.

141 Drug treatment is a devolved matter, although much of the analysis applies across all four home nations.

142 HM Government, *Putting Full Recovery First*, London: HM Government, 2012; HM Government, *The Government's Alcohol Strategy*, London: HM Government, 2012; HM Government, *Drugs Strategy 2010*, London: HM Government, 2010

143 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]

144 *Ibid* and National Treatment Agency, *Drug Statistics from the National Drug Treatment Monitoring System*, 2013[accessed via: www.nta.nhs.uk/uploads/ndtms_annual_report_200809_final.pdf (06.08.14)] (The fall to 2011/12 could be as high as 40 per cent but the methodology has changed and the data sets are no longer comparable)

145 Spence, D, *Evidence based medicine is broken,* 2014 [accessed via: www.bmj.com/content/348/bmj.g22?sso (06.08.14)]; Humphrys, K, *Circles of recovery,* Cambridge: CUP, 2004. The Tracer study underway at the National Addiction Centre is a welcome exception.

The American Physician Health Program (PHP)

The American Physician Health Program offers support to physicians seeking to recover from addiction. Its results demonstrate that the vast majority can recover from addiction if provided with the proper motivation, treatment and aftercare. It has strong expectations of abstinence, rigorous monitoring and the assertive links to mutual aid.[146]

Opiate addicts in the PHP saw remarkable progress: five-year abstinence rates of 79 per cent and return to work rates of 96 per cent were achieved. (In comparison, only 34 per cent of patients in England leave treatment 'drug-free' and as this measure of 'success' allows for a patient to be still using alcohol or prescription drugs it is likely that a great many of these people were not abstinent.)[147] Tellingly, doctors chose abstinence for themselves and other doctors: only one participant of the 904 was placed on methadone.[148]

This approach has been recognised by the NHS service which treats doctors in England who develop an addiction (featured below). It is a sad irony, and testament to the fact that recovery is still for the wealthy, that doctors treat themselves with an abstinent focussed approach but the service available to the public is still largely based on substitute prescribing. 51 per cent of those in treatment, for example, currently receive a prescription.[149]

NHS treatment for addicted doctors versus addicted patients

Whilst national treatment guidelines from NICE and PHE do not emphasise abstinence, the occupational health programme for doctors with an addiction in England actively promotes its impressive abstinence rate:[150]

'The outcomes of the service have remained consistently high. On average over the five years: 76 per cent remained in or returned to work whilst a practitioner patient and a 79 per cent abstinence rate for those treated for alcohol or drug addiction (compares to 10 – 20 per cent of those treated in the general population).'[151]

Such figures reflect the lack of ambition that still pervades much of the treatment system. If a doctor goes into treatment then the expectation is that he will become abstinent but for 'normal' members of the public entering treatment, expectations in many services are far too low. One study found that treatment workers estimated only seven per cent of their clients would achieve long-term recovery.[152]

146 Skipper & Dupont, 'The Physician Health Program: A Replicable Model of Sustained Recovery Management', in Kelly and White (eds), Addiction Recovery Management, New York: Humana Press, 2011, p293 [accessed via: http://gregskippermd.weebly.com/uploads/7/4/7/5/74751/php.replicable._book_chapter.pdf (06.08.14)]; (The key elements identified by the study are: Motivation, in this case, the prospect of being struck off; Personalised treatment, rather than simplistic prescribing; Rigorous care management to ensure treatment is effective; High expectations of abstinence-based recovery; Assertive links to mutual aid; and, Monitoring, and if necessary, reintervention)

147 Public Health England (PHE), Drug Statistics from the National Drug Treatment Monitoring System, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)] Skipper & Dupont, 'The Physician Health Program: A Replicable Model of Sustained Recovery Management',

148 Skipper & Dupont, 'The Physician Health Program: A Replicable Model of Sustained Recovery Management', in Kelly and White (eds), Addiction Recovery Management, New York: Humana Press, 2011, p293 [accessed via: http://gregskippermd.weebly.com/uploads/7/4/7/5/74751/php.replicable._book_chapter.pdf (06.08.14)

149 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]

150 Practioner Health Programme, The First Five Years of the NHS Practitioner Health Programme, 2014 [accessed via: http://php.nhs.uk/wp-content/uploads/sites/26/2014/05/Five-Year-Report.pdf (06.08.14)]

151 *Ibid*

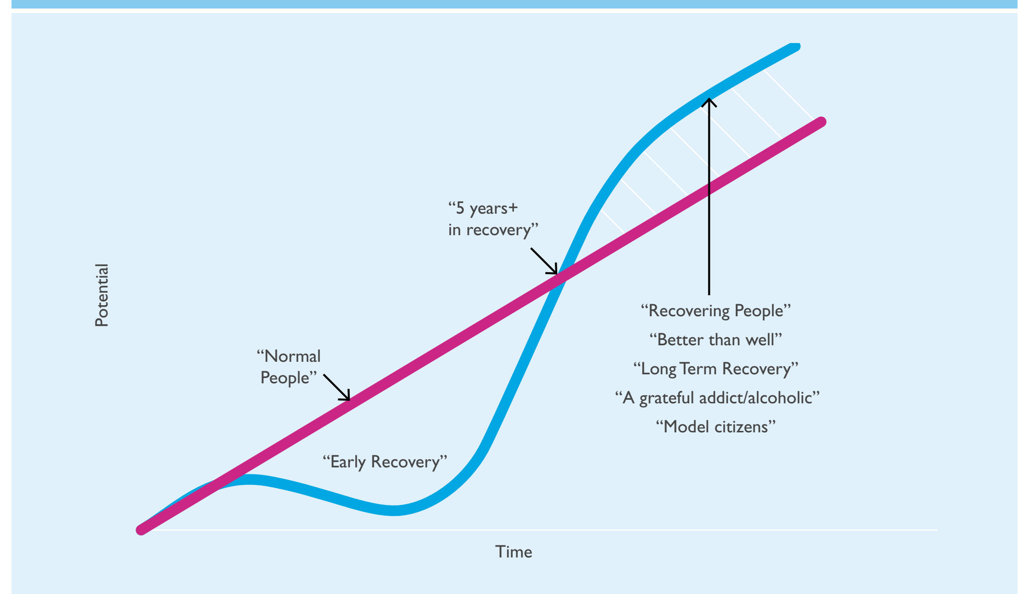
152 White, 'Toward an international recovery research agenda: An interview with David Best' in White (eds) The William White Papers, 2012 [accessed via: www.williamwhitepapers.com/pr/2012%20Dr.%20David%20Best.pdf (06.08.14)]

Other programmes with high expectations of abstinence and integrated support have also seen impressive results. Importantly, these have been amongst populations with less obvious amounts of recovery capital than doctors, for example, offenders. A randomised control trial carried out on Project HOPE which monitors abstinence with rigorous testing saw those with a 'HOPE condition' in their sentences 72 per cent less likely to use drugs.[153]

The importance of abstinence in helping people into recovery has been recognised by certain providers in the UK. For example, the highly respected charity Action on Addiction's SHARP programme states:[154]

> *Treatment is based on evidence that addiction can be a chronic, progressive illness that affects the mind, body and spirit, and that an effective remedy is total abstinence from all substances, including alcohol.*
>
> *Total abstinence can arrest addiction to a point that allows a person to live a happy life, full of love and hope; a life free from the debilitating symptoms of substance dependence.*
>
> *By total abstinence we mean abstinence from ALL mood-altering substances, including prescription and over-the-counter medicines (unless prescribed by a doctor for a specified condition and/or agreed with us at admission). Our staff will support people to achieve total abstinence before entering the main Community Recovery treatment programme.*

Figure 3: 'The power of recovery' graphic representation of the concept that the contribution to society of those in recovery exceeds the rest of the population after a certain time in recovery



153 McEvoy K, 'HOPE: A Swift and Certain Process for Probationers' in *National Institute of Justice, Journal,* 269, 2012 [accessed via: https://ncjrs.gov/pdffiles1/nij/237724.pdf (07.08.14)]

154 Action on Addiction, *Introduction to Community Recovery, Liverpool*, [accessed via: www.actiononaddiction.org.uk/News-Blog/Our-brochures/AOA-CR-Liverpool-A5.aspx (06.08.14)]

Once achieved, abstinence has a huge benefit to both the individual and society. Those in full recovery go on to work, pay tax and move off state benefits. As Philip Valentine, executive director of the Connecticut Community for Addiction Recovery, estimated for the CSJ *'after five years into recovery, people contribute more than a 'normal individual'*.[155]

Whilst the idea that someone in long-term recovery would contribute more to society than a 'normal' person is more commonly held by those in the field, a robust study of the productivity of those in long-term recovery would be invaluable in demonstrating the value of abstinence-based rehabilitation and recovery. Professor Jo Neale told the CSJ:

> *'It just sounds plausible. Whether or not there is empirical data is another question, but could easily be examined.'*

However, the current system, largely based on methadone prescribing rather than working towards abstinence, means that far too few people achieve recovery. Indeed, it is a charge against the treatment system that it often prolongs addiction rather than offering full recovery.[156] For example, the number 'parked' on methadone for four years or more increased by 26 per cent between 2010–11 and 2012–13 to 48,510.[157] This represents the chasm that still exists between the Government's stated ambition and the lack of change on the ground.

> *'Taking methadone didn't mean I stopped taking other drugs'.*
> John, six years on methadone before becoming abstinent in a residential facility
>
> *'Before prison I was in treatment but all it really was was another drug [methadone], it was rehab in here that dealt with the issues. I was still reliant on a drug'.*
> Female inmate at Send Prison discussing her experience of the RAPt rehab unit
>
> *'Methadone helped to begin with, but then there was nothing else, and soon it became as much a problem as heroin'.*
> Dom, three months in recovery

Encouraging abstinence-based treatment: measurements of success

The CSJ has consistently argued that one of the best ways to improve the commissioning of abstinence-based recovery would be to ensure that the measure of success for treatment services was how many and what proportion of patients left treatment abstinent. We have heard serious concerns about the current measures of success for treatments given by Public Health England (formerly the National Treatment Agency):[158]

155 Valentine in evidence to the CSJ.
156 Centre for Social Justice, *No Quick Fix*, London: CSJ, 2013
157 National Treatment Agency, *Drug Statistics from the National Drug Treatment Monitoring System 2010/11*, 2011 [accessed via: www.nta.nhs.uk/uploads/statisticsfromndtms201011vol1thenumbers.pdf)06.08.14)] and Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]
158 National Treatment Agency, Treatment Outcomes Profile (TOP) The protocol for reporting TOP A keyworkers guide 2010 Gateway 5.5.3, London: National Treatment Agency, 2010

> ***Treatment completed – drug free:*** *The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug.*
>
> ***Treatment completed – occasional user:*** *(not heroin and crack) – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.*

These are the two potential discharge codes by which addicts leave treatment and which are used to gauge whether treatment is successful. It is concerning that success by these criteria can mean that a patient may still be:

- Using alcohol (in any quantity);
- On a methadone prescription;
- In the case of 'occasional users', using illicit drugs;
- Addicted to prescribed medicines.

The CSJ has heard that all of these factors are a threat to a patient staying off the drug for which they have entered treatment and, consequently, are a threat to their recovery.

> *'Some people may need to be on prescribed meds when they leave, but it would be reckless to say "treatment completed, job done" if they're still using illegal drugs, or drinking, frankly.'*
>
> Amanda Thomas of Western Counselling in evidence to the CSJ

It is therefore our recommendation that to drive improvements in good practice and encourage practitioners to be ambitious for their clients, PHE, in consultation with NICE, should change the discharge codes so that someone can only be discharged as 'treatment completed' if they are not using illicit drugs, alcohol, and any prescription-only psychoactive medication without a note from a doctor.[159]

Encouraging local services to focus on recovery services

The CSJ has heard that the *Public Health Outcomes Framework* (PHOF) which is intended to drive improvements in public health at a local level does not sufficiently prioritise tackling addiction. For example, only three indicators out of 66 are focussed on alcohol and drugs, compared to four devoted to weight/obesity.[160] While the impact of obesity is large, estimates

159 PHE has announced a review of treatment guidelines and the consideration of more non-medical approaches to tackling addiction and supporting recovery should be highest on its list of considerations. [accessed via: www.gov.uk/government/consultations/drug-misuse-and-dependence-uk-guidelines-on-clinical-management (08.08.14)]

160 Department of Health, *Improving Outcomes and Supporting Transparency*, London: DH, 2013 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf (15/05/14)]

ranging from £2.6 to £16 billion, at its highest it range it is similar to the £15 billion cost of illicit drugs and not as high as the £21 billion cost of alcohol.[161]

> *'So many commissioners aren't experts in whatever they're commissioning, they need guidance.'*[162]
>
> Huseyin Djemil, local authority commissioner, in evidence to the CSJ

Previously over a third of the £2.66 billion public heath grant was ring-fenced for drugs and alcohol. With that ring-fence removed and a lack of priority in the PHOF, there is a danger that alcohol and drugs services will be reduced. Indeed there are reports that a third of local authorities, some with acute addiction problems such as Gateshead and Sheffield, are making plans to cut funds to addiction services.[163]

The CSJ has heard from several Directors of Public Health that reductions are likely:

> *'While the evidence shows that treatment provision can have a significant impact across a range of Public Health outcomes, it is likely to be difficult to retain existing levels of funding within the current environment.'*

> *'Both alcohol and drug treatment are likely to see reductions in funding in the coming three years as resources are shifted to focus more on the wider determinants of health, supporting other parts of local authority delivery.'*

Recommendations to drive recovery-focussed commissioning:

PHE and NICE should alter discharged codes so that someone can only be discharged as 'treatment completed' if they are not using illicit drugs, alcohol, and any prescription-only psychoactive medication without a note from a doctor.

To ensure local authorities invest adequately in drug and alcohol treatment, we recommend that the drug and alcohol components of PHOF have an increased prominence/weighting. The treatment tax outlined below will assist if additional funds are needed to procure drug-free treatment such as abstinence-based day programmes or residential rehab.

Appointing a Recovery Champion for England to drive improvement at a local level

New data on how many people leave treatment free of all drugs will help to draw attention to where services are working for patients and where they are not. To further drive improvements at a local level, the CSJ believes that there is a need for a Recovery Champion to review and hold to account the performance of local authorities.

161 National Obesity Observatory, *The economics burden of obesity*, 2010 [accessed via: www.noo.org.uk/uploads/doc/vid_8575_Burdenofobesity151110MG.pdf (08.08.14)], HM Government, *Drugs Strategy 2010*, London: Home Office, 2010 and HM Government, *Alcohol Strategy 2012*, London: Home Office, 2012

162 The CSJ will be producing recommendations on improving commissioning in its forthcoming voluntary sector paper.

163 *British Medical Journal*. 'Raiding the public health budget' 27 March 2014 [accessed via: www.bmj.com/content/348/bmj.g2274 (08.08.14)]

Establish a Recovery Champion for England (RCfE):

To help drive forward the new recovery movement in all parts of the country, we propose that a Recovery Champion for England is appointed to inspect services commissioned by local authorities and wider governmental infrastructure crucial to sustaining recovery.

Although there are many models upon which to base the concept, a useful one is that of the Independent Reviewer of Terrorism Legislation.

The Independent Reviewer of Anti-Terror Legislation

The Independent Reviewer reports to the Home Secretary on the working of related legislation, together with the operation of related statutes. The role includes reviewing secret information and interviewing key officials; visiting counter-terrorism units and community groups across the country; providing 'Snapshot' reports on specific operations; briefing journalists; and, giving evidence to Parliament.

The role is a part-time Public Appointment with approximately one day per week spent in the Home Office. The Reviewer has the assistance of a junior official at the Home Office and a special adviser, Professor Clive Walker, based at Leeds University.

The Reviewer makes recommendations to Government and works with community groups, NGOs lawyers, media, the courts and Parliament to further their agenda. Such a model is well-regarded by those involved and seen as a positive force to strengthen anti-terror efforts.

Similarly, the Recovery Champion would report to the Secretary of State for Health on how successfully local authorities are commissioning effective recovery services. They would:

- Be able to visit any service commissioned by a local authority and examine their reports;
- Have full access to all relevant data, including the National Drug Treatment Monitoring System and hospital admissions;
- Review any relevant records and correspondence held by the local authority (for example, tenders for local services could be examined and reviewed against delivery);
- Have the power to interview clients and staff in private;
- Be able to publish their findings to hold local authorities to account;
- Have access to government papers and officials across government. This will allow the RCfE to draw attention to those areas vital for tackling addiction and fostering recovery such as justice, housing, and employment.

Reports, either on the performance of individual authorities, or discrete recovery-related topics, would be compiled and submitted to the Secretary of State for Health and copied to the Social Justice Directorate. If the RCfE decided their concerns were not being acknowledged and dealt with by either local or national government, they would be free to state this publically.

'I like the idea of a recovery champion for England. I think Helen Newlove's role as a champion for crime victims is a good model, someone who has "been there" and can articulate the experience and needs of people such as herself.'

Professor Keith Humphreys, Former White House Drugs Policy Adviser

Treating new threats – New Psychoactive Substances NPS – 'legal highs'

A major task for the Recovery Champion for England should be to ensure all local authorities respond to the need for better treatment for NPS. Intended to either produce similar, or mimic, the effects of traditional drugs, such as cocaine, amphetamine, MDMA (ecstasy) or heroin etc., they can actually be more dangerous. One legal high branded 'Burst', sold openly in high street shops, has been likened by users to heroin and ecstasy combined.[164]

Indicators point to a large increase in both use of and harm caused by NPS, including: numbers in treatment, admissions to hospital, and related-deaths. Freedom of Information requests submitted by the CSJ to all acute trusts in England have found a dramatic rise in admissions for NPS, such as mephedrone and 'legal high' variants. The trend results show an increase of 56 per cent from 2009/10 to 2013/14. Worrying too is the fact that more than half of acute trusts did not collect data on this growing problem.

Deaths associated with NPS continue to increase each year: 97 people were found dead with NPS substances in their system in 2012, up from 12 in 2009.[165] Based on current trends NPS could be implicated in more deaths than heroin by 2016.[166]

The numbers of people entering treatment for NPS abuse are high and rising. In 2012/13 5070 people were in treatment for the abuse of commonly-called club drugs, up 49 per cent from 2010/11. Although some services are responding well, the CSJ has heard that the demand for specialist treatment is outstripping supply. One of the few 'legal high' specialists doctors told the CSJ, *'these are different drugs from heroin, and the users are different, younger. We need to develop treatments that work so we can nip the problems in the bud. We're lucky to have a service dedicated here. I know London and Leeds have suffered for lack of funding.'*

We need treatment services that know how to recognise and help people who abuse NPS. Some chemicals are so caustic that they can do severe internal damage, leaving damage that will last a lifetime. The CSJ met Joe from London who, after significant use of ketamine and similar drugs, has lost one kidney, with his other one only working at 15 per cent. He estimates his costs to the NHS in excess of £100,000 and will need a catheter for the rest of his life.

At present, treatment services are still geared to deal largely with opiate and/or crack users.

A national Recovery Champion should be leading the fight for recovery services from these new and dangerous drugs.

164 Crew drugs charity in evidence in the CSJ

165 National Programme on Substance Abuse Deaths at St George's University of London, *Drug-related deaths in the UK: January–December 2012*, 2013 [accessed via: www.sgul.ac.uk/research/projects/icdp/our-work-programmes/pdfs/drd_ar_2013.pdf (06.08.14)]

166 *Ibid.* This forecast is based on data from the four years for which NPS-related deaths are available. NPS-related test are stated to be 12 in 2009, 68 in 2010, 68 in 2011, and 97 in 2012. For the same years, heroin/morphine related deaths were 1219 in 2009, 718 in 2010, 576 2011 and 537 in 2012. Taking the last year increase for NPS and decrease in heroin, and projecting forward, the category NPS-related deaths will surpass those of heroin some point in 2016 at approximately 400-related deaths.

Bringing recovery experts into decision making

Part of the reason for the failure to commission services that help tackle addiction can be found in the enduring culture of prescribing – using drugs to tackle drug addiction. The rapid growth of the treatment sector at the turn of the millennium saw a workforce created that was at times equipped to do little else other than issue clean needles and a methadone prescription.[167] More development of the current workforce will be required to meet the ambitions contained within the Government's strategy. As one senior official told the CSJ:

> *'One of the biggest barriers to recovery is the current workforce. I have watched as multi-million pound treatment systems have been de-commissioned and re-commissioned at great public expense without any sustainable improvement in service quality.'*

The medical bias of addiction workers, as opposed to psycho-social practitioners, stems from the NHS involvement in delivering treatment services. Staff well qualified in physiological conditions have been adept at managing the physical symptoms of addiction but have enjoyed less success at helping the individual overcome the underlying issues driving the substance abuse.

The Expert Group for Recovery Orientated Drug Treatment, established to review practices after the 2010 Drug Strategy, represented an improvement on previous examples, containing more representation from the wider, non-medical recovery field.[168] Although these committees have contained some non-medical members, we must go further to rebalance adequately in favour on non-medical voices of recovery. This will help move focus from treatment to recovery.

To readdress this balance, we recommend that at every level of the addictions sector, a balance of committee members come from a non-medical and recovery-orientated background, including more people in recovery themselves. We recommend the UK authorities look to the United States where Michael Botticelli has been appointed as Deputy Director of National Drug Control Policy with some 24 years in recovery.[169]

As Keith Humphreys, former White House Drugs Policy Adviser, told the CSJ:

> *'Active addiction is highly visible, but recovery is often private and little noticed. As a result, both addicted people and the rest of the citizenry become pessimistic about the prospects of addicted people and can't see any positive future for them. That's why it is enormously important that the White House chief drug policy official, Mike Botticelli, is in recovery. He is the perfect illustration that a life of recovery is possible and that it can involve the highest levels of public service and career achievement.'*

167 Wardle, *The Drug Treatment Workforce,* 2013 [accessed via: www.fead.org.uk/docs/The%20Drug%20Treatment%20Workforce%20(20130114)%20copy.pdf (06.08.14)]

168 Department of Health, *Terms of Reference for the Expert Group*, [accessed via: www.nta.nhs.uk/uploads/rodtexpertgrouptermsofref-rev231210.pdf (06.08.14)]

169 The White House, Michael Botticelli, 2012 [accessed via: www.whitehouse.gov/ondcp/botticelli-bio 907.08.14)]

Recommendations to drive for national government via the Secretary of State for Health:

The Drugs and Alcohol Executive Team at Public Health England, together with the board itself, and any future expert committees on recovery, should rebalance towards recovery and include at least one person with personal experience of recovery.[170]

Recommendation for local authorities:

Health and Wellbeing Boards should have, as a statutory member, one local recovery champion. This will ensure the Joint Strategic Needs Assessments, together with the resultant plan, will have the input of someone who knows intimately the process of overcoming addiction and the local assets available to help with this. The addition of a statutory member will require legislation to alter s194 HSCA 2012.[171]

Recommendation for local recovery champions:

To ensure that local recovery champions are equipped to represent the interests of recovery effectively, and to avoid charges of 'tokenism', an association of recovery champions should be formed. This would formulate guidance on best practice and act as a voice, independent of treatment providers, for those in recovery.

A Treatment Tax – funding a new generation of residential rehab

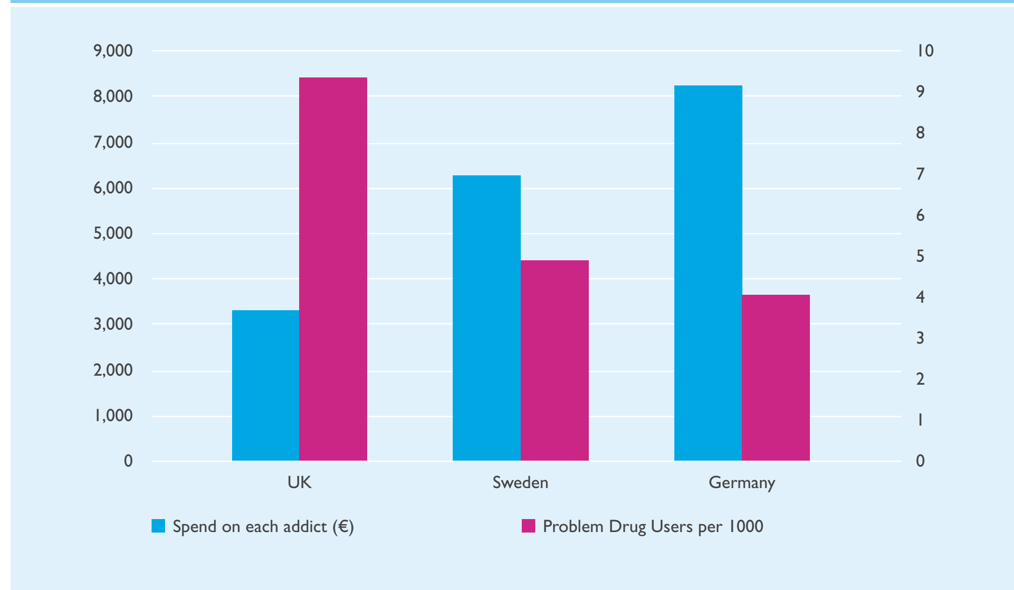
The UK should invest in turning around the lives of addicts. It will not only reduce costs to the health, welfare and criminal justice systems but also save many people from wrecking their lives and those of their families.

As a nation, the UK spends comparatively little on drug and alcohol treatment and has relatively poor results. Germany spends approximately €9,000 per addict per year and Sweden €6,000, while the UK spends approximately €3,000 per addict. This disparity contributes to the disproportionately high numbers of addicts in UK.[172]

Due to chronic underinvestment in effective, abstinence-based rehabilitation in the UK, the sector needs significant funds to develop enough rehabilitation centres to reduce the sizable drug and alcohol addicted populations. Of the 300,000 drug addicts and 260,000 alcoholics who would benefit from such high quality treatment, only a tiny minority are receiving it.[173]

170 Health and Social Care Act 2012 [accessed via: www.legislation.gov.uk/ukpga/2012/7/contents/enacted (06.08.14)]
171 s194 HSCA 2012 [accessed via: www.legislation.gov.uk/ukpga/2012/7/section/194/enacted 07.08.14)]
172 European Monitoring Centre for Drugs and Drug Addiction Website [accessed via: "http://www.emcdda.europa.eu//alias.cfm//countries/compare"www.emcdda.europa.eu//alias.cfm//countries/compare? (08.08.14)]
173 Please note that the drug addict population is a conservative estimate as it includes only heroin and crack addicts, yet this will be offset to some extent by overlap between the alcohol and drug populations www.nta.nhs.uk/uploads/estimates-of-the-prevalence-of-opiate-use-and-or-crack-cocaine-use-2011-12.pdf and http://findings.org.uk/docs/DL14.php

Figure 4: Comparative levels of investment per addict in European nations and levels of addiction[174]



To pay for this, the CSJ strongly recommends introducing a small, ring-fenced treatment tax on every unit of alcohol from 2015 that can be used to fund effective abstinence-based rehabilitation centres. CSJ analysis suggests that, in order to create enough capacity to meaningfully tackle the UK's addiction problems, the following levels of tax would be required:

- Half a pence on a unit between 2015 and 2017;
- One pence on a unit between 2018 and 2020;
- One and a half pence on a unit between 2021 and 2023;
- Two pence on a unit from 2024 onwards.

This tax would only apply to off-trade sales – i.e. it would exclude any sales in pubs or restaurants – and would, at two pence on a unit, add around four pence to a pint, 18 pence to a bottle of wine, and 56 pence to a standard bottle of spirits.

This would raise around £155 million a year between 2015 and 2017, around £290 million a year between 2018 and 2020, around £410 million a year between 2021 and 2023, and around £520 million a year from 2024 onwards.[175]

This money would be spent solely on setting up a network of abstinence-based rehabilitation centres. Currently there are approximately 125 residential rehabilitation centres in England, many of them of insufficient quality.[176] This falls someway short of providing effective treatment for the huge number of drug and alcohol addicts who desperately need it.

174 www.emcdda.europa.eu//alias.cfm//countries/compare? www.nao.org.uk/report/tackling-problem-drug-use/ (Germany has appox. 218,000 addicts and spends)
175 Please see Appendix II for further details of the model
176 Listed on www.rehab-online.org.uk/ run by Public Health England

To build capacity we recommend that those centres with the best recovery rates become sponsors of new centres. The highest quality 30 residential rehabilitation centres (ranked upon on the percentage of their residents who successfully completed treatment) should be invited to bid to become 'rehab-sponsors' and funded to open or mentor the opening of a new centre.

The CSJ has spoken to a number of the top performing rehabilitation centres who are well-equipped to take on this role, and are keen to do so.

> *'We know our model works, gets people clean, moves into recovery and re-engage with society and work … we could make it work in other places too, given the chance.'*
> Amanda Thomas, Western Counselling

> *'Our outcomes are solid, far better than the national average. With some investment we could help a lot more people.'*
> Kendra Gray, BAC O'Connor

Our analysis suggests that the treatment tax could fund the creation and running of 350 new rehabilitation centres with an average of 40 beds over a nine-year period. This would involve – on average – each of the 30 highest quality rehabilitation centres setting up a new centre every year, and the new centres being able to do likewise after five years of operation. While it is likely that some of those 30 rehabilitation centres would be unable or unsuitable to set up new centres with such frequency, this would be offset by those who would set up more than one every year.

Brian Dudley of Broadway Lodge told us:

> *'We set up two centres last year. With the right investment, we could do it again.'*

The creation of these new rehabilitation centres would enable around 330,000 addicts to receive treatment over a decade and create capacity for around 58,000 people to enter residential rehabilitation every year from 2024. This would significantly reduce the addict population as the very best providers are seeing two-thirds of their clients become abstinent, while all of the 30 rehabilitation providers earmarked for involvement in the programme have a success rate of around 50 per cent.[177] For more details on the analysis please see Appendix II.

Craig's story: the benefits of abstinence-based rehabilitation

Craig is a 40-year-old man who entered abstinence rehabilitation at the Burton Addiction Centre (BAC) in January 2011. Despite 27 years of drug use, and later criminality, Craig had never been offered abstinence-based rehabilitation before.

He was bought up with three siblings by his mother, his father having left when Craig was six. Craig was abused and bullied by a series of his mother's occasional partners. He committed his first criminal offence at the age of 18 and went to prison for the first time at the age of 20. It is conservatively estimated that Craig cost society around £400,000 through his stays in prison, hospital, as well as a result of being out of work and on benefits as a direct result of his addiction.

The effect of abstinence-based rehabilitation

Craig successfully completed his abstinence-based rehabilitation course, as well as a re-integration programme. He is now drug and alcohol free. Following his successful rehabilitation Craig gained work experience through volunteering at Langan's Tea Rooms, and as a Recovery Champion for RIOT where he worked with the police to educate children as to the hazards of drug use.

After six months volunteering at Langan's Tea Rooms Craig applied for a paid position at BAC O'Connor Detoxification Unit and gained paid employment. He worked within the detox unit for just over six months. Craig is now employed as a trainee therapist and he is studying for a BA (Hons) in Humanistic Counselling at Nottingham University.

Craig has his own flat living independently within the community.

To ensure that the investment is recovery orientated and sustainable, the Head of Social Justice at the Department of Work and Pensions should sit jointly with PHE officials in commissioning and/or granting awards from the Treatment Tax monies. This would help to ensure that a 'back-to-work' focus is prominent within this programme. Similarly, the Department for Communities and Local Government should be represented to ensure that housing issues are addressed swiftly, particularly for those who are relocating. Those who do seek to relocate, should be eligible for the Discretionary Housing Payment as outlined in the CSJ's *The Journey to Work*.[178]

177 www.nta.nhs.uk/uploads/roleofresi-rehab.pdf

178 Centre for Social Justice, *The Journey to Work*, London: CSJ, 2014

The need for investment in this sector is clear. By tackling addiction, the treatment tax will save lives, transform communities and help ensure a social recovery accompanies the UK's economic recovery. All for the price of 18 pence on a bottle of wine.

Considering families

A community and city in recovery – Action on Addiction in Liverpool

Liverpool is a city in recovery. Having been in the frontline of the heroin epidemics of thirty years ago, the City appears to have turned the tide. In the five years from 2006/07 to 2011/12, the estimated number of opiate and crack users has declined by 18.5 per cent – nearly double the national average, according to local prevalence estimates.

A key element of the progress must be attributed to the abstinence-based Community Recovery Centre set-up by Action on Addiction in 2005. The programme helps addicts to 'learn to live a full and satisfying life without drugs and alcohol' and their statistics are impressive, with 65 per cent completing treatment last year compared to a national average of 34 per cent. The programme lasts for 48 days of treatment over 11 full-time weeks of four and a half days. Clients can take a spiritual approach (12 step) or cognitive approach (ITEP) when starting the main programme which includes: one to one counselling; group work; relapse prevention; workshops and life-skills groups; and, social activities.

Beyond formal treatment, and key to sustaining successful treatment and continued abstinence, is the wider recovery community. The Brink Cafe is a dry bar providing a late night alternative for those wanting to socialise without being surrounded by alcohol. It provides entertainment seven-days per week as well as CV workshops and was set-up by Action on Addiction as a social enterprise – the proceeds funding support for those who have suffered alcoholism and addiction.

The role of the family is importing helping addicts to recover and sustaining recovery.[179] At present, however, not enough is done to protect families from the effects of addiction, nor are families fully enabled to help their addicted relatives. We need a treatment system that acknowledges and encourages the role of families in preventing addiction.

> 90 per cent of people think that having a parent addicted to drink or drugs is important when deciding whether a child is growing up in poverty.[180]

The CSJ has heard how a lack of engagement with families is holding back the success of treatment. During a focus group with a charity that supports carers carried out in the North East of England, the CSJ heard from parents and grandparents of addicts that:

179 Drug and alcohol, *Working with couples helps client and family* [accessed via: http://findings.org.uk/docs/nug_10_2.pdf (08.0814)];
180 Department for Work and Pensions, *Public Views on Child Poverty: Results from the first polling undertaken as part of the Measuring Child Poverty consultation,* London: DWP, 2013

"[My son will] go in, tell them what they want to hear, get his methadone, then come out and use. They haven't got a clue but when I try to tell them they say "I can't discuss that, it's confidential". They see him for two hours per week, I see him all week. Why won't they listen to me!?"

"By the end my husband would lie to the services, just to get over the session, get some meds, then he'd be drinking in the afternoon. I wasn't allowed in with him and they would ignore me. How could he get the right treatment if they didn't know what he was really doing!? When you're ill like that, you're not really in a fit mind but they still only listen to them."

As Brian Dudley, CEO of the UK's oldest rehab Broadway Lodge, said to the CSJ:

'We know working with families improves and sustains outcomes. It's a must for rehabilitation.'

Although current guidance points to the potential of family involvement, more could be done to encourage it.[181] A mechanism should be established for families/carers to feed-in to the treatment of their relatives/dependants. There should also be a presumption in favour of family engagement unless there are concerns that this would jeopardise the individual's recovery.

NICE (the National Institute for Health and Clinical Excellence) should review including the impact of treatment on family members/carers in assessments of the cost-effectiveness, benefits and risks of drug treatment.

Families, particularly with vulnerable children, need to be better protected from the risks of treatment. The litany of serious case reviews resulting from a child ingesting their parent's methadone suggests that current prescribing practice could be improved.[182]

- NICE should consider the risks to dependent children when reissuing its guidance;
- Guidance should highlight dangers that take-home methadone poses to children to ensure prescribers consider the impact upon any dependent children.

It would make sense for NICE, when approving treatments, to consider the impact upon families of those treatments. For example, it should compare outcomes for families/dependent children whose addicted parents have been through abstinence-based rehabilitation and those on long-term maintenance programmes.

The CSJ has also heard that there is very little mother-and-baby residential rehab units available – although there is no centralised data, experts have told us that there are perhaps only three in the country. This means that mothers are very unlikely to be given the opportunity to access the most successful form of treatment, despite the huge harm that their

181 NICE, *Drug Misuse and Dependence*, 2007 [accessed via: www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf (08.08.14)]
182 Centre for Social Justice, *No Quick Fix*, London: CSJ, 2013

addiction can do to themselves and their children – nearly 40,000 of the 68,000 looked after children were taken into care because of some kind of parental substance abuse.[183] As there are a large number of mothers starting treatment – including approximately 1000 pregnant women a year – new residential rehab services should offer facilities for their recovery.[184]

Recommendations to prevent and tackle addiction in families:

- A presumption of family involvement in treatment should be considered by NICE.
- NICE should review the impact and value of treatment upon children and families, for example the difference on outcomes of abstinence-based treatment and long-term substitute prescribing.
- When guidance is reissued, it should highlight dangers that take-home methadone poses to children to ensure prescribers consider the impact upon any dependent children.
- As the Government builds capacity in residential rehab it should ensure that more mother-and-baby services are made available.

183 Department for Education, *Statistical First Release: Children looked after in England (including adoption and care leavers) year ending 31 March 2012*, London: Department for Education [accessed on25/06/13 via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/167451/sfr20-2012v2.pdf.pdf (08/08/13)]

184 National Treatment Agency, *Parents with Drug Problems,* 2012 [accessed via: www.nta.nhs.uk/uploads/families2012vfinali.pdf (08.08.14)]

chapter four Responding to addiction

Every time an addict interacts with the state is an opportunity to help them into recovery. Yet, too little is made of these chances and, as a result, many who would benefit from treatment do not receive it.

This chapter explores how we can use more of these interactions to tackle addiction. In particular, we focus on welfare, criminal justice and the health system. We choose these three areas because they represent excellent opportunities to intervene in the lives of people who have often been forgotten by others, and each have levers by which addicts can be helped to recover.

Making the welfare system recovery-focussed

> *'Part of recovery means being willing and able to work, to earn a living, pay bills and make a positive contribution to the lives of your kids.'*
> Mark Gilman, Public Health England's Strategic Recovery Lead in evidence to the CSJ

Because addiction and worklessness are inextricably linked, it is essential that the welfare system does all it can to help people into recovery.

- One in fifteen of those out of work have a substance dependency;[185]
- Dependent drinkers are twice as likely to claim state benefits as the average citizen;[186]
- Only 18 per cent of the 200,000 people in drug treatment in 2011 in England were in employment;[187]

185 Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010, Hay G and Bauld L, *Population estimates of problem drug users who access DWP benefits*, London: DWP, 2008

186 Hay G and Bauld L, *Population estimates of alcohol abusers who access DWP benefits*, London: DWP, 2010

187 Department for Health, *Statistics from the National Drug Treatment Monitoring System*, London: Department for Health, 2012 [accessed via: www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf]

- The human costs of inaction are significant, with people stranded on welfare, and grandparents and other relatives forced to give up work to care for a grandchild (or other relation) whose addicted parent can no longer look after their child. The financial costs are also high: addicts receive £1.7 billion in benefits each year, while the welfare costs of looking after the children of addicts are £1.62 billion.[188]

Identifying addiction at the JobCentre

Although addiction is a major barrier to work for many, between 60,000 and 100,000 opiate and/or crack addicts access Department for Work Pensions-administered welfare benefits without engaging with treatment.[189] This is a missed opportunity to help those with an addiction move into recovery. As Kirsty McHugh, Chief Executive of the Employment Related Services Association, explained to the CSJ:

> *'Evidence from recent back-to-work schemes is that the level of alcohol and drug misuse among the long-term jobseeker population is higher than we previously thought. Often these concerns are not acknowledged or even recognised by those suffering from them and therefore we need good quality assessment of jobseeker needs and very highly trained advisers to both pick up problems and put in place the support that's required.'*

One reason for the lack of treatment take-up is the reticence of people with an addiction to reveal their condition to the Jobcentre adviser.[190] This can be because they are concerned that there will be an impact upon their benefit claim, or they fear the adviser may report them to the police, social services etc. The CSJ heard from people who were suffering from addiction whilst claiming benefits:

> *'I would go [to JCP] every couple of weeks, sit through the usual questions, and that was it. I couldn't work because I was using but I wasn't going to tell them. Didn't want to lose my girl.'*
>
> **Karen, in evidence to the CSJ**

> *'I didn't want them knowing anything about me … thought they would take my benefit if they knew I was using.'*
>
> **Melissa, in evidence to the CSJ**

The CSJ has also heard of cases where advisers will avoid addressing suspected addiction problems, waiting to pass on the claimant to the Work Programme.[191] James, who has volunteered in JCPs as a recovery champion helping to get addicts into treatment, told the CSJ:

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188 Gyngell K, *Breaking the Cycle*, London: CPS, 2011; United Kingdom Focal Point, *United Kingdom drug situation,* London: Department of Health, 2012 [accessed via: www.nwph.net/ukfocalpoint/writedir/userfiles/file/Report%202012/REPORT2012FINAL.pdf (08/08/13)]

189 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]; Prevalence of Opiate Use and/or Crack Cocaine Use, University of Glasgow [accessed via: www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf (06.08.14)]; Drugscope, Welfare Reform Bill 2009 Report Stage Briefing, 2009 [accessed via: www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=131D2BA9-3751-48FE-B5E1-865AFBE43E2D&mode=link&guid=508a2f4ade6f49e1b03f69cc4a98044e (07.08.14)]

190 Fisher C, *Evaluation of the Jobcentre Plus Intensive Activity trial for substance misusing customers*, London: DWP, 2011 [accessed via: http://findings.org.uk/count/downloads/download.php?file=Fisher_C_1.txt (07.08.14)]

191 Centre for Social Justice, *Up to the Job?* London: CSJ, 2013

> *'Some advisers just don't have the confidence to have the conversation…about someone's addiction. So they sit back and wait till the person is automatically sent to the Work Programme.'*

There are several methods by which detection rates of drug and/or alcohol dependency could be increased. These include intensive interviewing and the use of volunteers who have recovered from addiction/alcoholism.[192]

The Intensive Activity Period (IAP) approach (detailed below) allows claimants to build a relationship with their adviser which enables claimants to be more open about their barriers to work, such as addiction. Advisers, who also had experience of the previous system administering Jobseekers' Allowance, told the CSJ:

> *'I really enjoyed working like this. You have time to understand the client, gain their trust and get to know what barriers they may be facing. It means you can make real progress.'*

> *'I think IAP is fantastic. It gives me a structure to follow with coaching conversations flowing naturally, and it really gets the claimants engaged as it shows we are genuinely interested in them and giving them our time.'*

Intensive Activity Period (IAP)

Identifying the root causes: intensive interviewing and coaching
The Jobcentre in Hammersmith is putting new welfare claimants on to Universal Credit, the project to ensure work always pays, and is starting to help people back to work. A key element of this process is the IAP, which increases rates of detection of addiction and participation in treatment.

The programme involves two elements which workers and clients told us were crucial to its success. First, the initial benefit claim is resolved and this is made clear to the client so the meeting focus on work readiness. This removes, we heard, much of the reticence of clients to be candid with the adviser and allows them to see advisers more as an employment coach.

Second, there are four intensive interviews between the client and adviser within 11 days of the commencement of the claim. The first of these lasts 90 minutes. Leonie [not real name], an adviser working on IAP, told us 'the extended interviews allow us to get to know clients' needs far better and therefore decide how best to help. If you're in a gang, [for example] it can take more than a 10-minute chat [referring to the JSA system] to reveal that'.

Based on our visit to the Hammersmith Jobcentre and from the wide evidence we have gathered, we see potential for this approach to help detect addiction amongst some of those as yet reluctant to come forward.

As part of the development of IAP in relation to detecting addiction, we have heard that a more direct and thorough (but non-confrontational) approach to asking the individual

192 A vision for the long-term reform of the JobCentre is outlined in the Centre for Social Justice's recent reports, *Up to the job* and *The Journey to Work*.

about themselves may be effective. The CSJ has heard from a number of former addicts that they would regularly claim benefits and discuss the topic of barriers to work with Jobcentre advisers without ever being challenged about their addictions. As Jesse, who accessed welfare benefits whilst dependent on crack-cocaine, explained to the CSJ:

> *'My adviser never said "are you using drugs?" Not even tried to talk about it. I wasn't going to bring it up in my state.'*

One significant reason for this is that advisers often try to find out whether claimants have addictions indirectly. According to a JCP liaison officer who gave evidence to the CSJ, a typical question expected to identify whether someone has a drink and/or drug problem is: *'are there any issues in your personal life which you believe act to prevent you from taking employment?'*.

To overcome the ineffective indirect model, the CSJ recommends that Jobcentre Plus employs a smarter approach towards identifying claimants with addictions and encouraging them to get into treatment.

More direct questioning would be a simple way for staff to try to increase awareness of claimants' barriers to employment. If a positive result is recorded, this could trigger more rigorous testing and subsequent treatment. With the establishment of a more trusting relationship, for example, advisers could use the 'CAGE' questionnaire to check for signs of alcohol dependency.

The CAGE questionnaire has been proven as an effective tool in identifying alcoholism. One study determined that CAGE test scores of more than two had a 'specificity of 77 per cent and a sensitivity of 91 per cent for the identification of alcoholism'.[193] A positive test in CAGE could then result in clients being sent for more rigorous analysis assessments, for example the World Health Organisation's 10-question Alcohol Use Disorders Identification Test (AUDIT) test, or the 20-question Severity of Alcohol Dependence Questionnaire (SADQ) screening.[194]

The CAGE questionnaire:

Two affirmative answers indicate that the possibility of alcoholism should be investigated further.

- Have you ever felt you needed to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticising your drinking?
- Have you ever felt **G**uilty about drinking?
- Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

Such questioning is dependent upon openness and a good claimant/adviser relationship is therefore essential.

193 Bernadt, et al, 'Comparison of questionnaire and laboratory tests in the detection of excessive drinking and alcoholism' in *Lancet,* 6, 1982, pp325–8; [accessed via: http://ebm.bmj.com/content/10/1/26.full (07.08.14)]

194 NHS Choice website has details of these more extensive test [accessed via: www.talkingalcohol.com/files/pdfs/WHO_audit.pdf (07.08.14)]

Recovery Champions in Jobcentres

Locating Recovery Champions in Jobcentres is another method of detection that aims to allay claimants' fears and encourage openness. A Recovery Champion is someone who was in active addiction, overcame this, and now voluntarily uses their personal experience to help others to recover. Jenny, now in recovery and a champion herself, told the CSJ:

> *'This guy sat next to me in the waiting area. I never told my adviser a thing but this guy seemed normal, knew I was an addict and explained I could get help without losing my benefits.'*

Evidence suggests that having expertise located within the Jobcentre improves detection and uptake of treatment.[195] Although initial trials found the gains were not sufficient to justify the cost of the schemes, they did not include assessments of voluntary groups like RIOT recovery champions in the Midlands.[196] Such groups of people in abstinence-based recovery bring credibility and enthusiasm to recovery and employment and cost far less than established full-time workers.

Our recommendation is that Jobcentres are guided to reach out to abstinence-based voluntary groups, like RIOT.

Boosting awareness of existing support

We have also heard that advisers and/or claimants sometimes lack awareness of all the support available and that this can aggravate the transition into recovery. For example, there is specific support available through JobCentre Plus and local treatment services to help those with substance abuse problems into employment.[197] However some of those struggling with addiction are put off moving into independence by the perceived risks involved. James, who is two months clean and sober, told the CSJ: 'It's scary, not being on benefit. If you get a job, it's up to you. If you're short, you get in with some dodgy lender. Then that's pressure to relapse.'

> 'Liam, who's in recovery, was living in emergency accommodation, was concerned that he and his girlfriend might get into debt with their rent if they took on paid employment and then lost some of their benefit entitlements.'
>
> Professor Jo Neale in evidence to the CSJ

The Coalition has done much to tailor support to help those with drug and alcohol problems through treatment and into work, including removing job-search requirements for

195 Fisher C, *Evaluation of the Jobcentre Plus Intensive Activity trial for substance misusing customers*, London: DWP, 2011 [accessed via: http://findings.org.uk/count/downloads/download.php?file=Fisher_C_1.txt (07.08.14)]
196 *Ibid*
197 DWP, *Drug or alcohol dependency – new support from Jobcentre Plus*: DWP, 6 June 2011 [accessed via: www.dwp.gov.uk/adviser/updates/drugs-strategy/ (08/08/13)]

those in residential treatment.[198] Universal Credit will further embed this approach but the Government should go further in boosting awareness of current schemes amongst JCP staff, such as the Treatment Provider Referral 2 referral to treatment.[199] This will insure that people like Liam get the help they need to get their lives back on track.

To allocate resources in areas of greatest need, those Jobcentres whose detection rates are the lowest when compared with addiction prevalence estimates should be prioritised for any increased addiction training, and/or roll out of IAP and recovery champions.[200]

Recommendations to improve how the welfare system detects addiction:

To boost detection rates, the Department for Work and Pensions should consider the following:

- Jobcentres should aim to have the services of at least one recovery champion and should be guided to reach out to abstinence-based voluntary groups;
- Jobcentres with a lower level of detection than the local addiction prevalence estimates forecast should be prioritised for roll-out of programmes like IAP and recovery champions;
- To boost detection rates advisers should be equipped with knowledge and skills to conduct low level assessments, such as the CAGE questionnaire;
- Training and development of JCP advisers should ensure staff are aware of the help and support available to those with an addiction.

Welfare and treatment

> *'To break a methadone, wine and welfare culture requires a targeted approach. We can reform services (to offer more recovery) and we must also use the leverage of the benefits system to encourage recipients into abstinence-based treatment that will initiate and then sustain recovery from addiction and also build recovery capital that can result in a more productive life, which for many people will include working.'*
> **Huseyin, former heroin addict and now independent consultant**

Our welfare system could play a much more active role in helping addicts turn their lives around. Between 40,000 and 100,000 addicts in England are receiving benefits but not accessing treatment.[201] Those in employment face sanctions and ultimately dismissal should their dependency obstruct their ability to do their job but the same is not true of those supported by our benefits system. Rather, unless the system supports them into treatment, it is simply enabling their continued addiction, instead of helping them overcome it.

198 HM Government, *Putting Full Recovery First*, 2012 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recoveryroadmap.pdf(07.08.14)]

199 Working with Customers with Substance Abuse Issues, DWP, 2012 [accessed via: www.ldan.org.uk/PDFs/Prathiba%20Ramsigh-Chris%20Holbrough%20JCP.pdf (07.08.14)]

200 Prevalence estimates for local authorities are conducted by North West Public Health Observatory. NDTMS data could also be used and local crime statistics. Variations within local authorities mean not all JCPs would necessary qualify within an area of high prevalence. low detection.

201 Public Health England (PHE), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf (06.08.14)]; Prevalence of Opiate Use and/or Crack Cocaine Use, University of Glasgow [accessed via: www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf (06.08.14)]; Drugscope, 'Welfare Reform Bill 2009 Report Stage Briefing', 2009 [accessed via: www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=131D2BA9-3751-48FE-B5E1-865AFBE43E2D&mode=link&guid=508a2f4ade6f49e1b03f69cc4a98044e (07.08.14)]

The previous Government's Welfare Reform Act 2009 intended to establish a pilot which would have steered people with addictions towards treatment.[202] Claimants would have been required to answer questions about drug use and whether they were in treatment.

At the point of non-compliance or obfuscation they would have been required to attend a substance-related assessment, followed by testing and treatment as appropriate.

During this period, claimants in treatment would have received a 'treatment allowance' and job search requirements may have been suspended for a period to give them space to focus on their recovery.

The Bill also introduced a sanctioning regime for claimants of Jobseekers Allowance (JSA) and Employment and Support Allowance (ESA) who failed, without good cause, to comply. This required compliance and involved an interview to discuss their addiction, a substance-related assessment, drug testing or comply with a rehabilitation plan.

The then Work and Pensions Secretary stated:[203]

> *'… the Bill will ensure that people have every chance of getting back into work, but with an obligation to take up that support as well … [this] underpins why problem drug users will be expected to take up treatment, instead of just putting money into the pockets of drug dealers.'*
>
> Rt Hon James Purnell MP, March 2009

This positive plan, however, was not enacted before the 2010 General Election and the legislation was then superseded by the Welfare Reform Act 2012.

Whilst there were noticeable flaws in the proposal it contained two strong and crucially important principles. First, the welfare system should have a duty to establish whether people need treatment for addiction and then to help them to take it. Second, people with an addiction had a duty to take responsibility by accepting treatment if they wanted to continue to claim benefits in the same way.

As wise as these principles are, there is currently a major weakness in the ability of our system to implement them effectively. Due to the deficiencies of our current treatment system, any pilot would likely place large numbers on methadone. This would simply lead to people substituting one addiction for another and, ultimately, not help them to become clean.

For this reason we propose that the next Government pilot a scheme which re-establishes the principles agreed in the 2009 Act, but with the guarantee of high quality, abstinence-based treatment (including residential rehab). This would mean that the reform would only be phased in as new capacity in the abstinence-based rehabilitation estate became available (see proposals for a programme of expansion above).

202 Welfare Reform Act 2009 [accessed via: www.legislation.gov.uk/ukpga/2009/24/schedule/3]
203 Hansard, Column 860 , 17 March 2009 [accessed via: www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090317/debtext/90317-0017.htm (07.07.14)]

There are a number of options open to those who want to pursue a new active approach to intervene in the lives of addicts through the welfare system. In practice, this might mean that once a claimant had been identified as having an addiction, they would be offered abstinence-based treatment. If they accepted this, they would be placed in a suitable benefit category (perhaps Employment and Support Allowance (ESA) 'support group' (£108.15)) and have their conditionality suspended (for example, their job search requirements would be halted).

If a claimant declined the offer of treatment and refused to show willingness to face up to their addiction, they could then be placed on a lower category of benefit (perhaps ESA work-related activity (£101.15) or, in appropriate cases, Jobseekers Allowance (JSA)). They could also be required to take steps towards their own rehabilitation as agreed with their advisers, for example, a treatment awareness programme, educational session or specific interviews. Failure to comply with the agreed terms could then result in sanctioning.

> *'People often need something to push them to confront their problems. Some people are lucky enough to have a family that cares enough to confront them about their addiction. Others don't have anyone who's on their side, so the welfare system should fulfil this role.'*
> Noreen Oliver MBE, former alcoholic and founder of BAC O'Connor rehab

Offering a fair choice between effective abstinence-based treatment or changes to their benefit entitlements would encourage many people to consider recovery for the first time. Many former addicts tell us that some only seek help when faced with the harsh reality of continued drug or alcohol use. For some, change may be sparked by the loss of their job or their children, for others it might be unwanted contact with the NHS or criminal justice system. We believe the welfare system could play a part in that life change too. It would be fair too for those who fund our benefits system and supportive of those who need help within it.

> *'I decided to get some help when I ended up in hospital for the fourth time'*
> Lisa, former heroin addict
>
> *'It was when I got fired for turning-up late and being drunk … thinking about it afterwards I knew I had to stop'.*
> Mike, former alcoholic
>
> *'Getting pulled-over for drink-driving with my child in the car was what really made me think I had a problem'.*
> Beth, former alcoholic
>
> *'They said go to rehab or go to prison … that was nine months ago and I've been clean since'.*
> David, former heroin and crack addict

We urge an incoming Government to deliver where others have not been able to.

For those unwilling or unable to overcome their addiction

For those entrenched abusers of alcohol and drugs who refuse to engage with treatment and who have not been in employment for 12 months and show no sign of improvement, the use of welfare cash cards should be considered. This will help protect those struggling with addiction, their families, and communities.

The CSJ has been told of tragic cases involving children going hungry as one or both parents feeds their addiction instead of providing food for their dependants. Equally concerning, are those who receive their benefits and overdose on drugs having used all the money at once. The CSJ heard from Tommy, who runs a housing charity in the Midlands:

> *'We had a lady who just couldn't stop. She tried so hard but whenever she got money it went straight on drugs. It was totally irresponsible on the adviser, or the system, to give her money like that. We owed her, and her little boy, a duty of care.'*

The vulnerability of children whose parents have an addiction to drugs or alcohol means we must take every opportunity to ensure welfare payments are being used for their needs. Nor is this issue slight, there are approximately 335,000 children in the UK living with a drug-dependent parent.[204]

Although the paramount issue is about protecting vulnerable families, there is also the principle of fairness to the taxpayer. Many workers paying tax are frustrated at the idea that the welfare payments they fund end up in the hands of drug dealers. By restricting the purchases that welfare benefits can be used for, the flow of taxpayers' money direct to dealers will be stemmed.

There is some evidence from Australia that such an approach can be effective in increasing the level of welfare payment that goes towards the child's needs (see below).

Australian 'Basics' Card – 'Income management'[205]

Income management refers to a policy by which a portion of the welfare payments of some people are set aside to be spent only on 'priority goods and services', for example, food, housing, clothing, education and health care.

This programme has enjoyed the support of both left and right. The scheme was introduced by the Howard Government in 2007 and the Rudd and Gillard Governments have judged it a success. They have expanded the scheme so that it now applies throughout the Northern Territory and other designated 'disadvantaged areas' throughout Australia.

204 Manning et al, 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys' in *BMC Public Health*, 9, 2009

205 Australian Government Library, Is Income Management Working? 2012 [accessed via: http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/1603602/upload_binary/1603602.pdf]

Situations which the scheme covers include cases of child neglect and non-enrolment and/or non-attendance at school. In addition to these compulsory income management schemes, provision exists for people to voluntarily opt in.

Under income management, a percentage of the welfare payments of those subject to the scheme is diverted into a special account. As noted above, funds in this account may only be spent on priority items such as food, clothing, health items, education and training, child care, housing and utilities, and, transport.

There is also a ban on certain goods and services which must not be bought with income managed funds, including alcoholic beverages, and brewing paraphernalia. In addition, because cash is not transferred to the individual, the purchase of illicit drugs is restricted.

Findings from the analyses that have been undertaken are largely consistent, with participants reporting:

> *'… income management had delivered discernible benefits, particularly to children, women, older people, and parents and families. The benefits included more money being spent on food, clothing and school-related expenses; assisting with saving for white goods such as fridges and washing machines; less money being spent on alcohol, gambling, cigarettes and drugs; reduced levels of 'humbugging' (or harassment for money); and improved capacity for household budgeting.'*

Even the Australian Indigenous Doctors' Association study, which was not generally supportive of the scheme, observed:

> *'High levels of support for increased income to purchase food and other necessities for children, in particular, are likely to translate to improved health outcomes—both direct (as in improved health associated with improved nutrition) and indirect (as in, improved concentration, participation and learning ability and capacity, and improved educational outcomes).'*

Other studies have shown that 78 per cent of recipients of the card found it 'made their lives better'.[206]

The principle behind the use of prepaid cards has already become established in parts of England. Indeed the use of income management cards already occurs, with local authorities using them in Brent, Bury, North Somerset, Southwark, Kent and others.[207] For example, Bury uses a cashcard when transferring support payments to carers.[208]

We are aware of implementation challenges of such a scheme, however, the fact that similar cards are already in operation is promising.

We call on the next Government to accept the principle that sometimes income management is the most compassionate response for the protection of certain vulnerable people and conduct a pilot to test the practicality of such a scheme.

206 Creative Commons, *Cape York Welfare Reform Evaluation*. 2012 [accessed Creative Commons, Cape York Welfare Reform Evaluation. 2012[accessed via:http://www.dss.gov.au/our-responsibilities/indigenous-australians/publications-articles/evaluation-research/cape-york-welfare-reform-cywr-evaluation-report-2012 (07.08.14)]; Proceedings of Australian Senate Finance Committee, 2013, [accessed via: http://www.aph.gov.au/parliamentary_business/committees/senate/finance_and_public_administration/social_services/report/~/media/Committees/Senate/committee/fapa_ctte/social_services/report/c02.ashx (08.08.14)]

207 Wood and Salter, *The Power of the Prepaid*, London: Demos, 2013

208 *Ibid.*

Such a reform would go some way to restoring the public's long-term faith in the credibility of the welfare state.

Helping People to Sustain Recovery

When people complete treatment for addiction, they often require time to build and strengthen their recovery before taking up full-time employment. This is because the process of detoxifying helps enable the individual to tackle the root causes of their addiction, and learn to function as a citizen without a chemical crutch. The stress of being pushed to find work can lead to relapse. As Martin told the CSJ:

> *'After rehab was the first time in 14 years I had to live by myself without being out-of-my-mind. All these thoughts and feelings … even doing a shop for the week can bring on real anxiety.'*

As well as a tragedy for the individual, unnecessary relapse represents a waste of taxpayers' money funding their time in treatment and rehabilitation.

The current plans for Universal Credit are to allow people six months' 'suspended conditionality'[209] from when they enter treatment, meaning they will not be required to look for work whilst they focus on giving up drugs. At the end of this period, the Jobcentre adviser will review the progress of treatment and if they deem it necessary, they can extend the period of suspended conditionality (or withdraw it early if the claimant has stopped engaging with treatment). It is imperative that advisers are informed enough not to push people into seeking employment too early.

The ambition, to help those with an addiction into recovery and support them into work is admirable and shows how the welfare system is developing into one which helps individuals restore their lives, rather than trapping them in dependence. However there is a risk that Jobcentre advisers who are not experts in addiction will sanction people too early. As Sarah, who overcame alcoholism at Mount Carmel rehab in Streatham, told the CSJ:

> *'My JCP adviser was great and supportive, but they vary. My friend's one has been hassling him even though he's in a bad way. It's not helping him stay sober.'*

It is the recommendation of this group that, if someone enters treatment, a *presumption* of suspended conditionality is extended to 12 months, beginning from when treatment begins. This will allow advisers to provide the space for the individual to focus on his or her recovery.

As this is only a presumption, the adviser will be able to begin ending the suspended conditionality if there is evidence that either the individual is not engaging with treatment or no longer requires it.

209 Suspended conditionality – the receipt of out-of-work benefits without any requirements, for example, to seek work.

As Chip Somers, founder of the rehab charity Focus12 and in recovery himself, told the CSJ:

> *'Recovery is different for different people. Some will need longer and some will need a push.'*

Furthermore, the intensive nature of residential treatment is such that in many cases the recovering addict has to totally rebuild his or her life. Those with large amounts recovery capital may be in rehab for a couple of weeks however some people go to rehabilitation for three to six months, and in some cases nine or 12 months. It is important they are given the time and space to focus on their recovery. Consequently, the 12-month presumption should commence when the individual completes rehab.

Consideration should be given to the idea that decisions taken by the adviser on terminating the suspended conditionality before the 12-month presumption, should ultimately be subject to an expert panel as is currently with similar sanctions.[210] Some people will be ready for work within weeks. Those with more complex, traumatic histories may take a little longer but as the CSJ has seen first-hand, with the right support, people can recover.

Recommendations to make the welfare system more responsive to addiction:

- The Government should ensure that the welfare system does all it can to identify when people are suffering from an addiction and then offer and encourage them to accept treatment. In a local area with an effective abstinence-based residential treatment system which has spare capacity, a pilot should be conducted to test the effectiveness of incentivising treatment with enhanced ESA for those with an identified addiction. As capacity in the residential rehab system becomes available so the scheme should be expanded.
- For those with an identified addiction, who have continually refused offers of treatment and who have dependent children/spouses, we propose the piloting of a welfare 'cash-card'.
- There should be a presumption of suspended conditionality of 12 months for those entering treatment and those exiting rehabilitation.

Alcohol Hospital Admissions – Treating the condition, not just the symptoms

Alcohol abuse is taking an increasingly difficult toll on the National Health Service. While those admitted to hospital with an alcohol-related condition often receive a good service for a particular ailment or injury, for example liver disease or a fall, too little is done to tackle the alcohol abuse which is the root cause of their admissions. This burden is staggering, with one in eight NHS bed-days due to alcohol-related illness.[211]

Research undertaken by the CSJ challenges the assumption that Britain is getting its drink problem under control.[212] Our review has found that the number of people being readmitted

210 If a decision is appealed, it should be resolved before any loss of benefit occurs
211 Groves P., Pick S., Davis P. et al. 'Routine Alcohol Screening and Brief Interventions in General Hospital' in *Drugs: Education, Prevention and Policy,* 17, 2010, pp 55–71. [accessed via: http://findings.org.uk/count/downloads/download.php?file=Groves_P_1.txt (07.08.14)]
212 *The Guardian*, 'Booze Britain Sterotype flagging' 30 May 2014 [accessed via: www.theguardian.com/commentisfree/2014/may/30/booze-britain-stereotype-flagging-alcohol-consumption-down (07.08.14)]

for alcohol/drug related injuries and illnesses each year is rising. We are not using the opportunity that a hospital visit provides to address the underlying addictions leading to people coming back to hospital time and time again.

Alcohol dependency in England

Although the number of people drinking every week has declined since 2002, the number of alcohol-related admissions to hospital has more than doubled over the same period.[213] Britain has become increasingly addicted to alcohol over the past 20 years:

- Alcohol-related deaths have doubled since 1991 and liver disease is now one of the 'big five killers' alongside heart and lung disease, stroke and cancer and the only one to be *rising*;[214]
- One in 20 adults are now dependent drinkers;[215]
- 700,000 (nearly one in 16) children live with a dependent drinker;[216]
- Within Western Europe, only Norway has a worse rate of alcoholism than the UK.[217]

This rise in addiction has put significant pressure on health services:

- One in 16 hospital admissions are alcohol-related;
- One in eight NHS bed-days are taken-up with alcohol-related diseases;
- The bill to the NHS is some £3.5 billion – or £120 per taxpayer per year.[218]

Much of this demand for health services for alcohol-related injuries and illnesses is repeat demand. The CSJ sent Freedom of Information requests to each 'acute trust' in England asking them to how many people were admitted more than once with an alcohol-related condition in each of the past five years. The response rate was 40 per cent and the results were startling. In the last five years, the data indicates that the number of people readmitted has increased by 85 per cent.

Alcohol-related harm is concentrated in areas of deprivation, Manchester, for example, has the highest rate of alcohol-related admissions in England, drawn especially from its deprived wards.[219] In 2012/13, 543 were admitted twice or more times to Central Manchester University Hospitals with an alcohol-related condition.

These numbers may well be a gross underestimate as the CSJ has heard from doctors how the coding system, by which an admission is labelled, for example, as alcohol related, is not always followed with fidelity. We interviewed three doctors with recent experience of A&E units and all agreed that alcohol-related conditions were under-reported. One doctor said:

213 NHS Information Centre, Statistics on Alcohol 2011, London: Department of Health, 2012
214 Office for National Statistics, *Age-standardised alcohol-related death rates*, London: ONS, 2013
215 NHS Information Centre, Statistics on Alcohol 2011, London: DH, 2012
216 Manning et al, 'New estimates of the number of children living with substance misusing parents' in *BMC Public Health*, 9, 2009
217 Rehm R and Shield K, Alcohol consumption, alcohol dependence and attributable burden of disease in Europe, Canada: Centre for Addiction and Mental Health, 2012
218 *NHS Statistics on Alcohol*, 2013 [accessed via: https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2013/alc-eng-2013-rep.pdf (07.08.14)]
219 Local Alcohol Profiles for England, 2013 [accessed via: www.lape.org.uk/ (07.08.14)]

'If it's 3am, patients are lined up, tempers fraying, are we always going to take the time to code properly…?'

Case study – Portsmouth and alcohol[220]

Portsmouth is a city contrasted between the extremes of an international trading port and a burgeoning aerospace industry next to estates with deprivation rates amongst the highest in the country. Alcohol still takes a disproportionate toll on the city's residents.

Staff Nurse Sue Atkins, knows this better than anyone. She saw the same men regularly brought into her ward with conditions that existed due to alcohol abuse. After an acute bed-shortage, she resolved to do something to prevent these people continuing to clog-up her ward.

A screening programme was developed which saw people assessed for alcohol addictions when they were admitted. If they got a high enough alcohol-risk score, they would receive a visit from a specialist nurse who would discuss their condition and inform them of treatment options. Such follow-up could either occur with the hospital or with community services.

The new approach was successful. With an annual investment of £200,000 from Portsmouth Healthcare Trust, some £302,120 was saved in avoided admissions and bed stays. This does not include any reduced welfare or criminal justice costs but judging by the case studies reviewed, these would also have been substantial. Dr Richard Aspinall, Clinical Lead for Hepatolgy told the CSJ, *'the work done here effectively intervenes to disrupt these harmful cycles of behaviour. It gives people a chance to get themselves back on track'.*

The CSJ believes that no one, admitted with an alcohol-related condition, should be discharged without being offered some form of intervention and treatment. To make this possible, we suggest a number of recommendations.

First, NICE should review how alcohol-related admissions are handled by hospitals – looking closely at pockets of good practice such as that we have seen in Queen Alexandra Hospital and the Royal Hospital Liverpool.

Second, national standards for screening should be rolled-out and inspected. Whilst admissions should be screened until this problem is tackled, we recognise capacity building will be an issue and suggest that unplanned (emergency) admissions to hospital should be prioritised. Once this has been done, it should be extended to planned admissions where there is a probability of alcohol influencing the condition, e.g. liver problems or heart disease.[221]

Third, commissioners of healthcare (CCGs) should ensure that alcohol screening is taking place. The level of readmissions should form part of the public health outcome framework issued by PHE to ensure that Directors of Public Health 'buy-in' with their resources as well.

220 Jane Ward WMC Ltd, *Evaluation of the Effectiveness of the Alcohol Specialist Nurse Service*, 2012 [accessed via: www.alcohollearningcentre.org.uk/_library/ASNS_Final_Evaluation_Report_February_2012.pdf 07.08.14)]

221 Lim, S.S. et al, 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010', The Lancet, 380, 2012; Davies, S.C., *Annual Report of the Chief Medical Officer, On the State of the Public's Health*, London, Department of Health, 2012

Fourth, we recommend that the Government assesses the criminal justice and welfare savings of this intervention. This will allow for cross-departmental funding bids and possibly the development of a social impact bond to realise the savings made.

Recommendations to tackle readmissions:

- NICE should review guidance on how alcohol-related admissions are responded to by hospitals – looking closely at pockets of good practice such as in Queen Alexandra Hospital and Royal Liverpool Hospital.
- The Recovery Champion for England be allowed to inspect hospital wards to ensure they are implementing screening.
- Commissioners of healthcare (CCG's) should ensure that alcohol screening is taking place, and readmissions should form part of their funding assessment. The level of readmissions should form part of the public health outcome framework issued by PHE to ensure that DoPH 'buy-in' with their resources as well.
- The Department of Health should assess the criminal justice and welfare savings of this intervention. This will allow for cross-departmental funding bids and possibly the development of a social impact bond to realise the savings made.

The Criminal Justice System

Many of those who commit crime are addicted to drugs and alcohol. Between a third and half of new prisoners are estimated to have a severe drug problem in England and Wales and over half of offenders link their crime to their drug problem.[222] Furthermore, half of the victims of violent crime believe their attacker had been drinking.[223]

To tackle addiction and reduce its devastating impact on communities across the UK the criminal justice system needs to be effective at getting people off drugs and into recovery.

In this section we set out how to improve our approach to tackling addition for those who commit crime, looking separately at our approach in both prisons and the community.

Tackling addiction in the community

The reoffending rate of those serving sentences in the community is unacceptably high. Over a third of offenders (36 per cent) on community orders are caught reoffending within just 12 months of being sentenced. This reality is even worse for those sentences aimed at drug-addicted offenders, with over half (56 per cent) given a drug rehabilitation requirement (DRR) reoffending within a year of being sentenced.[224]

222 UK Drug Policy Commission, *Reducing drug use, reducing reoffending*, London: UKDPC, 2008; Prison Reform Trust *Bromley Prisons Briefings Factfile*, London: Prison Reform Trust, 2010

223 Flatley J, Kershaw C, Smith K et al, *Crime in England and Wales 2009/10*, London: Home Office, 2010

224 Ministry of Justice, Proven re-offending statistics – October 2010–September 2011, Tables 20 and 21, July 2013 [accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/225090/proven-reoffending-oct10-sep11.pdf (09/04/14)]; National Offender Management Service, Probation trust guidance on DRRs 2012-04-24, 2012

The effect of failing to tackle addiction in offenders is disastrous for communities, as those who reoffend after being given a sentence in the community commit around 160,000 crimes within a year – many drug-related.[225]

Sentences served in the community have a particularly important role in transforming lives and cutting crime. They have the potential to be a powerful tool for addressing the root causes of offending behaviour. By delivering sentences in the community, rather than prison, it is far more effective and cheaper to provide support that addresses underlying issues, such as dependence on drugs and alcohol.

Swift and Certain Sanctions

A new, more effective way of managing offenders under community supervision has been introduced across the United States – Swift and Certain (SAC) Sanctions. The approach ensures that those who are caught breaching their sentence in the community receive a swift sanction. Most often the sanction involves a few days in a jail cell. 'Swift and Certain' (SAC) Programmes have been implemented in around 20 States across the USA, and has had a remarkable effect on tackling drug and alcohol addiction. The approach has primarily – although not exclusively – been focussed on substance dependent offenders and has seen those with a SAC condition in their sentences up to 72 per cent less likely to use drugs.[226]

There are three essential elements that make the scheme successful:

- Swift: when offenders breach they are quickly seen by a judge, often on the same day, and receive their sanction immediately;
- Certain: the consequences of breaching are clearly communicated when offenders are sentenced and every detected breach is sanctioned;
- Fair: the severity of the sanctions are made proportionate to the frequency and manner of the breaches, with offenders often being sent for just one or two days in jail for a first breach.

In our report *Sentences in the Community* we called on the Ministry of Justice to introduce a pilot of the Swift and Certain approach, targeted at those offenders who have a drug addiction that fuels their offending – i.e., those given a Drug Rehabilitation Requirement as part of their sentence. In this paper we reiterate our support for this recommendation and highlight its importance as a means to get offenders off drugs and into recovery. Yet by itself this is not enough, and we also call for an expansion of drug courts in the UK.

Drug courts

A drug court is a problem-solving court-based programme that targets the addictions that are fuelling criminal behaviour. The aim is to use coercion and care to enable the individual to change their behaviour and kick their drug or alcohol addictions. Addicted offenders, together

225 Ministry of Justice, *Proven re-offending statistics – October 2010–September 2011*, Tables 20 and 21, July 2013
226 McEvoy K, National Institute of Justice, Journal No. 269, March 2012, HOPE: A Swift and Certain Process for Probationers; greater detail on this initiative can be found in our report *Sentencing in the Community*

with addicted parents with pending child welfare cases, are two of the main groups who are diverted into drug courts in the UK.

First, individuals are identified as having a drug or alcohol problem which contributed to their offence. If they are selected as suitable for a community programme they are asked to agree to a programme of treatment to overcome their addiction. Failure to comply, for example by testing positive for drugs, results in a series of escalating sanctions, potentially ending in a custodial sentence. The reward for compliance, conversely, is avoiding jail and, more significantly, the opportunity to end their self-destructive, addictive behaviour. Evidence detailed below shows that, if correctly implemented, drug courts effectively help offenders overcome their addictions, reduce crime, and save taxpayers money. While they have been widely successful in tackling criminal behaviour in both Australia and America, the criminal justice systems within the UK have not successfully implemented this approach.[227]

The case for drug courts

There is an extensive body of research from the United States, where drug courts have been pioneered, which shows they are effective at tacking addiction, as well as cutting offending, and reducing the costs of crime and social breakdown to the taxpayer.

Tackling addiction

Multiple studies have shown that drug courts reduce drug and alcohol addiction. One large study found that only 56 per cent of drug court 'graduates' were likely to report using any drug compared to 76 per cent of the comparator group.[228] Furthermore, at the 18-month follow-up test, while 46 per cent of the comparator group tested positive for drugs, only 29 per cent of the drug court 'graduates' did.

Beyond promoting abstinence, drug courts also serve to foster recovery capital within the individual necessary for sustaining a drug-free life after formal treatment has ended. Participants reported, for example, significant improvements in their familial relationships.[229]

Saving money

At a time when the Ministry of Justice has had to make savings of 25 per cent, the financial savings offered by the drug court model is one which should command attention. For example, in terms of direct savings realisable by the Ministry of Justice, drug courts have also been found to be more cost effective than prison.[230]

What makes an effective drug court?

There are several key factors that constitute a successful drug court. The 'key components' of drug courts stated by the National Association of Drug Court Professionals (NADCP) in America include:

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227 Law Reform Commission of Western Australia, *Court Intervention Programs*, 2009 [accessed via: www.lrc.justice.wa.gov.au/_files/P96-FR.pdf (07.08.14)] and The Multi-Site Adult Drug Court Evaluation, 2011, [accessed via: www.ncjrs.gov/pdffiles1/nij/grants/237108.pdf (07.08.14)]

228 The Multi-Site Adult Drug Court Evaluation, 2011, [accessed via: www.ncjrs.gov/pdffiles1/nij/grants/237108.pdf (07.08.14)]

229 *Ibid*

230 Law Reform Commission of Western Australia, *Court Intervention Programs*, 2009 [accessed via: www.lrc.justice.wa.gov.au/_files/P96-FR.pdf (07.08.14)]

1. A multidisciplinary team approach;
2. Ongoing schedule of judicial status hearings;
3. Weekly drug testing;
4. Contingent sanctions and incentives;
5. A standardized regime of substance abuse treatment.[231]

Analysis of these components has shown that fidelity to the full 'drug court model' is necessary for optimum outcomes when the programmes are treating their correct target population of high-risk, addicted drug offenders.[232]

Drug courts in England and Wales

The opportunity for drug courts to tackle addictions is significant, yet attempts to introduce them in England and Wales have not proven successful primarily due to failures of implementation.

Six Dedicated Drug Courts (DDCs) pilots were introduced in magistrates' courts in England and Wales from 2004. They attempted to introduce the keys components which had been identified in the international evidence.[233] However, there were several deviations from the standard model.

A lack of effective, abstinence-based treatment has long been a problem associated with drug rehabilitation programmes in the UK, as outlined at length in Chapter One. The treatment that has been provided as part of Drug Court has therefore often been a methadone prescription and little transformative therapy, such as that received in abstinence-based programmes in residential rehabs or day programmes like SHARP. As Tommy Killick, treatment adviser at the West London Drug Court, told the CSJ:

> *'The treatment options available are not as good as they could be, there are people I've seen that really needed rehab, but the resources are not there.'*

The pilots also failed to ensure that the sentencers were consistent. In only five per cent of cases was there sentencer continuity.[234] Having the same judge oversee an offender each time their case is reviewed is an important part of the drug court model. It enables the judge to make more informed decisions about the offender's progress, and offenders benefit from this consistency as they build a rapport with the judge. As Lee, who had graduated from the drug and alcohol court, told the CSJ:

> *'I have had loads of different judges. You can get round some and others just send you away for nothing. He [the Drug Court judge] was the first person in my life I can remember who seemed to care what happened to me. Whenever I got clean tests he*

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231 Bureau of Justice Assistance, *Defining Drug Courts,* 1997 [accessed via: www.ndci.org/sites/default/files/nadcp/Key_Components.pdf (07.08.14)]

232 National Association Drug Court Professionals, *Research Update on Adult Drug Courts,* 2010 [accessed via: www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Adult%20Drug%20Courts%20-%20NADCP_1.pdf (07.08.14)]

233 Ministry of Justice, The Dedicated Drug Courts Pilot Evaluation Process Study, 2011 [accessed via: www.natcen.ac.uk/media/28647/the-dedicated-drug-courts-pilot-evaluation-programme.pdf (07.08.14)]

234 *Ibid*

would say well done, when I didn't he was disappointed. He didn't shout or swear or nothing but explained why he had to remand. I knew I would see him again and I wanted to get the [clean] tests for him as much as me.'

The importance of continuity is demonstrated by considerable evidence from the USA showing that the relationship between the drug court judge and the defendant is key factor in promoting desistance.[235] Therefore, having the same judge oversee an offender each time their case is reviewed is crucial in both helping the judge to make more informed decisions about the offender's progress and in helping offenders build a rapport with the judge. There are now a number of studies which show drug court participants who had higher numbers of reviews in front of the drug court judge also reported committing fewer crimes and using drugs on fewer days.''

Finally, a lack of rigorous evaluation of the pilots has also compounded the roll-out of drug courts. Unlike the Family Drug and Alcohol Court, which had a robust, independent evaluation conducted by the Nuffield Foundation, the effectiveness of the criminal Drug Courts remains unassessed. As Sophie Kershaw of the FDAC explained to the CSJ:

'… having the evaluation behind us meant that when the pilot funding went ran out we had evidence to take to funders and say "this will save you money".'

Those involved in the court pilots are convinced of their effectiveness but without an evaluation behind them, have been unable to convince Her Majesty's Court Service of their efficacy. Judge Andrew Sweet, who sat in the West London Drug Court, told the CSJ:

'We had numbers showing it worked but they weren't evaluated to the right level. We know what we do makes a difference … instead of the same face over and over, this interrupts the cycle.'

Recommendations to tackle addiction and reoffending:

The Drug Court model should be re-trialled with adherence to all the factors identified as key. West London, given its experience, would appear a natural choice for such 're-trial'.

A full evaluation of the pilot should be undertaken so that when it draws to a close, the model is not dependent on central government but can rather take its model to other commissioners. Such an evaluation could compare the effectiveness of the drug court model against the DRR.

Treatment in prisons

Prison also provides a unique opportunity to intervene positively and powerfully in an individual's life. It is important that the time offenders spend in prison is used productively to undermine the root causes of their offending – tackling drug and alcohol addictions is a

235 Carey, et al,. 'Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes, and Costs', NPC Research. [2008]. Available: [accessed via: www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf (07.08.14)]

crucial part of this. Yet, far from tackling addiction, it seems that many prisons are currently awash with drugs and alcohol.

Addiction in prison

Prisons are not effectively tackling addiction. In 2010–11, 38 per cent of those who entered local prisons had a drug problem and nearly one-third estimated that they would leave prison still abusing drugs.[236] Similarly 22 per cent of prisoners arrive in prison with a drink problem and 19 per cent expect to leave as such.[237]

The Government is piloting ten drug recovery wings to remedy this with an evaluation due in 2015. There are also other prisons conducting their own recovery wings outside of the official trials. These pilots vary significantly in their approach and it is too early to take a view on which will be successful. What we can say is that some appear to reflect the practices from successful rehabilitation outside the prison system. Others appear to embody some of the elements of over-prescribing, the problems of which we set out in Chapter One.

Manchester – Recovery Through the Gate (RTTG)

Manchester's recovery wing contains features which reflect what is thought to embody best recovery practice. The programme includes:

1. An eight-week intensive, compulsory programme including life skills, victim awareness, mutual aid (AA, NA, SMART), Family Groups, personal mental and physical health;
2. Education, employment or working as a peer mentor;
3. A minimum of 13 weeks of support in the community upon release.

The programme accommodates 22 individuals. It is located separately and securely from the rest of the prison and is therefore able to keep-out drugs more easily. This segregation allows inmates to focus on their rehabilitation with disruption from prisoners who may still be taking drugs.

Importantly, the aim is for participants to leave abstinent from drugs. Prisoners are not released detoxed and unsupported but rather they are 'supported through the gate'. Such an approach represents an exciting innovation in rehabilitation for prisoners with an addiction. Indeed, this feature was identified as 'defining'" in the interim evaluation.[238]

Although resources were limited, with access to a small gym, yard for an hour a day, and a claustrophobic lack of natural light, it is impressive that inmates and therapeutic staff were highly positive about the programme.[239] As Loraine Heath of HMP Manchester told the CSJ: *'As well as the focus of SMART recovery there is an emphasis of healthy living which incorporates daily physical activity thus promoting them taking responsibility for their own health.'*

By providing an opportunity for abstinence together with the recovery capital to remain drug-free, Manchester RTTG, represents a promising agent of delivery for the ambitions of the Drug Strategy and Transforming Rehabilitation programme.

236 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011
237 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011
238 Lloyd et at, *Evaluation of the Drug Recovery Wing Pilots: Scoping and Feasibility*,
239 Lloyd et at, *Evaluation of the Drug Recovery Wing Pilots: Scoping and Feasibility*,

As Mark Gilman, Strategic Recovery Lead at PHE, told the CSJ:

> *'I think the success is down to the use of peers and people in recovery (who were once themselves in HMP Manchester and other prisons) going back in with a very simple message – "There is a solution. We know how it works. We were where you are. We will show you exactly how to do what we have done and get what we have got – recovery".'*

Despite improved access to mutual aid and the trialling of recovery wings, it is concerning that inmates are receiving more methadone than ever before whilst fewer are being detoxified. The number of substitute prescriptions has nearly trebled since 2007 to 33,198 in 2011/12.[240] The worst practices of endless methadone-maintenance prescribing, highlighted in community drugs treatment in *Breakthrough Britain,* now appear throughout the prison estate. The HM Chief Inspector of Prisons for England and Wales observed that *'it was noticeable that large numbers of prisoners received methadone maintenance treatment without regular treatment reviews.'*[241]

The CSJ heard from a GP and pharmacist how lax approaches to prescribing meant that too many prisoners were being prescribed strong painkillers, including opiates, when they were not needed. One pharmacist who works in a prison told us:

> *'It keeps the prisoners happy and the wings quiet. It doesn't tackle the problem at all in the long term.'*

This was confirmed by a GP who went into a different prison as a locum:

> *'I went to a prison and the amount of prisoners on strong painkillers was incredible … I then see people come out, who might be on heroin but now they're addicted to pregabalin too.'*

The effects of overprescribing are also being felt in communities. Having become addicted to prescribed drugs like pregabalin and gabapentin, drug-using offenders are having to source these drugs when they leave prison.

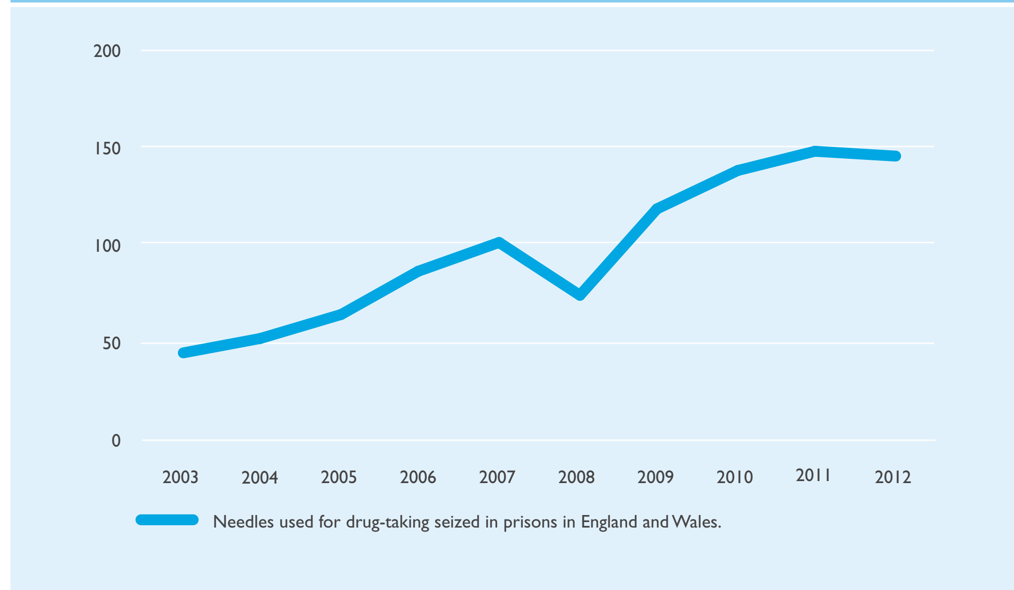
Many prisons are also failing to tackle the supply of illegal drugs into prison. For instance, one survey revealed that a third of prisoners who had ever used heroin reported first using it in prison.[242] The rise in needles confiscated in prison also indicates that there is a growing drug problem within the estate (Fig 2).

240 Hansard, Written Answers, 3 December 2012 [accessed via: www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121203/text/121203w0003.htm (08.08.13)]

241 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011

242 Ministry of Justice, *Compendium of reoffending statistics and analysis, SPCR Sample 1, Wave 1 questionnaire tables* London: Ministry of Justice, 2010

Figure 5: Rise in needles found in prison[243]



Alcohol abuse, similarly, is too familiar in the prison estate. In some prisons, alcohol is readily accessible and alcohol-related incidences are increasing.[244] A recent report into HMP Lincoln, for example, found that alcohol is widely available, with prisoners telling inspectors how easy it was to procure alcohol.[245] On a visit to one prison, the CSJ was told that Eastern European prisoners, who have increased in number since 2005, were 'master brewers' and that much of the 'hooch' in prison was not found by the authorities.

Compounding the availability of alcohol is the lack of alcohol recovery services currently in prison – despite the fact that 22 per cent of prisoners arrive with a drinking problem and 19 per cent expect to leave with one. Just under half of prisons inspected have no alcohol-related services or programmes available.[246] The Prisons Inspectorate found that at every stage in prison, the needs of prisoners with alcohol problems are less likely to be either assessed or met than those with illicit drug problems. Services for alcohol users were very limited, particularly for those who did not also use illicit drugs.[247]

It is our recommendation that the prescribing rates per prisoner per prison are published by Her Majesty's Prison Service, in conjunction with the Department of Health. This will serve to highlight those prisons which may have inappropriate prescribing practices and assist in holding Governors to account

Tackling addiction in prison

More needs to be done to tackle the supply of drugs and alcohol into prison, and to treat those in prison with addictions.

243 Hansard, 3 December 2012

244 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011

245 HM Chief Inspector of Prisons, *Report on a full unannounced inspection of HMP Lincoln*, HM Chief Inspector of Prisons for England and Wales, 2012

246 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011

247 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2010–11*, London: The Stationery Office, 2011

To most people it is self-evident that prisons should be drug- and alcohol- free. The idea that prisons, which are supposed to be both punitive and rehabilitative, could be home to people regularly taking drugs or alcohol is perverse. Yet this is the reality in vast parts of the prison estate and action is required to address this sorry state of affairs. The CSJ will be publishing a wider review which will look at this topic in greater detail in 2015.

Further to ensuring that prisons are drug- and alcohol- free, they also need to be places where prisoners receive effective treatment to tackle their addictions. There will be learning to be taken from the completed drug recovery wing pilots regarding the specifics, but in general the treatment received in prison needs to mirror the level received by those in abstinence-based rehabilitation which is provided in the community. This includes:

- Working to increase client motivation;
- Personalised treatment, rather than simplistic prescribing;
- Rigorous care management to ensure treatment is effective;
- High expectations of abstinence-based recovery;
- Assertive links to mutual aid (AA/NA/SMART);
- Monitoring, and if necessary, reintervention to get the addict back on track.

This recovery focussed approach to treatment must also be supported by prison guidance. The current guidance says that longer-term prisoners *"can be encouraged to use their time in prison to achieve abstinence"* and that this option should be discussed.[248] Instead of merely being encouraged, this should be a clear ambition of treatment as stated in the Patel Report.[249] Prisoners should be motivated to work for abstinence-based recovery and transfers from community treatment to prison and visa versa should maintain this continuity. However, such long-term rehabilitation work is obviously challenging in an environment of short sentences and the movement of prisoners around the estate.

To ensure prison treatment services are working towards recovery, the Recovery Champion for England (RCfE) should be able to access prisons, review the treatment services available and the prescribing practices. The RCfE should also be able to interview staff and prisoners.

Recommendations on tackling addiction in prison:

- Prison prescribing rates per prisoner should be published to assist in assessing levels of supply on prescribed drugs into a prison.
- Guidance to say prisoners should be motivated to abstinence-based recovery and this should be reflected in the services that are commissioned. The Recovery Champion for England should be allowed to review these services.

248 Department of Health, Clinical Management of Drug Dependence, 2006 [accessed via: http://www.nta.nhs.uk/uploads/clinicalmanagementofdrugdependenceintheadultprisonsetting-incamendmentatpara7.7.pdf (06.08.14)]

249 Patel, *Treatment in Prison*, www.ohrn.nhs.uk/resource/policy/ThePatelReport.pdf

Conclusion

The burden of addiction on society is huge. Hundreds of thousands of people are trapped in a dependence which ruins their lives and damages their families and communities.

For too long, successive governments have failed to substantially reduce these problems. As our analysis has shown, general levels of addiction have barely fallen in many years despite the huge sums of money spent.

People who suffer from addiction have long been an unheard minority in British politics, considered too unpopular a cause to be championed by many politicians, too often viewed only through the prism of crime or welfare statistics. This is as short sighted as it is unjust.

This report calls for a concerted effort to undermine addiction in the UK by:

- Educating young people to discourage them from using drugs;
- Reducing the supply of those drugs;
- Identifying addicts when they come into contact with public services and finding them treatment;
- Offering effective treatment that gets addicts off all drugs and alcohol and allows them the best chance of rebuilding their lives.

By adopting this holistic and sustained approach, government can both reduce the supply of, and demand for, dangerous substances and, in so doing, help to reverse addiction in the UK in a way never yet attempted.

Appendix 1

Criminal Justice (Psychoactive Substances) Act 2010 – Republic of Ireland

1. Main provisions of the Act

A central provision of the Act is the definition of the term **"psychoactive substance"** in **section 1 (Interpretation)** of the Act as meaning a substance, product, preparation, plant, fungus or natural organism which has, when consumed by a person, the capacity to—

a. produce stimulation or depression of the central nervous system of the person, resulting in hallucinations or a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood, or
b. cause a state of dependence, including physical or psychological addiction.

Section 2 (Exclusions from application of Act) excludes from the scope of the Act specific products which are subject to licence, authorisation or other control. These include medicinal products, animal remedies, intoxicating liquor, tobacco and food. Controlled drugs, which are subject to the Misuse of Drugs Acts, are also excluded to avoid duplication. Section 2 also provides that the Minister for Justice and Equality can by order exclude other products from the application of the Act.

Section 3 (Prohibition of sale, etc. of psychoactive substances) provides for the offences of selling, importing and exporting psychoactive substances for human consumption. Subsection (1) provides for the offence of selling a psychoactive substance knowing or being reckless as to whether it is being acquired or supplied for human consumption. The definition of "selling" (see section 1 of the Act) is broad and includes supplying, distributing, offering for sale, exposing or keeping for sale and being in possession for sale. It covers sales over the internet and home delivery services.

Subsection (2) provides that it is an offence to import or export a psychoactive substance knowing or being reckless as to whether it is being acquired or supplied for human consumption.

Subsection (3) provides for a rebuttable presumption that the person concerned knew or was reckless as to whether a psychoactive substance was being supplied or acquired for human consumption.

In coming to a decision on whether this presumption should operate, the court can have regard to indications given by the person that the substance may have psychoactive effects, the presence of drugs paraphernalia at the place to which the proceedings for the offence relate and whether it is reasonable to find that the substance is being sold, imported or exported for an alternative lawful purpose, taking into account cost and quantity. This applies notwithstanding any oral or written statement or indication given on packaging, etc. that the substance in question is not psychoactive or is not intended or fit for human consumption.

Subsection (4) provides that it shall be a defence for a person accused of an offence under this section to prove that he or she is a person specified in **section 6**, which ensures that the lawful professional activities of doctors, dentists, pharmacists, etc. will be outside the scope of the offence provisions.

Section 5 (Prohibition of advertising of psychoactive substances, etc.) provides for the offence of advertising a psychoactive substance. It is an offence for a person to publish or display (or cause to be published or displayed) any advertisement knowing or being reckless as to whether the advertisement indicates an intention to sell, import or export a psychoactive substance for human consumption. It is also an offence to publish an advertisement promoting the consumption of a substance for its psychoactive effects and providing information on how or where a psychoactive substance may be obtained.

Section 6 (Sale, etc. of psychoactive substances permitted in certain circumstances) provides that certain categories of persons, such as doctors and pharmacists, who sell, import, export or advertise psychoactive substances will not commit an offence under the Act if their actions are for the purpose of their profession and are otherwise lawful.

Section 7 (Prohibition notice) provides that a Garda Superintendent (or higher) may serve a prohibition notice on a person where he or she is of opinion that the person is selling, importing, exporting or advertising psychoactive substances for human consumption.

Section 8 (Prohibition order) provides that where a Garda Superintendent (or higher) is of opinion that a person is not in compliance with a direction contained in a prohibition notice, he or she may apply to the District Court for an order prohibiting the person from engaging in activities relating to the sale, importation, exportation or advertising of specified psychoactive substances.

As this is a civil rather than criminal procedure, the burden of proof will be less than that required for a criminal prosecution. The proof required will be on the balance of probabilities rather than beyond reasonable doubt.

The court may make a prohibition order if having considered the evidence before it and all the circumstances of the case, it is satisfied that the person has engaged in an activity

specified in the prohibition notice and it is necessary to prevent the person from engaging in or continuing to engage in such activity. It is an offence to fail or refuse to comply with a prohibition order.

Section 10 (Closure order) provides that where a person is convicted of any of the main offences under the Act, the court may make a closure order. A closure order will prohibit the person concerned from operating any business or engaging in any specified activities connected with the sale, importation, exportation or advertisement of psychoactive substances for human consumption. The closure order will apply to the place where the offence was committed or any other place specified in the order but will not prevent a person from carrying out any lawful activities in the place concerned. A closure order may be made for a period not exceeding 5 years. It is an offence to fail or refuse to comply with a closure order.

Sections 12 and 13 provide for Garda powers to search suspects and search and seize in relation to places and vehicles. **Section 14 (Powers of officers of Customs and Excise)** extends these powers to officers of Customs and Excise in cases of suspected unlawful importation or exportation of psychoactive substances.

Section 16 (Taking of samples) sets out the procedure for the treatment of samples of substances taken by the Garda Síochána or Customs and Excise

Section 20 (Offences) provides that a person guilty of an offence under the Act is liable on summary conviction to a fine of up to €5,000 or imprisonment for up to 12 months or both. This penalty applies to minor offences which are prosecuted in the District Court. A person convicted on indictment of a more serious offence under the Act is liable to an unlimited fine or to imprisonment not exceeding 5 years or both. Section 20 also includes provisions regarding forfeiture of substances, etc. on conviction for an offence under the Act.

Section 22 extends the powers of search and seizure of Customs officers at ports and points of entry to the State in relation to controlled drugs so that those powers also apply in relation to psychoactive substances.

2. Subsequent developments and issues arising

While the operation of the 2010 Act continues to be monitored, it appears that the legislation has achieved its main objective which was to tackle the headshop trade in Ireland and the widespread public availability of unregulated psychoactive substances.

Since the enactment of the 2010 Act, some of these products have made their way onto the illegal market and appear in Garda seizures, but as the vast majority of them are now subject to the Misuse of Drugs Acts, they can be dealt with under that legislation.

While there has been at least one conviction secured under the 2010 Act, essentially the 2010 Act is seen as a back-up measure to the Misuse of Drugs Acts, which is the primary legislative mechanism used in Ireland for controlling psychoactive substances.

The Department of Health has been and continues to be active in bringing new psychoactive substances under the controls of the Misuse of Drugs Acts and has sought to use generic definitions of substances as much as possible.

Given the covert and illegal nature of the online trade in new psychoactive substances, it is difficult to assess the extent of the effects of the 2010 Act on that trade, which is an international problem. Many of the substances involved are now subject to control under our Misuse of Drugs legislation or by the import prohibition provisions in the 2010 Act which apply to psychoactive substances not subject to the Misuse of Drugs Acts. While internet availability remains a channel through which new psychoactive substances may be available, the Irish Customs authorities continue to closely monitor any such trade and make seizures of such products.

A further range of psychoactive substances were brought under the controls of the Misuse of Drugs Acts in November 2011 (approximately 60 substances, although more generic definitions of substances were included where possible – thus extending the extent of controls).

Appendix II

This appendix sets out the basic model and assumptions behind the Treatment Tax, which is proposed on page 62.

Further to the quantitative assumptions set out in the footnotes of the model, our work is based on the following key qualitative assumptions:

- The rate of change in alcohol consumption (in units) per capita per year is assumed to be the average of the previous five years from the base year of 2013.
- The tax will only be levied on alcohol purchased in off-trades (i.e. purchased from retailers in a domestic capacity).
- Demand for alcohol is assumed to be inelastic on a whole as suggested by the 2010 study produced by the HMRC entitled 'Econometrics Analysis of Alcohol Consumption in the UK'.
- The top 30 residential rehabilitation centres can each create a new centre every year; however these newly created centres will not be operational until the beginning of the next 12 months.
- A newly created residential rehabilitation centre will be able to set up another new centre from its fifth year of operation.
- We assume the average period for abstinence-based recovery per patient is 12 weeks.

Treatment Tax – table part 1

	2015	2016	2017	2018
Projected average alcohol consumed per annum per person aged 15 and over (units)[1]	890	866	842	819
Estimated UK Population aged 15 and over[2]	53,403,501	53,745,480	54,076,931	54,423,510
Projected total alcohol consumption (units)	47,511,650,127	46,518,274,439	45,534,959,288	44,583,147,913
Estimated % purchased from off-trades[1]	67%	67%	67%	67%
Assumed levy per unit	£0.005	£0.005	£0.005	£0.010
Estimated total levy revenues	**£159,164,028**	**£155,836,219**	**£152,542,114**	**£298,707,091**
Total number of residential rehabilitation centres at end of year	60	90	120	150
of which,				
New set-up (operational in Year 2 of set up)	30	30	30	30
In operation (cumulative)	30	60	90	120
Estimated number of patients in treatment per annum	4,560	9,120	13,680	18,240
derived by,				
Estimated number of beds per centre	40	40	40	40
Estimated occupancy rate at any one point in time[3]	96%	96%	96%	96%
Estimated occupied beds at any one point in time	38	38	38	38
Total number of occupied beds	1,140	2,280	3,420	4,560
Assuming 12 week recovery period, estimated bed 'turnover' per annum	4	4	4	4
Estimated average cost to maintain a patient in a residential rehab centre per 12 week course[4]	£7,200	£7,332	£7,467	£7,605
Estimated total cost of setting up new residential rehabilitation centres	£60,000,000	£62,228,314	£63,373,315	£64,539,384
Estimated total cost of running residential rehabilitation centres	£32,832,000	£66,872,218	£102,154,000	£138,711,511
Estimated in-year levy surplus/(deficit)	**£66,332,028**	**£26,735,688**	**(£12,985,201)**	**£95,456,197**
Estimated levy surplus carried forward	**£66,332,028**	**£93,067,716**	**£80,082,516**	**£175,538,712**

Treatment Tax – table part 2

	2019	2020	2021	2022
Projected average alcohol consumed per annum per person aged 15 and over (units)[1]	797	775	754	734
Estimated UK Population aged 15 and over[2]	54,759,814	55,093,178	55,422,339	55,746,331
Projected total alcohol consumption (units)	43,641,273,162	42,715,405,968	41,804,480,358	40,907,744,403
Estimated % purchased from off-trades[1]	67%	67%	67%	67%
Assumed levy per unit	£0.010	£0.010	£0.015	£0.015
Estimated total levy revenues	**£292,396,530**	**£286,193,220**	**£420,135,028**	**£411,122,831**
Total number of residential rehabilitation centres at end of year	180	210	270	360
of which,				
New set-up (operational in Year 2 of set up)	30	30	60	90
In operation (cumulative)	150	180	210	270
Estimated number of patients in treatment per annum	22,800	27,360	31,920	41,040
derived by,				
Estimated number of beds per centre	40	40	40	40
Estimated occupancy rate at any one point in time[3]	96%	96%	96%	96%
Estimated occupied beds at any one point in time	38	38	38	38
Total number of occupied beds	5,700	6,840	7,980	10,260
Assuming 12 week recovery period, estimated bed 'turnover' per annum	4	4	4	4
Estimated average cost to maintain a patient in a residential rehab centre per 12 week course[4]	£7,745	£7,887	£8,032	£8,180
Estimated total cost of setting up new residential rehabilitation centres	£65,726,908	£66,936,283	£136,335,822	£208,266,602
Estimated total cost of running residential rehabilitation centres	£176,579,753	£215,794,585	£256,392,740	£335,713,328
Estimated in-year levy surplus/(deficit)	**£50,089,869**	**£3,462,352**	**£27,406,466**	**(£132,857,098)**
Estimated levy surplus carried forward	**£225,628,581**	**£229,090,932**	**£256,497,398**	**£123,640,300**

Treatment Tax – table part 3

	2023	2024	2025
Projected average alcohol consumed per annum per person aged 15 and over (units)[1]	714	695	676
Estimated UK Population aged 15 and over[2]	56,150,102	56,546,776	56,935,544
Projected total alcohol consumption (units)	40,085,846,565	39,273,501,629	38,470,383,543
Estimated % purchased from off-trades[1]	67%	67%	67%
Assumed levy per unit	£0.015	£0.020	£0.020
Estimated total levy revenues	**£402,862,758**	**£526,264,922**	**£515,503,139**
Total number of residential rehabilitation centres at end of year	380	380	380
of which,			
New set-up (operational in Year 2 of set up)	20	-	-
In operation (cumulative)	360	380	380
Estimated number of patients in treatment per annum	54,720	57,760	57,760
derived by,			
Estimated number of beds per centre	40	40	40
Estimated occupancy rate at any one point in time[3]	96%	96%	96%
Estimated occupied beds at any one point in time	38	38	38
Total number of occupied beds	13,680	14,440	14,440
Assuming 12 week recovery period, estimated bed 'turnover' per annum	4	4	4
Estimated average cost to maintain a patient in a residential rehab centre per 12 week course[4]	£8,331	£8,484	£8,640
Estimated total cost of setting up new residential rehabilitation centres	£47,133,046	-	-
Estimated total cost of running residential rehabilitation centres	£455,853,937	£490,032,853	£499,049,457
Estimated in-year levy surplus/(deficit)	**(£100,124,225)**	**£36,232,069**	**£16,453,682**
Estimated levy surplus carried forward	**£23,516,075**	**£59,748,144**	**£76,201,826**

1 Institute of Alcohol Studies (IAS): Alcohol Consumption Factsheet updated August 2013 http://www.ias.org.uk/Alcohol-knowledge-centre/Consumption/Factsheets/Total-consumption-in-the-UK.aspx (alcohol consumption is projected using average of movement over previous 5 years from base year of 2013)

2 Office for National Statistics (ONS): Population Estimates for the United Kingdom

3 Quoted from one of the leading providers of residential rehabilitation in the UK

4 National Treatment Agency for Substance Misuse (NTA) 2012 report on *The Role of Residential Rehab* www.nta.nhs.uk/uploads/roleofresi-rehab.pdf. This report quotes on average £600 a week per reahb course

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