

TRANSFORM

DRUG POLICY FOUNDATION

Drug policy 1997-2007

The evidence un-spun: Overwhelming Failure

Background

In 1998, the UN hosted a General Assembly Special Session on Drugs (UNGASS 1998) under the slogan “A Drug-Free World: We Can Do It”. The Declaration which emerged from this session, to which the UK is a signatory, calls for the elimination or significant reduction of illicit drug cultivation, production and trafficking, and a significant reduction in demand for illicit drugs by 2008.

Following on from this session, the Government produced its current 10-year strategy, appointing Keith Hellawell as UK “Drug Tsar” to oversee it. This strategy was widely criticised for not measuring impact on public health and for setting unrealistic targets. In addition, no methodology was established to gather the relevant data, nor was baseline data available against which the targets could be compared.

In 2002, following an enquiry by the Home Affairs Select Committee, the post of “Drug Tsar” was quietly dropped and the UK Strategy reworked. The main change was the replacement of specific, numerical targets with vague, directional goals (with the exception of drug treatment targets) and David Blunkett, then Home Secretary, talked for the first time about “maintaining prohibition”¹.

How does the Government measure its performance?

Before looking at the Government’s performance against its own targets, it is useful to consider how the Government has key ways it has decided to measure its performance and what information it uses.

Drug Harm Index: In 2004, a PSA target was introduced to “Reduce the harm caused by illegal drugs (as measured by the Drug Harm Index, encompassing measures of the availability of Class A drugs and drug-related crime)”.

The Drug Harm Index has been widely criticised² not least because the Home Office itself has decided what to class as a ‘drug harm’ and what weight to give to each harm in formulating the index. It has also been criticised for failing to include significant drug-related harms and costs such as the high rates of unemployment and homelessness amongst dependent users, lost tax revenues through unemployment, reduced work productivity and absenteeism, harm caused to partners, children, families, etc of users and costs thereof. Significantly absent are harms caused by UK drug consumption and UK policy to drug producer and transit countries such as Afghanistan and Colombia. It also fails to make distinctions between harms caused by drugs and harms caused or exacerbated by policy.

British Crime Survey: The Government relies heavily on British Crime Survey figures, which are quoted throughout the current strategy consultation document.

BCS is useful for tracking changes in trends. However, as its own reports acknowledge, BCS is likely to significantly underestimate true levels of drug use because (i) it does not cover some key groups that have relatively high rates of drug use such as the homeless and those in prisons and student halls of residence, and (ii) problematic users will often have lives that are so busy or chaotic that they are hardly ever at home. A Home Office study in 2000 estimated that there were 5-6 times more offences committed in a comparable period than estimated by BCS³.

¹ p.6, Updated Drug Strategy 2002

² See, for example, ‘A review of the UK drug strategy PSA targets and Drug Harm Index’ by Dr Russell Newcombe of Lifeline (2006).

³ Solomon et al, (2007) Ten years of criminal justice under Labour, Centre for Crime and Justice Studies

What has the Government delivered?

Considering the Governments four key target areas (Quoted strategy targets shaded grey): Young people, Crime/communities, Drugs treatment/drug related death, and Drug availability

1. Young People

1998:

Overall aim: Help young people resist drug misuse in order to achieve their full potential in society
Their Full Potential in Society

Key target: Reduce the proportion of people under the age of 25 reporting the use of Class A drugs by 25% by 2005 (and by 50% by 2008).

2002:

Overall aim: Prevent today's young people becoming tomorrow's problematic users

Key target: Reduce the use of class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially the most vulnerable young people.

Class A drug use amongst under 25s:

Government claims⁴ "Class A drug use is stable".

Comment:

- An alternative way of expressing this would be Class A drug use has not fallen since 1997 (despite the Government repeatedly saying this is a key target and spending billions on it)⁵.
- British Crime Survey 2006 reports a statistically insignificant fall in reported Class A drug use in past year by 16-24 year olds, down from 8.6% in 1997 to 8.0% in 2006.
- Reported Class A drug use in past year by 11-15 year olds has not fallen either (it has remained unchanged at 4.3% since 2001)⁶ (data from previous years not comparable).
- Reported Class A drug use by all vulnerable young people has increased, from 23.2% in 2003 to 26.6% in 2004⁷

The above statistics are for use of *any* Class A drug, which includes drugs whose use has fallen, including LSD and Ecstasy. These are the least harmful of the Class A drugs, widely acknowledged to be misclassified⁸. Use of the most harmful class A drugs, the specific target of Government policy, (namely crack cocaine) has risen dramatically. Heroin use rose up until 2001/2 and has then stabilised at a historic highpoint. The UK has amongst the highest levels of heroin and cocaine use in Europe⁹.

- BCS 2006/07 showed that reported use of cocaine powder amongst 16-24 year olds has virtually doubled since 1997 (up from 3.1% in 1997 to 6.0% in 2006/07) and reported use of crack cocaine has increased (up from 0.3% to 0.4%).

4 All Government claims referred to in this note are taken from Annex A of current Drug Strategy consultation document.

5 British Crime Survey (BCS) 2006/07 shows 8% of 16-24 year olds reported using any Class A drug in the past year. This was a statistically insignificant fall, down from 8.6% in 1997.

6 Information Centre on Health and Social Care (NHS) Statistics on Drug Misuse: England,

7 Home Office Departmental Report 2006, p. 97-98.

8 Including: the Police Foundation Inquiry 2001, Home Affairs Select Committee 2002, the RSA drugs inquiry 2007, and Blakemore, Nutt et al. the Lancet 2007

9 EMCDDA annual report 2006

Frequent use¹⁰ of any illicit drugs:

Government claims: *“Frequent use of any drug among vulnerable 11-15 year olds (those who had been truanted or excluded) has fallen from 20 per cent in 2003 to 11 percent in 2006”¹¹.*

Comment

The consultation document only includes statistics on truants and excludees, omitting other vulnerable groups. “Vulnerable groups” has been defined as *“those who have ever been in care, homeless, offenders, truants or school excludes”¹².*

- Frequent use of any drug by ALL vulnerable young people has *increased* from a reported 32.3% in 2003, to 34.7% in 2004¹³.
- Amongst all 16-24 year olds, frequent use of any drug has fallen by just 2 % since figures were first collected (from 11.6% in 2002/03 to 9.5% in 2005/06, according to BCS 06/07). This small fall (mainly due to long-term decline in cannabis use) is not mentioned in the consultation document.

Miscellaneous Government claims made in various Home Office print and online publicity¹⁴:

“Since 1998, the proportion of 16-24 year olds reporting:-

that they have ever taken any drug has fallen by 16 per cent;
that they had ever taken any Class A drugs has fallen by 18 per cent;
use of any drug in the past year has fallen by 21 per cent;
use of cannabis in the past year has fallen by 24 per cent.”

Comment

- These figures (from BCS 05/06) relate to *“past year”* or *“lifetime”* use of drugs and will include people who used a drug as little as once. It is frequent, longer term use of drugs, especially opiates and/or cocaine, which has the potential to cause most harm.
- The figures have presumably been included because they look like solid achievements. They are, however, less impressive than they might first appear because they are percentages of a percentage.

A less misleading way to present the above figures¹⁵ might be:-

Since 1998, the proportion of 16-24 year olds reporting:-

that they have ever taken any drug has fallen from 53.7% to 45.1%
that they have ever taken any Class A drugs has fallen from 20.5% to 16.9%;
use of any drug in the past year has fallen from 31.8% to 25.2%;
use of cannabis in the past year has fallen 26.2 % to 21.4%.

- Presented this way, the picture is one of high prevalence rates and small falls in use. These statistics have also been cherry picked from the huge quantities of data thrown up by the BCS (and DoH annual survey of 11-15 year olds) to present data in the best possible light. Other measures of, for example lifetime drug use amongst 16-59 year olds show increases since 1997 on almost every drug. Similarly ‘ever having used a drug’ amongst 11 year olds has risen from 1% in 1996 to 14% in 2005 (a 1400% rise to use the Home Office technique)

¹⁰ “Frequent use” of a drug is defined as “usually at least once a month within the last year”.

¹¹ Smoking, drinking and drug use among young people in England in 2006: headline figures, a survey carried out for the Information Centre for Health and Social Care and the Home Office.

¹² In the Crime and Justice Survey (2003).

¹³ Home Office Departmental Report 2006

¹⁴ ‘Tackling drugs Changing lives: turning strategy into reality’ January 2007

¹⁵ For further analysis of how Government “spun” these and other figures, go to <http://transform-drugs.blogspot.com/2007/04/new-report-drug-use-amongst-11-year.html>

2. Communities / Crime

1998

Overall aim: To protect our communities from drug-related anti-social and criminal behaviour

Key target: Reduce the levels of repeat offending amongst drug abusing offenders by 25% by 2005 (and by 50% by 2008).

2002

Overall aim: Reduce drug-related crime and its impact on communities

Key target: Reduce drug-related crime, including as measured by the proportion of offenders testing positive at arrest.

Reduce drug-related crime

Government claims: *“Drug-related crime is falling: acquisitive crime – to which drug-related crime makes a substantial contribution – has fallen by 20 % since the introduction of the Drug Interventions Programme”*¹⁶(drug strategy consultation document gives no reference for this statistic).

Comment:

- Whilst dependent drug users are thought to be responsible for a majority of “acquisitive crime”, this is primarily fundraising related activity to pay the hugely inflated costs of illicit drugs, rather than intoxication related.
- Nor is it the only “drug-related” crime. For example, much gun crime is related to turf wars amongst rival drug gangs, and most street prostitution is also related to fundraising to feed an illegal drug habit (80-95% of street sex workers are involved ‘to feed a serious drug habit’¹⁷).
- International criminal activity relating to UK drug markets is not included in these measures.
- Government has never defined “*drug-related crime*”¹⁸, there is no published methodology for measuring it, and no consistent data collection to allow trends to be analysed. Government claims are based on inference from inconsistent secondary data sources such as NEW ADAM.
- The degree to which Government policy is responsible for any drop in crime is also a moot point. Prices of heroin and cocaine have fallen by around 20% during the drug strategy period – it could easily be claimed that the this failure of supply side controls has resulted in the success on the crime stats since dependent users have to steal less to maintain their habit.
- Recent falls in acquisitive crime should not necessarily be attributed to DIP as there has been a long-term decline in BCS recorded crimes, which began in 1995.¹⁹
- Home Office research undertaken by York University²⁰ estimates that problematic drug users (of heroin and cocaine) are estimated to commit 36m drug-motivated crimes each year, 56% of the total number of crimes, and that drug-motivated offences are estimated to be responsible for a third of the total cost of crime (£19bn). This cost includes security expenditure, property stolen, emotional impact on victim, lost output and expenditure on criminal justice system. Extrapolating this figure over the lifetime of the 10 year drug strategy produces a figure of over £100 billion in crime costs.

¹⁶ The drug strategy consultation document gives no reference for this statistic. The January 2007 Tackling drugs Changing Lives Bulletin, however, references Walker A, Kershaw, C Nicholas S (2006) Crime in England and Wales 2005/06

¹⁷ Home office consultation document on prostitution; ‘Paying the Price’ (2004), p.12.

¹⁸ **Mike Penning:** “To ask the secretary of State for the Home Department what assessment his Department has made of the proportion of crime undertaken as a direct consequence of drug addiction” [PQ No.16701] **Paul Goggins:** “Crime statistics used for monitoring overall crime trends, such as recorded crime and the British Crime Survey, do not contain information about the drug habits of individual offenders or their motivation for offending. It is therefore not possible to provide firm estimates of the total amount of crime undertaken as a direct consequence of addiction”.

¹⁹ BCS recorded 11 million offences in its first year (1981). This figure rose throughout the 1980s and 1990s, peaking at 20 million offences in 1995. Since then, there has been a steady decline.

²⁰ Christine Godfrey et al (2002) – ‘The economic and social costs of Class A drug use in England and Wales, 2000’ and Lorna Gordon et al (2006) – [3. The economic and social costs of Class A drug use in England and Wales, 2003/04 \(Measuring different aspects of problem drug use: methodological developments\)](#), Home Office Online Report 16/06

3. Drug Treatment and Drug-related Deaths

1998

Overall aim: To enable people with drug problems to overcome them and live healthy and crime-free lives

Key target: Increase participation of problem drug abusers in drug treatment programmes by 55% by 2004 (by 66% by 2005 and by 100% by 2008).

2002

Overall aim: Reduce drug use and drug-related offending through treatment, and drug-related death through harm minimisation

Key target: Increase participation of problem drug abusers in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

2004

PSA target: Reduce harm caused by illegal drugs Including substantially increasing the numbers of drug-misusing offenders entering treatment through the criminal justice system.

Participation in drug treatment programmes

Government claims: 'Government has exceeded its drug treatment targets (number of admissions to treatment increased from 85,000 in 1998 to 181,000 in 2004/05).'

Comment:

- Government has exceeded its main target and also made some progress towards target of 1000 drug-misusing offenders entering treatment a week (up from 438 per week in March 2004, to 579 per week in March 2006²¹).
- Numbers entering treatment is, however, a relatively crude measure. If someone enters treatment and then relapses, for example, they are counted again if they re-enter treatment. In 2005/06, "new clients" accounted for just over 81,000 (less than half the total)²².
- "Treatment" can mean a number of different things. It has been alleged that Drug Action Teams (DATs) were using cheaper options such as methadone treatment and day centres to meet targets whilst 1,200 beds in residential treatment are unoccupied²³.
- After Government introduced a target to increase the proportion of drug users sustaining or completing treatment programmes in 2002/03, figures rose by about 15% in the first year but only increased by 3% in 2004/05 and 2% in 2005/06²⁴.
- Completing a treatment programme is not the same thing as ending a dependence on drugs. The proportion of people who are discharged from treatment 'drug free' has fallen from 5.8% to 3.5%²⁵.
- Government statistics focus almost exclusively on process measures (that respond quickly to increased spending) rather than output measures (which actually show policy effectiveness). The overall impact of treatment programmes may be relatively small. According to a recent report by the UK Drug Policy Commission, the benefits of treatment to individuals and families "is unlikely [to have] translated into a substantial and measurable impact on overall levels of dependent drug use and crime at the national level due to the large numbers of users remaining untreated, the high rate of relapse, the variable effectiveness of treatment and the continual influx of new users"²⁶.

²¹ Solomon et al (2007) Ten years of criminal justice under Labour , Centre for Crime and Justice Studies.

²² Solomon et al, op. cit.

²³ Solomon et al, op. cit.

²⁴ Solomon et al, op. cit.

²⁵ Benyon et al (2006) A retrospective cohort study of drug treatment clients in the North West of England, BMC Public Health.

²⁶ UK Drug Policy Commission (2007), An analysis of UK Drug Policy

Government claims: Drug-related deaths have fallen from 1,538 in 1999 to 1506 in 2005²⁷.

Comment:

- The Government claims drug-related deaths have fallen very slightly, the consultation document describes a fall of 2% between 1999 and 2005 (a statistically insignificant fall of 32).
- The source for this claim is unclear, however, as the reference given is for a report which looks at drug deaths between 2000 and 2004²⁸. It is also noteworthy that the Government has chosen to quote the level of drug-related deaths in 1999 as a benchmark rather than 1998 which has a higher figure but is the benchmark year used for other statistics in the document. The annual drug death figures are very volatile from year to year (indicating problems with the measures, and with using them as a measure of success), allowing them to be cherry picked to show success where none is evident.
- According to the latest Office for National Statistics (ONS) figures²⁹, drug-related deaths have actually *risen by just over 10%* from 1,457 in 1998 to 1,608 in 2005.
- N:B the true level of drug-related deaths is likely to be higher than ONS suggests as its figures only include deaths which are directly linked to drug use and occur shortly after use (and which are recorded on death certificates). Its figures do not include deaths caused by longer term use such as respiratory diseases, nor does it include deaths from indirect causes such as infectious diseases, car accidents and violence.³⁰
- The United Kingdom has the 2nd highest rate of drug-related deaths in Europe³¹.

²⁷ Drug Strategy consultation document : "Our communities : your say", 25th July 2007, Key Facts (Annex A)

²⁸ Health Statistics Quarterly Spring 2006, Office for National Statistics

²⁹ Health Statistics Quarterly Spring 2007, Table 3, page 86, Office for National Statistics

³⁰ For more discussion and data see the Transform Fact research Guide to drug deaths here:
http://www.tdpf.org.uk/MediaNews_FactResearchGuide.htm

³¹ European Monitoring Centre for Drugs and Drug Addiction, 2006 Annual Report.

4. Drug Availability

1998

Overall aim: To stifle the availability of illegal drugs on our streets

Key target: Reduce the availability of Class A drugs by 25% by 2005 (and by 50% by 2008).

2002

Overall aim: Reduce the supply of illegal drugs

Key target: Reduce availability of illegal drugs by increasing: proportion of heroin and cocaine targeted on UK which is taken out; disruption/dismantling of criminal groups responsible for supplying substantial quantities of Class A drugs to UK market; and recovery of drug-related criminal assets.

Reduce availability of illegal drugs:-

Government claim: Government makes no claims about availability itself. It makes various claims, instead, about its proxy measures³².

Comment:

- The Home Office admitted in its Annual Report of 2002 that drug availability is “difficult to measure”. This is not the case. Trends in availability can easily be ascertained through a combination of street price data, drug purity data (both of which are routinely collected) combined with systematic surveys of drug users (not routinely collected by any Government agency). The failure of the Government to collect or present any meaningful data on the key target for assessing all supply side enforcement spending is an inexplicable and inexcusable hole in the drug strategy evaluation process.
- Regarding drug purity and street price: Between 2000 and 2005 the price of heroin fell from £70 to £54 per gram, powder cocaine fell from £65 to £49 per gram, crack fell from £23 to £18-£19 per ‘rock’ and ecstasy fell from £9 to £4 per tablet.³³
- Prime Minister’s Strategy Unit reported (in 2003) that sustained drugs seizure rates of 60-80% would be needed to put successful traffickers out of business³⁴. The market share of drugs seized is estimated to be about 12% for heroin, 9% for cocaine and 25% for cannabis³⁵. The PM’s Strategy Unit also described Government interventions against the drug business as “*a cost of business rather than a substantive threat to the industry’s viability*”.
- According to the UK Drug Policy Commission (UKDPC), “*major changes in seizures levels are likely to have only minor effects on street prices*”.
- The UKDPC report also refers to several international studies that show drug seizures do not usually affect rates of drug use and just one contrasting example “*the Australian heroin drought*”. UK has been unable to replicate the Australian heroin shortage, however, because the two countries are different, e.g. Australia is geographically isolated and has a relatively small heroin and cocaine market.
- An increase in drug seizures and disruption of drug gangs is perfectly consistent with far more drugs being available. Indeed all indications are that this is exactly what has happened in the UK during the last 10 years.
- According to the latest Arrestee Survey³⁶, for those arrestees who had ever bought heroin, crack and powder cocaine, “*the drugs were always available to a significant majority when they had enough money to buy them*”. Among those who had bought heroin in the last year, 79 per cent said that it was available all the time and 18 per cent reported it was available most of the time. Crack and powder cocaine followed a similar pattern.
- Even if Government were able to have a significant impact of availability, and even if this were to result in price rises, this would arguably lead to increased harm as dependent users committed even more crimes to fund their habits.

³² for more discussion of this see ‘After the War on Drugs, Options for Control’ p.24: ‘Availability: an example of poor evaluation’ [http://www.tdpf.org.uk/Transform After the War on Drugs.pdf](http://www.tdpf.org.uk/Transform%20After%20the%20War%20on%20Drugs.pdf)

³³ SOCA (2005), UK threat assessment:

³⁴ No. 10 Strategy Unit Drugs Project: Phase 1 Report: “Understanding the issues” (2003).

²⁴ Pudney et al, “Estimating the size of the UK illicit drug market” in N. Singleton, R. Murray and L. Tinsley (eds), Measuring different aspects of problem drug use: Methodological developments (Home Office OLR 16/06).

³⁶ Boreham et al, Arrestee Survey Annual Report : October 2003-September 2004. Home Office

Conclusion

The Government has removed numerical targets (except for treatment) to make them easier to meet, and routinely cherry picks and “spins” figures (percentages of percentages) to give a misleading impression of success when the reality is far less positive. It is difficult not to conclude, however, that despite records levels of expenditure, the Government is no nearer to achieving its key targets.

Most glaringly, use of what the Government has very specifically identified as the most harmful drugs (opiates and/or cocaine) has not fallen at all since 1998, both have risen to historically high levels which are the highest in Europe. Related problems of crime, public ill health and social nuisance associated with the use of these drugs, and their illicit markets, have risen accordingly.

Since the Prime Minister’s own Strategy Unit concluded reducing availability to the degree needed is not achievable, and since the Government’s efforts to reduce demand for the most harmful illicit drugs has had no impact, the Government needs to fundamentally alter its approach to reducing the harm caused by drugs, not continue with more of the same as its consultation documents appears to be suggesting.

It is imperative that the debate on the future of UK drug policy not be clouded by statistical misrepresentations and spin that dresses up failure as success. This is in no one’s interest and will lead to the perpetuation of failure rather than meaningful engagement with evidence of what works and a rational and honest debate about the future direction of UK drug policy.

Transform Drug Policy Foundation August 2007

www.tdpf.org.uk

0117 941 5810
info@tdpf.org.uk

TRANSFORM
DRUG POLICY FOUNDATION

About Transform

Our Mission:

Transform exists to reduce harm and promote sustainable health and wellbeing by bringing about a just and effective system to regulate and control drugs at local, national and international levels

Our Activities:

- Research, policy analysis and innovative policy development
- Challenging government to demonstrate rational, fact-based evidence to support its policies and expenditure
- Promoting alternative, evidence-based policies to parliamentarians and government agencies
- Advising non-governmental organisations whose work is affected by drugs
- Providing an informed, rational and clear voice in the public and media debate on UK and international drug policy

Our Vision:

- Social justice: restoration of human rights and dignity to the marginalised and disadvantaged, and regeneration of deprived neighbourhoods
- Reduced social costs: an end to the largest cause of acquisitive crime and street prostitution, and consequent falls in the non-violent prison population
- Reduced serious crime: dramatic curtailment of opportunities and incentives for organised and violent crime
- Public finances: the financial benefits of discontinued drug enforcement expenditure and the taxation of regulated drugs
- Public health: creation of an environment in which drug use can be managed and drug users can lead healthier lives
- Ethics: adherence to ethical standards and principles, including fair trade, in the manufacture, supply and distribution of drugs
- Reduced war and conflict: an end to the illegal drug trade's contribution to conflict and political instability in producer and transit countries