

## The UK Drugs Strategy 2017: Contexts and Analysis.

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### Abstract

**Purpose:** The purpose of this paper is to examine the content of the strategy and assess its claims to be evidence based.

**Design/methodology/approach:** This study is a close-reading of the text with commentary on specific content and reference to wider contexts.

**Findings:** The strategy makes use of evidence in its sections on treatment. Much evidence, including that of the UK ACMD, is dismissed or ignored. The issue of funding in times of austerity is not considered in the strategy. The range and complexity of drug use and users are not fully considered.

**Research limitations/implications:** The strategy can be seen as an idealised ambition with little basis in reality without funding to support its aims.

**Practical implications:** The Strategy involves no additional funding for the implementation of its requirements and recommendations.

**Social implications:** There is no consideration of the impact of macro-economic policy on the extent of drug misuse.

**Originality/value:** Other commentaries on the strategy are emerging. This paper is a more extensive consideration than has so far appeared.

**Keywords:** Alcohol, Drug policy, Evidence, Drug-related deaths, ACMD, Drug users

**Paper type:** Viewpoint

### Introduction.

John Major's Conservative government published the UK's first national drugs policy in 1995. Early strategy titles reflected initial ambitions – Tackling Drugs Together (1995), Tackling Drugs to Build a Better Britain (1998), Reducing demand, restricting supply and building recovery: (2010) <sup>1</sup>. The latest in the series was published, much delayed, on July 14 2017 with the more prosaic title "2017 Drug Strategy". The introduction to the 2017 Strategy states: "Our overall aims therefore remain to reduce all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence." (HM Government 2017a, Page 7.) This is to be

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<sup>1</sup> Other strategies were: Updated Drug Strategy, 2002; Drugs: protecting families and communities, 2008; Reducing demand, restricting supply and building recovery supporting people to live a drug free life, 2010.

achieved through four themes or strands: reducing demand; restricting supply; building recovery; and global action, a strand newly introduced in this strategy. The devolved administrations in Wales and Scotland publish their own strategies. Clarification of the roles and powers of the devolved administrations, introduced in 1998 but still being explored, may prove significant in the development of future UK policy in the drugs field, especially if such powers are repatriated to Whitehall on Brexit.

“Tackling drugs together” was preceded by an extensive consultation (HMSO 1994). The Prime Minister’s introduction to the strategy referred to “effective partnership” between government and others, a term which persists in successive strategies, as does the commitment to reduce the demand for illegal drugs. Common too to each of the strategies has been the use of the term “drug misuse”, of which more later. For many, the 1995 strategy was an attempt to establish shared aims and responsibilities for government departments, aims and responsibilities which had not always been explicit, accepted or implemented. The consultation document included up-to date and accurate summaries of the illegal drugs situation in the UK. The consultation had been extensive, involving central government, local government, national statutory bodies and the voluntary sector and NGOs, now customarily referred to as civil society organisations.

An additional feature of the 1995 strategy, to which the 2010 and 2017 strategies have returned, was that no additional central government funding was provided to implement the strategies and the increased requirements laid on local government, the police and the NHS, amongst others. The 1995 Central Drugs Co-ordinating Unit has been revived in the 2017 Strategy, albeit renamed, in the form of a Home Secretary-chaired Drug Strategy Board. Labour’s 1998 strategy had introduced a United Kingdom Anti-Drugs Co-Ordinating Unit, whose lead officer became known as “the drugs czar”. The 2002 strategy was accompanied by additional funding for the range of activities it identified, much of it in the criminal justice system, and by regular seminars at which the Home Office reported back on strategy progress and achievements; and an additional strategy title of Tackling Drugs, Changing Lives.

### **Contexts.**

There are two contexts in which the UK drug strategy can be considered to operate, the international and the domestic. Characterised by the availability of much evidence and research, both might be expected to have an influence on the content and direction of a national strategy which claims to have been developed using the evidence base. The extent of evidence, example

and research now available to national governments could provide the basis for developing national strategies based on evidence, informed by evaluated practice elsewhere, and which move away from the inflexible and dogmatic practices which persist in many countries. This assumes a willingness on the part of governments to accept that the policies which they have followed for the past fifty years might be counter-productive and are failing to achieve their stated aims.

### **International.**

The work of the Global Commission on Drug Policy, initiated by former and, increasingly, serving heads of government and international diplomats, has shown how the workings of the international conventions on illegal drugs have been consistently damaging. The Commission's initial report (Global Commission on Drug Policy, 2011) analysed the impacts of the prohibition-based international conventions. In 2016 a United Nations General Assembly Special Session was convened to consider the workings of the international conventions; and to respond to the mounting criticisms of the conventions and the prohibition approach on which they are based (often referred to as "the war on drugs"). These criticisms come from individual nations, regional associations, civil society and human rights organisations; and some UN agencies. While the UNGASS outcome document (United Nations, 2016) disappointed policy reformers, the extent of the challenge to the conventions and the quality and substance of the arguments presented gave representatives of governments attending UNGASS in New York in April 2016 (and the preceding months of debate and negotiations) the opportunity to be informed about alternatives to existing approaches. The United Nations Office on Drugs and Crime publishes annual reports on its work and, effectively, the success or otherwise of the international conventions<sup>2</sup>. Its annual reports (UNODC, 2017) are shadowed by civil society NGOs, and an alternative report is now produced to analyse more critically the impacts and workings of the conventions. (Count the Costs, 2016.)

Regional reports and commissions have criticised and challenged the prohibition approach and the conventions. Individual nations, amongst them Bolivia and Uruguay, have adopted policies which are in opposition to the conventional interpretations of the conventions. Several US States have legalised the use of cannabis for medicinal purposes; cannabis for recreational purposes; or

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<sup>2</sup> The international conventions on illegal drugs are: Single Convention on Narcotic Drugs, 1971; Convention on Psychotropic Substances, 1971; Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

both. Some national governments now permit the use of cannabis or cannabis-based pharmaceutical products while others have decriminalised illegal drugs and regulate their sale.

### **Domestic.**

The principal legislation concerning illegal drugs is the Misuse of Drugs Act (1971). Introduced by the Home Office, its provenance is a signifier that UK governments continue to see illegal drugs primarily as a criminal justice, not a health and welfare, issue. The MDA has been amended in some respects since its original publication, including permitting some harm-reduction practices to be used by treatment agencies to avoid conflict with the law.

The MDA has been supplemented by the Psychoactive Substances Act (2016). According to the 2017 Strategy, this Act “...completes the legislative tool kit and fundamentally changes the way we tackle the supply of psychoactive substances not already covered by the Misuse of Drugs Act. It removes their availability from open sale on the UK’s high streets and puts an end to the fast-paced nature of the market.” (HM Government, 2017a, p. 17.) This claim has been made before the evidence has been collected and assessed: the workings and impact of the PSA are still to be “reviewed” (not evaluated), and not before the end of 2018. Non-government sources argue that the market has been displaced, not abolished; that products continue to develop and change; and that the market has increasingly shifted on-line.

The Home Office published “An evaluation of the Government’s Drug Strategy 2010” in July 2017. Using data to the end of 2015, the intention was that evaluation “of the Government’s Drug Strategy 2010 contributes greatly to the evidence base for the Government’s new Drug Strategy”. (HM Government, 2017b, 6.) The 2010 strategy introduced the concept of recovery as its principal aim, a concept initially further defined as abstinence. The evaluation document is critical of the workings and impacts of the strategy, questioning how well an estimated £ 16.6 bn. was spent. It acknowledges that: “In the absence of the data and high quality evidence necessary to undertake a full impact evaluation of the strategy, the evaluation is based on a theory of change approach...The Government made it clear that it would not be desirable or achievable to undertake a single evaluation encompassing the whole of the strategy...” (Ibid, 6.)

The Strategy theme “Building Recovery” maintains the 2010 emphasis on recovery, promising to facilitate the delivery of an enhanced joined-up approach; the right interventions; improving quality and outcomes. This section refers to ensuring that “the right interventions are given to

people according to their needs” although these “needs” are not comprehensive and the final reference to “supporting every individual to live a life free from drugs” reinforces a narrow view of “needs” and, hence, responses. Recovery and a life free from drugs remain the universal aims, thus relegating some treatment options to second-best status, for example medically supervised heroin, and user preferences. Any earlier “consultations” seem to have excluded the voices and opinions of users, as distinct from service users; there is no acknowledgement that some may choose to continue to use illegal drugs and to do so with recognition and support from services to enable them to do so safely. Treatment responses have been homogenised. (In contrast, the Strategy recognises that children and young people may have differing needs and are not a homogenous group (Ibid, Page 10), acknowledging, belatedly, what health service research and documents have recognised since the 1990s. (cf. Health Advisory Service, 1996.))

The Strategy refers to stronger governance and accountability, planning to establish a Drug Strategy Board chaired by the Home Secretary. “The Board will use greater transparency and data on performance to support action by local services...” and will work with a national recovery champion. It is not clear how these proposals might improve either accountability or the provision of effective treatment. An additional set of monitoring bodies and functions may be seen as a move by central government to take back some of the responsibilities of local bodies, undermining the localism agenda. A lack of vision on the part of government may explain the constant Strategy references to accountability, information sharing and partnership rather than analysis and synthesis of evidence and experience to produce a more realistic and informed strategy and set of responses which recognise reality rather than wishful thinking.

Outside government, two of many well-argued and widely consulted reports came to the conclusion that existing prohibition-based approaches were not working and were not achieving the intended results. The Police Foundation (2000) report into the effectiveness of the MDA concluded that the legislation had serious flaws and called for a strengthening of harm reduction practices, requiring amendment of the MDA. This argument continued with reference to the benefits for some drug users of medically-prescribed heroin. The report noted that “...the criteria by which drugs are classified have never been clearly defined.” Referring to the basis on which the MDA was introduced, the report comments: “...we have been forcibly struck by the lack of research and the weakness of the information base about drug use in the United Kingdom...” In broad summary, the report states: “It has become increasingly clear to us that the eradication of drug use is not achievable and is not therefore either a realistic or sensible goal

of public policy...there is no strong evidence that drugs have become harder to obtain or more expensive. Nor has there been any decrease in purity. There has also been a growth in the range of synthetic drugs available.” The report concludes: “such evidence as we have assembled...all point to the conclusion that the deterrent effect of the law has been very limited”.

A similarly wide-ranging report was commissioned by the RSA to “examine all aspects of the relationships between public policy and the use and abuse of illegal drugs.” (RSA, 2007) It concluded that “The idea of a drugs-free world...is almost certainly a chimera” and that “the concept of ‘drugs’ should be extended to include alcohol, tobacco, solvents and a range of over-the-counter and prescription drugs. All psychoactive substances, not just illegal drugs, can cause harms and do.” This report considered the whole basis on which drug policy in the UK has been constructed, recommending “that policy on the use of illegal drugs and other psychoactive substances including alcohol and tobacco should be pragmatic rather than moralistic. It should be aimed...at reducing harms...[and] should be given greater prominence in the context of broader social policy”, including social exclusion. A Misuse of Substances Act, replacing the Misuse of Drugs Act, should include alcohol and tobacco and prescribed medicines, which should, along with illegal drugs, be regulated. The remit of the ACMD should be extended to include these additional substances. Additionally “The aim of drugs policy should be to reduce harm. The widest possible promotion of harm reduction measures should be an integral component of a pragmatic drugs policy. For example, drug consumption rooms should be made available where it is in the public interest to do so.” Similar critiques and recommendations have been made by, amongst others, House of Commons Select Committees and Royal Colleges.

### **Advisory Council on the Misuse of Drugs.**

The Advisory Council on the Misuse of Drugs was established by Section 1 of the Misuse of Drugs Act 1971. Its purpose was defined as monitoring the illegal drug situation of the UK; assessing implications of “harmful effects sufficient to constitute a social problem”; advising government of the responses which could be taken to restrict or supervise “the arrangements for their supply” and to enable “persons affected by the misuse of such drugs to obtain proper advice...[including] treatment, rehabilitation and after-care”; promoting research into “any matter which in the opinion of the Council is of relevance for the purpose of preventing the misuse of such drugs or dealing with any social problem connected with their misuse”; and to consider and advise on “any matter relating to drug dependence or the misuse of drugs which may be referred to them by any one or more of the Ministers”. (Misuse of Drugs Act 1971,

Section 2.) These duties and responsibilities, a combination of the directed and the autonomous, are re-stated in the Home Secretary's letter to the ACMD setting out its latest work programme: "I am keen to strike a balance between the Government's requests for advice to inform our priorities and those matters the Advisory Council chooses to investigate independently, so that the Council can focus on those areas where it can add the most value and make the greatest impact." (Home Office, 2017.) The remit of the ACMD still excludes alcohol.

The ACMD report on reducing opioid-related drug deaths published in December 2016 (ACMD 2016b) is included in the Strategy's End Notes, a reference which acknowledges the report's existence without consideration of its findings and recommendations. A government response is promised: in answer to parliamentary questions earlier in 2017 this was to happen "within three months"<sup>3</sup>. A response did appear on July 26 2017 but the document posted on the Home Office web-site was taken down later the same day. NGOs were able to download the response, published as an annexe of responses to ACMD reports and recommendations. The opportunity for this report and its implications and its recommendations to inform the Strategy was not taken. Now again available, the undated covering letter from ministers to the ACMD accepts most of the recommendations, with the exception of the recommendation on drug consumption rooms, where it states: "The Government has no plans to introduce drug consumption rooms. It is for local areas in the UK to consider, with those responsible for law enforcement, how best to deliver services to meet their local population needs." These responses were all published after the publication of the Strategy<sup>4</sup>.

The ACMD's response to the draft strategy is not referred to in the published Strategy. It may not have been considered as evidence, although the preponderance of End Notes from the ACMD (10 references to 9 separate publications) could indicate that such references are used to boost the status and authority of the Strategy. The ACMD response was based on the then draft strategy, which retained the three strands of the previous, 2010, strategy: reducing demand; restricting supply; building recovery. This response expressed concern about funding; the frequent re-procurement and associated loss of staff, a point acknowledged in the Strategy; and that a more nuanced approach to recovery be adopted: "Recovery should not be equated purely with abstinence from drugs". (ACMD, 2016a, Section 4.4.1 The response also recommends that

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<sup>3</sup> <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-01-19/60861/>

<sup>4</sup> <https://www.gov.uk/government/publications/drug-misuse-and-dependency-government-responses-to-acmd-reports>

heroin-assisted treatment be provided, a recommendation not included in the Strategy. Additional concerns around funding and the impact of commissioning practice are included in the ACMD report on commissioning of drug treatment (ACMD, 2017).

### **Evidence.**

The Strategy uses the word “evidence” twenty-two times, the term “evidence based” fifteen times. The Strategy claims a commitment “to grounding our approach in the latest available evidence. The Evaluation of the 2010 Drug Strategy has contributed greatly to the evidence base for this Strategy and we will continue to monitor evidence from around the world to understand how we can best respond to the challenges that drugs present to the UK and our international partners.” Strategy content does not fulfil this commitment: some evidence is dismissed, other ignored, and references and citations are absent. The Strategy has eighty-four End Notes, effectively References. Of these, forty-seven are government publications – two from the Department of Health, five from the Home Office, eight from Public Health England and ten (two of which are to the same publication) from the ACMD. Of the End Notes referring to publications by authors, four are reports commissioned by the Home Office. Ten of the End Notes refer to publications by NGOs or academics.

The International Comparators report (Home Office, 2014) is absent from the End Notes. This report indicated that the “toughness” of a nation’s legal responses and sanctions for drugs offences had little or no impact on the prevalence of drug use, (as had the Police Foundation report fourteen years earlier), challenging the punitive approach to drug policy adopted by successive UK governments. This conclusion is clearly relevant to the Strategy mention of decriminalisation: “We are aware of decriminalisation approaches being taken overseas, but it is overly simplistic to say that decriminalisation works”. (HMG 2017 Page 17.) This brusque statement dismisses evidence and experience from other nations, seemingly with no consideration or reflection on its possible relevance to the UK.

Evidence cited in ACMD reports and responses has not been included in the Strategy. While this might indicate a focus by the Home Office on the conclusions of its own Advisory Council it could also be seen as a reluctance to include references to “evidence” which does not align with the Strategy approach; or contradicts Strategy content. As noted above, responses to ACMD reports which might have been used in the development of the Strategy were first made after the Strategy’s publication. This applies to both government and civil society documents. The ACMD

submission commenting on the draft 2017 strategy (ACMD 2016a) refers to academic papers which are not referenced in the final Strategy: Byford et. al. 2013; Pierce et. al., 2015; Stevens, 2008; Strang et.al. 2012; Strang et. al. 2015. All of the references in the executive summary of the evaluation of the 2010 drug strategy are to government publications (HM Government 2017b). The ACMD provides references to the evidence it cites; the Home Office does not.

Reports have long commented on the poor evidence base from which government social policies, including drug policy, have been developed. The ACMD has observed “that the evidence base for policy decisions is not sufficiently developed” and that “interventions aimed at reducing the supply of illicit drugs...are rarely piloted or subject to thorough evaluation.” (ACMD, 2016a.) This document questioned the Strategy claim that “45 percent of acquisitive crime is committed by heroin or crack users. It would be useful to explore the evidential basis for this claim”. (ACMD, 2016a.) There is no qualifying comment in the Strategy on how much illegal drug use is financed from users’ disposable income, as with alcohol and tobacco.

The ACMD has recommended the collection of more extensive survey questions to establish as accurately as possible the extent of substance use in the UK. The current Crime Survey for England and Wales is limited to households and the 16 – 59 age group. As many have pointed out, this excludes older people, shown in other surveys to also use illegal drugs and pharmaceuticals and equally likely to misuse alcohol; homeless people; prisoners; and other marginal groups, whose use is more likely to be harmful than those ‘caught’ in a household survey. There have been recent indications that the Office for National Statistics suggests removing the questions about illegal drugs from the household survey.

A careless, misleading or misrepresentative use of “evidence” occurs in the reference to Personal Social and Health Education in schools. PSHE has provided the opportunity for teaching about and discussion of topics of interest to young people, with an emphasis on sex and relationships education and education about tobacco, alcohol and other drugs. PSHE was a major component of the Healthy Schools Programme introduced by the Labour governments of 1997 – 2010 in response to WHO Europe recommendations. Funding for this programme, and the associated training, ended in 2010 when the coalition government came into power. Since then governments have praised PSHE but have not made it a compulsory part of school provision. The Strategy includes the claim that “The Children and Social Work Act provides powers for the Secretary of State for Education to make PSHE, or elements therein, mandatory in all schools”.

In fact, section 34 the Act says that the Secretary of State “must” make certain requirements “at schools in England” that they provide relationships and sex education, while Section 35 says that Secretary of State “may” make similar requirements regarding “personal, social, health and economic education (beyond that required by virtue of section 34)”. There is no specific requirement or reference in the Act to drug education. (Children and Social Work Act, 2017.)

### **Language.**

The term “misuse” is consistently utilised throughout the Strategy, a terminological convention long adopted by UK governments. This is based on a legal approach to drugs: drugs are illegal and therefore any use of them is, by definition, misuse, inhibiting a more nuanced consideration of the differing ways in which illegal drugs are used, not all of which would be described as “misuse” in a medical or social sense. The Strategy aims to help people who use drugs “to stop and to live a life free from drug dependence”, equating any drug use with dependence. Other Strategy references are to one aspect of drug use - e.g. the link to acquisitive crime - implying that it is the norm: all drug use looks like this. The link made to acquisitive crime is not substantiated by NTORS data.

Providing help, treatment, and support services so that users can “live a drug-free life” continues to set an abstinence goal which is not universally accepted or realistic; and which detracts attention from maintenance and harm reduction approaches. That this might be a factor in the recognition that “fewer drug users are coming into treatment” is not considered. That the focus on recovery - abstinence - and a response by some drug users that treatment does not recognise their situations, could contribute to recent increases in drug-related deaths is similarly not considered.

The section considering – and recognising – co-morbidity (referred to as co-occurring in the document, and to those longer in the field known as dual-diagnosis) is welcome if somewhat belated. The reference to preventing “escalation to more harmful use” avoids mention of the relevance of harm reduction practice for existing users, and the ability and legality of treatment providers to recommend and support such practices, another ACMD recommendation ignored (ACMD, 2016b.)

### **An ageing cohort: drug related deaths.**

The introduction to the Strategy (Home Office 2017a, Page 5) includes the only substantive reference to drug related deaths. They are later mentioned in the section on Physical and mental health and linked to an “ageing cohort” of, mostly, opiate users; and “co-occurrence” with mental health conditions. The text makes no further consideration of the high death rates. The 2016 UK statistics were published on August 2 2017 (ONS, 2017). The number of UK drug related deaths has continued the increase which began in 2014. Contrary to the Strategy emphasis on an ageing cohort, the ONS statistics high-light that “people aged 40 to 49 years have the highest rate of drug misuse deaths in 2016, overtaking those aged 30 to 39 years”. The UK rate for drug related deaths amongst 15 to 64-year-olds is almost three times that of the average European rate (ONS, 2017.) The Strategy does acknowledge the contribution made to mortality figures by the use of opioids and pharmaceutical products. The Strategy contains no response to the relevant ACMD report (ACMD, 2016b.)

### **Resources.**

One test of the Strategy will be the resourcing available to implement its continuing foci and the additional, mostly bureaucratic, Strategy demands and expectations. The Strategy is clear about responsibilities and duties, especially of public sector bodies, but gives no indication of how this whole set of demands is to be achieved when the funding of these bodies has been dramatically reduced since 2010 (by 40% for local authorities), and will continue to reduce. Although many of the Strategy’s expectations and recommendations are sound and appropriate, the resourcing of local authorities, the prison service, the NHS, the police, probation is insufficient for them to fulfil their existing statutory duties. There are already regional variations in the availability of naloxone and the new pharma-therapies to combat Hepatitis C. The Strategy requires blood-borne viruses to “be treated through coordinated services”, over-looking the existing inability to do so and providing no indication of how this might be done in the immediate future.

Reference to local authority funding from business rates income is a distraction which disguises the absence of central government funding. Business rates funding was introduced when central government Pooled Treatment Budget funding was ended in 2013. Rather than acknowledging the continuing reductions in funding for drug and alcohol services (and public health generally), government maintains the fiction that resources are available and adequate. “The Government has confirmed the continuation of the ring-fenced Public Health Grant to local authorities until April 2019 - which funds drug and alcohol services (treatment and prevention). During this period we will maintain the condition for local authorities to ‘have regard to the need to improve

the take up of, and outcomes from, drug and alcohol services' ". (Home Office letter to ACMD: ACMD response to the development of a new drug strategy July 11 2017.) The ACMD commissioning report states that "The ACMD found evidence of reductions in local funding for drug misuse treatment in England (from 2008–09 to 2010–11 by around 12%). However, it was difficult to establish a clear picture on more recent trends due to changes in financial reporting and a lack of comparable published financial data." (ACMD, 2017)

### **Young People.**

Young people feature in the reducing demand section of the Strategy and its emphasis on prevention. Schools are ascribed a prevention role which runs counter to the broader educational emphasis on academic achievement fostered by governments, interpreted by many schools as over-riding the provision of pastoral support and coverage of affective aspects of education. While schools can have significant influence, they are one of many agencies and factors in children's lives. Absent once more from this section is any recognition of the wider socio-economic factors which shape children's lives, with young people seen as passive and lacking autonomy and skills. Emphasis on prevention programmes ignores the experience of health promotion research which points out that information alone does not change behaviour. The government's own evaluation of its 2010 strategy (HM Government, 2017b) acknowledges the failure of media campaigns to deter young people from using illegal drugs.

There is no acknowledgement that those young people who are substance dependent by late adolescence are often so following childhood abuse, physical and/or sexual, by people close to them. While this may be implicit under the label of "mental health", this section's coverage of needs and responsible agencies disguises the existence of this group of young people. Sexual exploitation and sexual abuse appear to be seen as similar or synonymous, failing to distinguish between the essentially commercial (exploitation) and the essentially personal (abuse). The findings and recommendations of an ACMD report on young people's use of tobacco, alcohol and other drugs (ACMD, 2006) do not seem to have informed this Strategy.

### **Alcohol.**

There is a belated recognition that there are parallels between alcohol and illegal drugs in terms of harms caused; and treatment and recovery needs. Nevertheless, alcohol often appears in brackets after drugs in the Strategy text. The one reference (in the Introduction) to "poly-substance misuse" fails to clarify that alcohol is the substance most frequently used alongside

illegal drugs. There is less explicit acknowledgement of alcohol as a drug: Home Office minister Sarah Newton commented in the July 18 2017 House of Commons debate on the drug strategy “...alcohol taken in moderation is not a dangerous drug...”, an example of the de-contextualising of drug issues.

The insistence in the Strategy, and in parliament, that illegal drugs are illegal because of the harms they cause has not been extended to a similar consideration of the effects of tobacco and alcohol, each of which causes greater social and individual harms than illegal drugs. The Strategy once again misses the opportunity to consider illegal drugs and alcohol in a joint strategy. The government continues to resist the introduction of minimum principal unit pricing for alcohol in England.

## **Discussion**

Twenty-two years after the first UK national drugs strategy, many features of the first strategy remain and it is pertinent to enquire what relevance and purpose a national drug strategy now has; how far the 2017 Strategy can be said to advance rather than replicate previous strategies; and what assessments are being made of the “success” of the series of strategies.

The foreword to the Strategy claims a need to address “the underlying factors that can lead to drug use” (HM Government 2017a, 3), suggesting that the document will adopt an analytical and reflective approach. The content, however, is largely descriptive. Consistent with previous documents originating from government, the final paragraph of the Foreword repeats the aim of creating or maintaining “a society which works for everybody ...[and]...a life free from drugs...” (HM Government 2017a, 3) This aim combines political rhetoric with an unrealistic and discredited claim, and sets a pattern of cherry-picking evidence which often ignores or dismisses the widely-available evidence challenging the continued realism and efficacy of prohibition approaches. Never explicitly stated or acknowledged, this approach continues to align UK policy and practice with the prohibition approach deemed to be required by the international conventions, signalling continued support of “the war on drugs” although this term is no longer used by the UK government.

The aims to ensure that “we are reaching those who need support” (Page 6) and that “the right interventions are given to people according to their needs” (Page 7) will not be achieved if the needs of users who do not accept or want a no-use result are ignored. The only Strategy

treatment option remains recovery, a term used as a synonym or euphemism for “abstinence.” Acceptance of other treatment options has now appeared in government responses to ACMD recommendations (Home Office/Department of Health, 2017), first published in an undated letter after the Strategy and not seemingly incorporated into the Strategy. This again calls into question the validity of the Strategy’s twenty-two references to “evidence.” While accepted for many aspects of treatment, evidence has not been used for wider aspects of policy making if it presents any challenge or alternative to the existing approach.

Consideration of harm reduction has been side-stepped in the Strategy, a long-term trend in successive UK strategies, and has been superseded by the insistence on recovery. For a document which emphasises a basis in evidence, this is a startling continued omission. It is also a rejection of much of the advice which the ACMD and others have provided to government. The basis for this is difficult to identify. A Strategy launch event in South London in September<sup>5</sup> included a robust assertion that harm-reduction “is there all through”. This is difficult to equate with the emphases on recovery and leading a life free from drugs, as these exclude long-term opioid substitution therapy, heroin-assisted treatments, needle exchanges, and drug consumption rooms, all ACMD and elsewhere recommended provisions and proven life-savers - and all of which, with reservations around consumption rooms, have now, post-Strategy publication, been endorsed by government in its response to ACMD reports (Home Office/Department of Health, 2017). Their Strategy status remains unclear.

The Strategy’s description does provide a comprehensive view of drug use and users in the UK., including recognition of the links between the trade in illegal drugs, human trafficking and modern slavery; and the role of organised crime. Chemsex, cannabis, novel psychoactive substances, the misuse of medicines and pharmaceutical products, and performance enhancing drugs are included in the picture-setting, although this can be seen as down-playing the continued predominance of opiate and opioid use and their role in the rising numbers of drug-related deaths. The reference to “...emerging...use of multiple drugs (poly-substance use)...[which] poses an evolving challenge”. (ibid., 5.) implies that poly-substance use is a new phenomenon, or one which government is only now aware of or prepared to acknowledge: those in the research and treatment fields have been aware of this for decades. The role of alcohol in poly-substance use is not acknowledged. There remains a reluctance on the part of government to accept the role of alcohol and tobacco as drugs which also cause harm to individual users and

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<sup>5</sup> On September 11, 2017, attended by the Author.

to wider society. An evidential consequence of this is the consistent presentation of statistics about “drug misuse” with no comparative statistics for the same behaviours (e.g. driving under the influence) and prevalences relating to other substances (e.g. alcohol) which are in much wider use in the UK, causing greater harms. Recommendations from several reports that the ACMD have its remit broadened to include alcohol have been consistently rejected by government.

Consideration of these topics and ‘new’ patterns of use illustrate an awareness of developments in substance use and misuse, including the links between intimate partner violence and substance – including alcohol – use. There may be a form of ‘catch up’ in the Strategy’s narrative, to demonstrate that government is aware of changing patterns of drug use and drug using behaviour. There is little accompanying analysis of the wider issues – origins - which these specifics - symptoms - indicate, including the existence of a consumer-led market. The emphasis remains one of condemning substance use without attempts to understand it, individually and socio-economically.

The linking of the heightened death rate to an “ageing cohort” could be seen as explaining away an unwelcome set of indicators, newly described as “silently silencing” (Stevens, 2017.) As described earlier, it also misrepresents the statistics. There may be a reluctance to dwell on the mortalities as doing so could question the “success” or relevance of the Strategy and its predecessors. Some commentators have suggested that the strategic shift from harm reduction to abstinence from 2010 has contributed to the increase in drug related deaths - the Strategy’s sole reference to “harm reduction” occurs in a paragraph about smoking.

More up-stream analysis would have noted that the cohort of older injecting opiate users began its drug-using career in the 1980s., a time of considerable economic hardship; high unemployment; a reduction of the reach and accessibility of the welfare state and its associated benefits; and increased economic inequality as a result of the macro-economic policies being pursued by the Thatcher governments. Social epidemiologists have argued convincingly and with extensive statistical and research evidence that the greater the inequality of a nation’s distribution of wealth, as measured by the gini-co-efficient, the greater the social ill-health – rates of imprisonment, substance misuse, inter-personal violent crime, suicide, teenage pregnancy, educational drop-out, long term unemployment, homelessness. (See Marmot, 1999; Wilkinson, 2000, 2005; Wilkinson and Pickett, 2009) This is a syndrome of factors which is again present in the UK, magnified by austerity, raising the prospect of a new generation of marginalised drug

users whose premature deaths will become apparent in twenty years or so. The Strategy speculates that “a new and younger cohort of heroin and crack users could emerge...[which] could lead to a new increase in crime, together with wider social and health harms...” (HM Government 2017a, p. 27.) This suggests an inevitability, but does not consider how far this might be a result of existing social and economic policy; and how the consequences described might be mitigated by changes in policy. This indicates that the approaches adopted by the Strategy will have a minimal impact on substance use and misuse if pursued in isolation from a re-consideration of macro-economic policy, currently identified with austerity.

The role of the ACMD is confirmed de jure: its latest work-programme continues to include elements of the original responsibilities of acting on government direction and conducting its own research and other activities (Home Office, 2017). De facto, it's less clear how far government accepts Council's advice and recommendations. References to the advice of the ACMD seem to simultaneously acknowledge Council and dismiss much of its work, with reports and recommendations on khat, novel psychoactive substances and opioid-related deaths being rejected; a failure of government in 2014 to consider the collection of base-line data about khat use to inform any assessment of the impact of its criminalisation; and the extended negotiations between the Home Office, the Department of Health and Council around the use of foil as a harm-reduction measure for treatment agencies working with heroin users, negotiations which delayed acceptance of this recommendation for three years. The statement that government “will carefully consider any recommendations to inform future policy” (HM Government, 2017a, 28) made by the ACMD when considering the commissioning of drug treatment and recovery services is not convincing in the light of the consistent rejection by government and the Home Office of ACMD recommendations.

There is a broader dishonesty which can be seen reflected in the lack of recognition in the Strategy of the whole issue of resourcing and funding of public sector services. While references to joint responsibilities, partners and partnerships, sixty in all, may be seen as constructive and realistic (and reminiscent of the first, 1995, drugs strategy) they can also be seen as leaving open the possibilities of attributing responsibility for failure to a range of bodies other than central government, which does not see its own responsibility for the Strategy extending to providing the funding needed to meet the responsibilities placed on others. To require public-sector bodies to do more with less is either an example of ignorance on the part of government of the impact of austerity policies for the past seven years (and, on present indications, five more to come); or

cynicism. The disregard of reality of the specific commitment to “continue to provide funding for a wide range of voluntary and community sector organisations that support children and young people” (Ibid., 11) can be applied to the whole Strategy. The Strategy identifies those institutions and professions it sees as responsible for improving health and well-being at a very “down-stream” stage, focussing on symptoms rather than origins. Government’s role in setting the wider contexts in which illegal drug use occurs is not examined, nor is its role in providing adequate funding for those given responsibilities to be able to fulfil them – the drivers are not provided with a car. Continuing a driving metaphor more frivolously: look, no funds!

The timing this summer of Strategy-relevant publications – the Strategy; the response by the Home Office to the 2016 ACMD report on drug related deaths; the ACMD report on commissioning; and the ONS statistics – has resulted in inhibiting the incorporation of much evidence and many recommendations into the Strategy, although the core text had been largely completed in March 2016. Opportunities to consider the implications of the mortality figures, the issues of funding and commissioning, and the adoption of ACMD reports which contain harm-recommendation recommendations have been missed – some would say avoided.

The discussion of “prevention” maintains the pretence that governments can stop certain behaviours when the most that can be realistically expected is to recognise, respond and manage. A test of a realistic strategy would be to see how far it provides advice and resources to respond to the consequences of illegal drug use; and to adequately resource such responses. Much government “support” for professions, agencies, local authorities and commissioners is in the form of legislation, regulation and guidance. This can be seen as a burden and a form of control, and may be received negatively by those who do not have the staffing, skills and funding to make best use of such support, even when it is relevant and useful. Management, monitoring and assessment seem to be taking the place of face-to-face treatment. Thus many of the aims and ambitions of the Strategy are, quite simply, unattainable and unrealistic.

### **Conclusion.**

The Strategy claims that “we are reaching those who need support” and that “the right interventions are given to people according to their needs” misrepresent its content. The Strategy is confined to entry into treatment with a recovery outcome and its completion. This approach, while appropriate for many drug users, excludes others who have little prospect of or desire to lead “drug free lives”. It also excludes consideration of harm-reduction and maintenance

approaches, a further dismissal of ACMD, amongst other, reports and recommendations. Although it includes a comprehensive and largely accurate account of illegal drug use in the UK, the Strategy relapses into a moralising approach to what it is prepared to countenance as government supported or approved practice, leaving a strong impression that the aims are defined for what drug users should be like rather than what drug users are like. With its emphasis on prevention and its curt statement “We have no intention of decriminalising drugs.” the Strategy might be considered to represent a neo-prohibitionist praxis, if not ideology. It is only in this sense that it might be considered a “strategy.”

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