The UK Drug Strategy 2021:

Failing to Learn from the Past, Failing to Look to the Future.

Abstract:

The latest UK drug strategy, *From harm to hope,* was published in December 2021, with introductions by the Prime Minister and three senior Ministers. None remain in government.

The strategy set ambitious aims for crime reduction; the reduction of drug harms and the number of drug related deaths; and the use and availability of illegal drugs. It emphasised the use of evidence to inform implementation, and working with other agencies and the devolved administrations – Northern Ireland, Scotland, Wales. The focus on evidence is not borne out by the negation of existing and available evidence, a characteristic emphasised in an ACMD review commissioned in connection with the strategy

New funding for treatment and recovery, recommended by the 2020 and 2021 Black reviews to rebuild local authority public health budgets, forms part of the strategy. Contradictory amounts for treatment and recovery funding are cited. References to these amounts are misleading: spend on enforcement is included in treatment and recovery figures. There is no acknowledgement that reduced capacity resulted from previous governments' austerity policies. More than two years on, doubts are emerging about continued government commitment to the new levels of funding.

The strategy focused on symptoms, not origins, of drug use, harms and availability – what, not why. The emphasis was crime, not health. Increased criminal penalties were the core response to demand reduction. Socio-economic factors and inequality were not considered.

The strategy's aims are rhetorical rather than realistic.

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This paper is written as a critique by a reflective practitioner. Based on a close-reading of the Strategy text, testing its ambitions and claims against reality, it was prompted by the Strategy's inherent dishonesty.

Key Words:

Evidence – funding – terminology – harm reduction - socio-economic – inequality

Introduction.

The core UK drug legislation is the 1971 Misuse of Drugs Act. Parliamentary debates on the introductory Bills [1] alluded to the 1961 UN Single Convention on Narcotic Drugs. This Convention attempted to harmonise national drug policies, at the time essentially prohibitionist, with the intention of reducing or ending the availability and use of what in the UK are referred to as *'controlled substances'*, in the Conventions, inaccurately, as *'narcotic'* drugs. It emphasised the duty of states *'to prevent and combat this evil'* (United Nations Office on Drugs and Crime, 2013, 5) with an ultimate aim of creating a drug free world. The MDA linked UK legislation to the Conventions and the prevailing consensus on drug policy. UK governments regularly publish national strategies with a domestic focus, outlining intentions to respond to drug issues. These strategies have made little reference to the UN Conventions other than generalised statements about global responses with which UK strategies may align; international partnerships; and, in 2017 and 2021, ambitions for the UK to play a global role, linking foreign policy and drug policy.

The first national, cross-departmental UK drug strategy was published in 1985 (Home Office, 1985). It marked a transformation of British drug policies, with '*a new emphasis on law enforcement and legal and penal control'* and a shift from the previous, more *'benign'* and *'medico-centric'* person centred approach, the so-called British system (Stimson, 1987, 477, 481), which adopted a harm-reduction approach. The subsequent *Tackling drugs together*, 1995, more clearly delineated departmental roles and established local bodies to implement and oversee the strategy. Revised strategies have appeared at regular intervals [2] : all have emphasised cross-departmental responsibilities and roles for government responses. The latest, *From harm to hope*, was published on December 6 2021. A Foreword by the Prime Minister and introductions by the Secretaries of State for Health and Social Care, Home Office and the Combatting Drugs Minister, a Home Office post responsible for the monitoring and implementation of the Strategy, indicated the importance of the Strategy to government priorities and reputation. Responding to the Black Reviews (Black, 2020, 2021), commitments to improving treatment and recovery services were supported by increased funding. Strategies now apply to England only; drug and other social and health policies are devolved to the Scottish, Welsh and Northern Ireland administrations.

Strategy Content.

The Prime Minister's Foreword described the Strategy as *'a new approach'* because *'the old way of doing things isn't working'* (HM Government, 2021, 3, 4). The Secretaries of State and the Combatting Drugs Minister summarised Strategy aims: to reduce crime, deaths and drug-related harms, and to break supply chains. The Secretaries asserted: *'This is the first ever Drugs Strategy that commits the whole of government and our public services to work together and share responsibility'* (HM Government, 2021 (henceforth Strategy) 5). An introductory overview outlined three strategic priorities: breaking drug supply chains; delivering a *'world-class'* treatment and recovery system; achieving a generational shift in the demand for drugs. Each priority has how, who and what sections, 'how' emphasising the additional investment in treatment services, 'who' cross-agency

[1] Proposed UK legislation is presented by governments to the Houses of Parliament as a Bill. Once debated, amended and having received Royal Assent, the proposals become law, an Act of Parliament.

[2] 1998: Tackling drugs to build a better Britain; 2002: Updated drugs strategy; 2008: Drugs: protecting families and communities; 2010: Drug strategy 2010; 2017: 2017 Drug Strategy.

and cross-departmental roles, responsibilities and expectations, 'what' restating the core aims. Given the Strategy's ambition, its 10-year time scale is realistic, if familiar.

The aims were expressed in confident, aspirational and assertive language: the Strategy '*will deliver*' more treatment places*, 'prevent nearly 1,000 deaths', 'is an evidence-based and modern approach',* will '*reduce overall use towards a historic 30-year low within a decade'*. The treatment chapter listed success criteria: additional provision, higher recovery rates, reductions in drug related deaths, funded by investing *'£533 million over three years to rebuild local authority commissioned substance misuse services in England'* (Strategy, 6, 11, 47, 34). Reducing demand for illegal drugs would be achieved by reducing the number of drug users and enabling *'children and young people* [to] *grow up in a safer and healthier environment'*. Programmes to support families and children will operate through the national Supporting Families Programme, part of the government's levelling-up agenda [3]. *'[R]educing the demand for drugs among adults and preventing and reducing use among children and young people'* will be informed by creating a *'world-class'*, '*world-leading evidence base'* (Strategy, 45, 46) on demand reduction, advised by a cross-disciplinary summit to inform strategy implementation [4] .

Details of Strategy implementation across government departments and public sector bodies clarify commitments in the Ministerial forewords, describing local government and delivery partners as the foundation of the strategy, *'empowered and resourced to deliver results'*. Responsibilities are defined, alongside an emphasis on multi-agency partnerships, putting *'the principles of comprehensive treatment and recovery alongside tough and effective enforcement and ambitious prevention',* to be informed by national standards. National and local outcomes, frameworks and accountability will be developed to ensure consistency of expectations and measurement of results against strategy aims. A list of interventions shows *'the range of support that an individual with addiction might need to access'* which, implicitly, local partnerships should commission or provide (Strategy, 53, 54). Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery), '*a pathfinder programme…. underpinned by a robust monitoring and evaluation framework, building the evidence base to inform our longer-term strategic approach'* [5] centred on police and local authority leadership, is presented as a template for local authority practice. A Home Office/Department of Health and Social Care programme, it is intended to integrate treatment, recovery and enforcement in a co-ordinated law enforcement approach. Expected to work in local multi-agency partnerships, agencies and their roles are outlined, with reporting lines and data collection, analysis and sharing regarded as essential to identify and meet specific local needs. A Joint Combating Drugs Unit, established in July 2021 and headed by the Minister for Combatting Drugs, will check outcomes against targets, develop metrics, track progress and disseminate good practice (Strategy, 56 – 60). National and local bodies will be required to produce annual reports, including showing how local priorities have been identified, for which relevant guidance was published in June 2022 [6] .

Contexts

The 2017 strategy set no time-scales for realising its outcomes. It established the role of a national recovery champion, retained in the 2021 Strategy. The quality of analysis and writing in

[3] Referring to wider government policy, the term 'level up' appeared four times, 'levelling up' six.
[4] The summit took place in May 2022, discussing programmes of multi-agency work, its monitoring and guidance. It did not consider 'new approaches'. (Personal communication from attendee).
[5] https://www.gov.uk/government/publications/project-adder/about-project-adder
[6] https://www.gov.uk/government/publications/drugs-strategy-guidance-for-local-delivery-partners

2017 is markedly distinct from that of the 2021 Strategy: in clear and analytical language, using established terminology, it presented a comprehensive over-view of the UK drugs situation. In common with its predecessors, it was framed around integrated and cross-agency responses. It provided no additional funding (Stothard, 2017). The 2021 Strategy appears ill-informed, rejecting established terminology and concepts and the history and practice of the UK drugs situation. The statement that '*over 300,00 people are addicted to heroin and crack cocaine'* is followed by an estimate that 300,000 people use opiates and/or crack cocaine, conflating use with dependence, diminishing Strategy credibility. Media interviews with Ministers in April and May 2022 condemning 'recreational drug users' as drivers of crime implied 'recreational use' as a new phenomenon, not recognising that most illegal drug use is recreational, not dependent. Aldridge, Measham and Williams (1998, 6) defined recreational drug use as *"involving mostly weekend use of any drugs in (recreational) social settings and at recreational leisure times….we…use the term…with care, to distinguish the use of the vast majority of adolescents and young adults from the daily, dependent and chaotic heroin and crack cocaine consumption usually characterised as 'problem drug use.' "* In a further example of established knowledge presented as new insight the Strategy stated *'People with drug addiction often have physical and mental health needs which must be met to enable a successful outcome from treatment.'* (Strategy, 21, 45, 12, 31, 37).

The Black Reviews were commissioned by the Secretary for Health and Social Care in February 2019, partly in response to the continuing increase in the number of drug related deaths, shown by then newly published statistics. The first part covers the drug situation, the second treatment. The Reviews' summaries, conclusions and recommendations are acknowledged as informing Strategy targets. The extent of the Reviews was restricted: *'The brief was wide but specifically excluded changes which would need changes in the legal framework either for drugs or for treatment'*. Part One '*highlighted the association of any drug use with social inequalities'* (Finch, 2022). The Reviews pointed to cuts in treatment provision, resultant falls in the numbers of individuals in treatment, and high levels of unmet need. Without acknowledging that local authority funding cuts are a direct result of central government policy, the Reviews found *'A prolonged shortage of funding has resulted in a loss of skills, experience and capacity from this sector'* (Black, 2020, Key Finding 13), compounded by rapid cycles of commissioning, and concluded that *'the public provision we currently have for prevention, treatment and recovery is not fit for purpose, and urgently needs repair'* (Black, 2021, Conclusion). Responding to the Reviews the Strategy acknowledged that *'capacity of the treatment system is insufficient to meet the need'* and that Strategy priorities '*are underpinned by Dame Carol Black's landmark review. This recommended a new long-term approach…delivered by the whole of government... Through this strategy, we will deliver all the key recommendations from part two of the review.'* (Strategy, 12, 15). Similar data collection and analysis was previously undertaken for Focal Point Reports prepared for the European Monitoring Centre for Drugs and Drug Addiction annual reports, a practice ended when Britain left the European Union.

Collaboration and Co-operation.

References to supply routes implied that UK policy would be aligned with that of the United Nations Office on Drugs and Crime. Undertakings to '*work with…experts and advisers…working with our international partners to shape the global debate on drugs'* specify FiveEyes, the Commission on Narcotic Drugs and UNODC as international partners (Strategy, 15). CND is the executive arm of the UNODC, which, with the International Narcotics Control Board, interprets, monitors and attempts to ensure compliance with UN Conventions. FiveEyes is a military intelligence alliance. There are no references to the World Health Organization. The efficacy and relevance of the international drug control Conventions are increasingly questioned, including by other UN

agencies (Klein and Stothard, 2018; Tinasti and Bewley-Taylor, 2020). The Strategy represents a growing divergence between a distinctly prohibitionist and crime-centred UK approach and UNODC and INCB thinking, which has become less dogmatic and more responsive to realities and to member states' amendments and commentaries, increasingly emphasising human rights, health and harm reduction. In September 2023 the UN High Commissioner for human rights called for drug policy to be based on health and human rights, acknowledging the failure of existing approaches[7] (UN, 2019).

The Strategy announced a UK-wide sharing programme *'to enable us to work closely with counterparts in the devolved administrations'* (Strategy, 19), the use of the word 'us' signifying that it is the Westminster government which sets regulatory and legislative frameworks. The references to Scottish practice do not mention Scotland's de-facto decriminalisation of some drug offences [8] , or its political and professional support for drug consumption rooms, with advanced preparation and planning in Glasgow and an initial needs assessment in Edinburgh. Both require a legislative initiative by the Westminster government, effectively a veto (Nicholls et. al., 2022; Scottish Parliament debate May 31 2022 [9]). A subsequent White Paper acknowledges that the devolved administrations in Wales, Scotland and Northern Ireland may disapply its penalties and sanctions (Home Office, 2022, 12). Equivalent strategies for the devolved administrations, published by their health departments, pre-date *'From harm to hope'*. The Scottish strategy specifically includes alcohol. Scotland's Minister for Drugs Policy has responsibilities which are health and person centred, and include reducing deaths from drugs [10]. The grudging but responsive consensus at the international level contrasts with the fractious dissensus of UK policy and practice, and divergences in social policy.

Evidence and Research.

Introducing its claim to be '*putting evidence at the heart of this approach*" the Strategy stated: *"We will become world-leading in our approach, with evidence-led and data-driven interventions, and a commitment to build the evidence base where necessary…'* [11] . Although intended to reinforce this claim, references to accelerating *'research breakthroughs'*, working with experts, and research programmes to be undertaken by UK universities, indicate dismissal, disregard or ignorance of existing evidence and research, undermining the claim. (Strategy, 15, 40, 46) . Contrary to past claims and commitments, there has been minimal use of evidence-based approaches in UK drug policy, with much existing research and evidence, national and international, consistently negated by successive governments. Bacon and Spicer comment that the Strategy approach to supply control *'is misguided and undermines claims of this part of the Strategy being evidence based'* and *'…this 'new approach' to supply control is fundamentally the same as previous strategies'* (2022, 2, 1). This questions the preparedness of government to accept and implement the results and implications of research which challenge its political and ideological views. The Strategy implies that available evidence

[7] https://www.ohchr.org/en/documents/thematic-reports/ahrc5453-human-rights-challenges-addressing-and-countering-all-aspects

[8] Scottish proposals for more wide-spread decriminalisation announced in 2023 were immediately rejected by the Westminster government.

[9] https://www.parliament.scot/chamber-and-committees/official-report/what-was-said-in-parliament/meeting-of-parliament-31-05-2022?meeting=13794&iob=125054&qry=drug%20deaths

[10] https://www.gov.scot/about/who-runs-government/cabinet-and-ministers/minister-for-drugs-policy/

[11] The Strategy mentions evidence-based 8 times; evidence base 10; evidence 5; evidence-led once; research 4.

and research covering all aspects of the UK drug situation is irrelevant or non-existent, and that only research and evidence emanating from the Strategy will inform future policy. The disregard of much existing evidence is paralleled by the disregard of established terminology.

Concurrent with the Strategy, the Advisory Council on the Misuse of Drugs was commissioned to conduct a review of drug prevention [12]. Presented to Ministers in May 2022, the review countered Strategy claims about evidence and research. The covering letter to the Combatting Drugs Minister referred to *'available evidence'*, emphasising that *'Strategies to reduce vulnerability must also target structural and social determinants of health, well-being and drug use'. 'Evidence that guidance and policy issued by government departments reflect the above advice'* will form part of the measurement of impact of adoption of the review's recommendations. The review emphasised that *'Persistent, systematic, multiple-factor deprivation is a key driver of negative health outcomes. Similarly, drug-related harm is strongly associated with socioeconomic position and social exclusion; harm is greater amongst those who live in economically deprived areas and those with lower individual and socioeconomic resources'* (ACMD, 2022, covering letter, 5, 6), reiterating consistent failure to consider socio-economic factors.

In contrast to the 84 end-notes to the 2017 strategy, most of the Strategy's 53 foot-notes refer to Government sources, not independent research. Many of the foot-noted web-links are to government initiatives, data and funding programmes, with no detail of impact or evaluation. Advanced as sufficient 'evidence' of claims made in the text, links are to whole strategies, not specific pages or sections. A reference to enhanced 2021-22 public health grant spend (Strategy, 34) is followed by the claim that this has resulted in successful interventions: programmes in progress at the time the strategy was written cannot be judged to have resulted in the outcomes claimed as they were neither complete nor evaluated. Repeated references to Project ADDER (also not yet (December 2022) evaluated) give it more prominence than previous strategic partnerships, such as Drug and Alcohol Action Teams, the Home Office Drug Prevention and Advisory Service, Police and Crime Commissioners and, as the ACMD prevention report reminds us, the Crime Survey for England and Wales and National Drug Treatment Monitoring System. Learning and practice from these agencies are not acknowledged. The Strategy appears to seek research reinforcing rather than informing its approaches.

Evidence and recommendations dismissed or not acted on include some from the ACMD. Neither the 2017 nor 2021 strategies mention ACMD recommendations on the legal status of khat or its 2016 report *Reducing Opioid Related Deaths*; advice that the Psychoactive Substances Bill would remove the provision of harm-reduction advice by some retailers was dismissed (Home Office, 2015). A Home Office report (Home Office, 2014) examining the impact of criminal sanctions on the availability and use of illegal substances in several jurisdictions found no link between severity of sanctions and availability and use: it is not referenced in either strategy. The Strategy refers to the ACMD twice, on pages 46, where its *'significant expertise'* is acknowledged, and 61, where there is an undertaking to '*work with experts, including the Advisory Council for* [sic] *the Misuse of Drugs'*. No ACMD reports are referenced. There is no mention of collaboration with European bodies: there are now no formal relations with the EMCDDA and its extensive evidence base and research programmes, including the novel psychoactive substances early warning system. While unsurprising in a government ideologically committed to Brexit and

[12] [12] The ACMD was established by the 1971 Misuse of Drugs Act *"to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused…and to give… Ministers…advice on measures…which in the opinion of the Council ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse"* (Misuse of Drugs Act 1971, 1 (2))

withdrawal from European institutions, professionals are concerned at the impact on UK drug science (Hickman et. al., 2021).

The rejection of decriminalisation (Strategy, 13) without considering international examples and assessments of decriminalisation further contradicts claims that the strategy will be evidence-based or evidence-aware: '*[E]nding criminalisation of people who use drugs is recommended best practice from the Government's own expert advisers (the ACMD), all 31 lead agencies of the UN including The World Health Organisation and UN Office on Drugs and Crime, as well as the Royal College of Physicians, the UK Faculty of Public Health, the Royal Society for Public Health - and many other authoritative voices'* (Release, 2022; see too Holland et. al., 2022, 4 and UN, 2019). Scottish developments are not referred to. The implied increased use of custodial sentences does not consider the ramifications of increased prisoner numbers, nor recognise that the prison and criminal justice services are themselves at reduced capacity resulting from austerity. This rejection is paralleled by the dismissal of the evidence around drug consumption rooms, making the claim that *'We will be learning from existing good practice, both in the UK and internationally'* (Strategy, 40) difficult to substantiate.

Crime and punishment.

The Strategy sub-title and the ambition that *'we will turn the tide on drug crime'* confirm the continuation of a crime-based approach. Reducing demand for illegal drugs is to be achieved by the use of escalating criminal sanctions for people who use drugs, with *'a White Paper to be even bolder in achieving tougher and more meaningful consequences for illegal drug use'* announced, reinforcing the position that *'Illegal drug use is wrong and unlawful possession of controlled drugs is a crime'*. (Strategy, 47, 11). The White Paper, *Swift certain tough,* was presented to Parliament on July 22 2022 in a written statement. In it, the Home Secretary described the Strategy as *'tough but smart',* promised *'a tough, escalatory framework'* and *'reforms to strengthen the response of policing and the criminal justice system to drug possession offences'* (Home Office, 2022, 3, 5. The majority of prosecutions under the MDA have been for possession, not supply). Suggesting that recreational drug users will be subject to heightened penalties seems a perverse form of levelling up. Imposing and strengthening criminal penalties replicate previous approaches, an individual, not systemic, analysis and approach to drug policy ignoring the failure of punitive approaches, in the UK and elsewhere, to reduce the demand for and use of illegal drugs. An impact study of the Psychoactive Substances Act 2016 concluded: *'While the PSA has reduced the visible sale of NPS and is likely to have decreased total sales and consumption, this has been accompanied by an increase in total NPS deaths, likely due to increased potency of supply, and fewer opportunities for peer-to-peer education regarding safe use of NPS following criminalisation of supply. The PSA has also likely indirectly increased harms, via a shift to conventional drugs with poorer safety profiles, potentially creating a larger problem than that which it originally sought to address'* (Humphries, 2022), a succinct summary of the fallacy and negative outcomes of criminalisation expected to reduce the use and availability of illegal drugs. The aim of 'prohibiting' illicit substances is acknowledged to have failed: the target of prohibition has become the use and consumption of illicit substances, not the substances themselves, shifting policy focus to people who use drugs. In October 2022 some PCCs and Chief Constables called for cannabis to be reclassified as a Class A substance, a call supported by the Home Secretary [13], referring to it, against the evidence, as a 'gateway' substance, an apparent attempt to rehabilitate a discredited theory.

[13] https://www.thetimes.co.uk/article/suella-braverman-wants-to-make-cannabis-a-class-a-drug-7fpfdb3ql

The assertion of a link between drug use and acquisitive crime is repeated, despite research questioning mono-causal claims of drug use as a major cause of crime (Lurigio & Schwartz, 1999, Reuter & Stevens, 2007, Stevens 2011, Seddon and Stevens, 2023). Crime and violence associated with drug use and that associated with the operations of the illicit drugs market are not disaggregated, failing to distinguish the use of drugs from the trade in drugs. The claim that drugs drive half of all homicides derives from a statement in the Serious Violence Strategy (Home Office, 2018, 9), unsupported by evidence and misrepresented in the Strategy (Holland et. al., 2022, 2).

The disproportionate use of drug laws against younger black populations, foreseen by Young (1971) and Bean (1974) and demonstrated by Shiner et al. (2018) and by government-commissioned research (Aust & Smith, 2003), is acknowledged: that discrimination in practice undermines the legitimacy of law is not. The origins of the 'disproportionate' impact of policy implementation and the wider prevalence of racism in public institutions are not explored. While reference is made to money laundering, current practice by financial and other institutions and individuals is not rigorously overseen, partly a result of under-resourcing of investigative and enforcement agencies, a further austerity outcome, partly political hesitancies about taking action against the ingenuities of the scrutiny-averse rich and their enablers.

Funding.

The Strategy announced increased funding for treatment services. Contradictory amounts are quoted: an initial figure of *'almost £900 million of additional funding over the next three years'* for treatment and recovery services is followed by references to £780 million; and £533 million for local-authority commissioned treatment services, as part of an overall drug spend of *'more than £3 billion'* (Strategy, 6, 11, 8, 32, 34, 7, 11). Claiming that *'the total treatment and recovery spend* [will be] *more than £2.8 billion over three years'* (Strategy, 32) is inaccurate: total Strategy spend includes previously announced funding for enforcement and policing. As confirmed in the White Paper (Home Office, 2022, 3) it is the £780 million for treatment and recovery which is new money. The local guidance repeats the misleading reference to a total spend of over £3 billion over three years (HM Government, 2022, 6), confusing 'new' spending on treatment services with previously announced spending on enforcement. Finch (2022) comments '*the financial calculations are rather opaque…It is a 10-year strategy and the financial settlement is only for three years'.*

In line with Treasury spending-review time scales, announced funding is for three years, and only for England. There is no commitment to funding continuing after the initial period: 'ring fenced' funding of local authority public health services ended in 2021; and future public health funding will be from business rates. While the increased funding for drug and alcohol treatment services is to be welcomed, it is unlikely to be effective if other public sector partner services and agencies cited as contributors to the Strategy do not benefit from similar restoration of funding. A National Audit Office report refers to uncertainty over longer-term funding and underspending by some Departments, concluding that this combination *'restricts the ability of local authorities to recruit and plan strategically'* (National Audit Office, 2023, 10). Some funding will be conditional on local outcomes (Strategy, 60). There is no indication that provision of drug and alcohol services will be put on the same statutory basis as sexual health services. There are concerns that funding allocations may be based on political considerations rather than social and

health needs, implied by the term "place-based" funding [14]. Answering a parliamentary question in autumn 2022 a Health Minister declined to confirm that the additional funding would be protected [15]. Sumnall commented: *'Strategy success is dependent on reversal of austerity'* (2022, 3).

Drug related deaths, Recovery, Harm reduction.

In a further departure from established terminology the term 'drug related deaths' is not used in the Strategy, '*deaths associated with drug use'* being substituted. One Strategy ambition is *'to have … prevented nearly 1000 deaths, reversing the upward trend on drug deaths for the first time in a decade'* (Strategy, 9) by the end of 2024-25, with no consideration of how it will be achieved, a major Strategy omission: the number of drug related deaths in England and Wales continues to rise [16]. This ambition demands structural and systemic solutions, including macro-economic policy, approaches not considered by the Strategy. There is no reference to the ACMD report on reducing opioid deaths (ACMD, 2016): the government's July 2017 response to that report accepted recommendations on data collection and provision of integrated services; monitoring treatment provision to ensure value for money; the continuation of opioid substitution and heroin assisted therapies; and ensuring the availability of naloxone. Organisational and administrative recommendations were accepted, practical life-saving ones less so. The use of naloxone and the role of needle exchange and syringe programmes were acknowledged. There was no acceptance of opioid substitution using buprenorphine, other than in prisons; or acknowledgement of Scottish professional and political support for drug consumption rooms, supported by some English police and crime commissioners and chief constables, omissions consistent with the incomplete acceptance by government of the ACMD report's recommendations. There are no references to drug testing, provision of which is hindered by Home Office licencing requirements.

The ACMD 2016 recommendation that the provision of drug consumption rooms be considered was rejected: *'the government has no plans to introduce drug consumption rooms',* a position re-stated in a 2018 Ministerial comment that the government had *'no intention'* [17] of introducing DCRs. Both statements misrepresented international evidence on the impact of DCRs [18]. Government does not recognise the contribution of DCRs to reducing drug related deaths, professed and contested legal concerns about their operation being prioritised over health and life-saving interventions and the advice of independent commentators: *'In the United Kingdom, in 2020, there were 4,517 deaths related to illicit drug use; the highest rate of drug related deaths since records began. It is necessary to provide the full range of evidence-based drug treatment and harm reduction interventions to prevent these deaths'.* (Faculty of Public Health, June 20 2022 [19]).

[14] See Financial Times January 22 2022: https://www.ft.com/content/00db4fc5-3f3e-4c0c-abc1-5d9e471fe109; Financial Times August 6-7 2022: https://www.ft.com/content/da8c676c-e596-43ce-8964-31b722cc79ee

[15] https://questions-statements.parliament.uk/written-questions/detail/2022-10-27/73129

[16] 2022 figures, released in December 2023, show that this increase continues. Increased deaths from opiates are a Europe-wide phenomenon, with UK rates the highest in Europe. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2022registrations

[17] https://www.gov.uk/government/publications/drug-misuse-and-dependency-government-responses-to-acmd-reports

[18] www.thelancet.com/public-health Vol 7 March 2022

[19] https://www.fph.org.uk/news-events/fph-news/call-to-amend-misuse-of-drugs-regulations-to-make-it-easier-to-pilot-overdose-prevention-centres/

Recovery and treatment are not defined in the Strategy. A reference to *"OC"* remaining *'substance-free'* (Strategy, 39) may indicate a view of recovery as a euphemism for abstinence, government's preferred treatment outcome. When equated with abstinence, 'recovery' becomes a politically and ideologically loaded term, with no recognition that many people who use drugs do not see a substance free - abstinent - future as realistic, necessary or desirable. The Black reviews see recovery as wider than 'treatment', recognising that many people who use drugs have complex physical and mental health, employment, housing and offending needs. The Strategy implies a false opposition between recovery and harm reduction: both can be pursued without detriment to either. This distancing was reflected in 2017 NICE guidelines on drug prevention [20], with its two mentions of harm reduction but no substantive discussion or recommendations. The implicit favouring of abstinence demonstrates ideological, not evidence-based, policy making.

There are five Strategy references to harm reduction, two in the panel on the Welsh government approach, one in the Northern Ireland panel, two in '*place-based additional funding'*. The rationale, benefits and role of harm reduction are not considered. The history of government endorsement of harm reduction at the time of the 1980s. HIV/AIDS epidemic is not acknowledged. Stevens (2022) points out that some treatment involves elements of harm reduction. There are no references to HIV and HepatitisC programmes or needle-exchange services' contributions to harm reduction, opioid substitution treatment or drug consumption rooms (Stevens, 2022; Holland et. al. 2022). Such 'in passing' mentions of harm reduction indicate that it will not be a Strategy priority, contradicting claims that the Strategy will benefit the 'health needs' of people who use drugs: *'Harm reduction interventions are mentioned but with very little detail'* (Finch, 2022). The undertaking *'to expand and improve the quality of a full range of evidence-based harm reduction and treatment interventions'* (Strategy, 35, 39) is similarly contradicted by the rejection of much evidence-based practice. There are no references to Police and Crime Commissioners' harm reduction initiatives, implicitly rejecting their practice. Some PCCs and Chief Constables had introduced de facto decriminalisation for some possession offences: Cleveland's PCC introduced and funded heroin assisted treatment. Initially seen as an exercise in local autonomy and the adoption of innovative harm reduction approaches, the successor PCC withdrew funding for HAT in September 2022. These could have been examples of local practice being more responsive (and evidence based) than central government priorities, as Stimson (1987, 479) anticipated in his reference to *"interpretation and discretion in local practice"*. The Strategy view of harm reduction sits somewhere between neglect and rejection, contrary to an aim to reduce drug harms.

Discussion.

The Ministerial introductions to the Strategy present it as '*an evidence-based and modern approach'*. Yet content and proposals reinvent, reinstate and rename existing and previous practice and structures, incorporating discredited analysis and approaches, simultaneously denying and replicating content, aims and approaches of past strategies, and negating existing research and evidence, collectively indicative of an amnesia regarding previous UK drug policy. Finch (2022) commented *'The strategy is not revolutionary, it is more of the same and in many ways a wasted opportunity to make the health of drug users central to policy'*. It invents new terminology – '*breaking drug supply chains'* and *'achieving a generational shift in the demand for drugs*' replace supply reduction and demand reduction, perhaps attempting to substantiate its *'new approach'*. Ministerial assertion that this is

[19] National Institute for Health and Care Excellence: 2017: drug misuse prevention: Targeted interventions

the first drugs strategy to require working together and shared responsibility is quite simply untrue: previous strategies have consistently included cross-departmental authorship and cross-disciplinary and agency implementation since the first, 1985, strategy [21]. Proposals in the 2022 local guidance effectively re-invent Drug and Alcohol Action Teams and the UK Anti-Drugs Co-ordinating Unit. What is 'new' are the partial restoration of treatment funding; the ambitious language; intensification of criminal justice responses; and pretensions to global status [22]. *'[T]he old ways of doing things'* - what they were and why they were not working - are not clarified, nor is *'a new approach'* (Strategy, 11, 3). A National Audit Office report comments: *'The 2021 strategy focuses on the same core themes as the 2010 and 2017 strategies'* (National Audit Office, 2023, 7). Changes in Ministerial post-holders in the autumn of 2022 call into question political commitment to the Strategy: none of the four proponents of the Strategy remains in government; the post of Combatting Drugs Minister no longer appears in listings of ministerial responsibilities [23].

References in the Black reviews and the Strategy to the need to 'rebuild' treatment services fail to acknowledge the impact of funding cuts in public sector services since the introduction of austerity in 2010. Its legacy persists, making many Strategy expectations about the contributions of, amongst others, education, housing and health (Start for Life, the Supporting Families Programme, *'a new and improved youth offer'* (Strategy, 50, 51)) to treatment and recovery unrealistic. It is not clear if spending by these sectors is separate to or part of Strategy funding. An emphasis on custodial responses similarly ignores pressures on the courts, probation and prison services, further denial of both the current reality of public sector capacity; and political responsibility. 'Levelling up' may have been a response, but not acknowledgement, by one Conservative administration to the societal damage done by earlier Conservative administrations. A decade of dis-investment and funding reductions of the public sector will not be repaired by publication of a document which ignores long-standing socio-economic factors and inequalities underlying social issues (ACMD 1998, Reuter & Stevens, 2007), factors which need to be addressed if the *'ambition to reduce overall use towards a historic 30-year low'* is to be realised. That *'Drug use and harms have been rising, blighting neighbourhoods and holding them back from levelling up to their full potential'* (Strategy, 9, 11) presents drug use as cause rather than effect, shallow analysis contributing to the lack of realism of this (and previous) strategies. Bacon and Spicer comment: *'The second omission is the role of inequality…the Strategy ignores that* [drug markets] *and their harms flourish in conditions of deprivation and social exclusion. In this sense the Government appears to be putting the cart before the horse, placing its attention on the symptoms of inequality, rather than addressing inequality as a root cause itself'* (2022, 3, 4). An NAO report on the strategy concluded that *'The strategy has not yet…begun to address the complex causes of illegal drug use'* (National Audit Office, 2023, 7).

The Strategy sub-title confirms priorities: cutting crime comes before saving lives, an emphasis on reducing drug use and availability before reducing drug deaths and harms. There is more text on reducing drug related crime than on reducing drug related deaths [24] . Responsibility for drug policy remains with the Home Office (ministry of the interior) while other jurisdictions, including the UK's devolved administrations, see it as a public health issue housed in health ministries. A crime-based approach focuses on symptoms, not causes, failing to acknowledge that much drug crime and harm is created by laws intended to control the availability and use of

[21] Home Office: 1985: Tackling drug misuse: a summary of the government's strategy.
[22] The term 'world leading' is used six times, 'world class' twice. In keeping with post-Brexit rhetoric, there is more than a hint of British exceptionalism
[23] Checked August 17 2023
[24] The Strategy uses the term 'crime' 149 times, 'health' 89, 'drug deaths' 6.

illegal drugs; and socio-economic factors. It reflects a resort to criminalisation in response to social issues, and the consequences of spending decisions which have reduced or removed supportive and preventive provision.

The Strategy envisages 'recovery' in binary terms of illness and wellness, not a spectrum, again dismissing evidence and example, although *'Managed addiction or drug free'* (Strategy, 54) implies that 'recovery' could be tailored to meet the needs of the individual, with some choosing to remain users and not required to become abstinent: *'Many of those who experiment with or use drugs do so without experiencing significant harm'* (ACMD 2022, 4), are not dependent, lead lives which include family relationships and responsibilities, work, study and participation in society. While drug use is illegal, it is not axiomatically disabling: it is the legal contexts and associated stigma which create the situations the Strategy identifies. Strategy effectiveness will be, in part, influenced by the flexibility and autonomy available to commissioners of treatment services, and the ability of those in treatment to negotiate their 'recovery', not have it imposed. The Strategy does not consider recruitment and retention of professionals and the loss of experienced staff as a consequence of disinvestment in treatment (and other public sector) services. In the contexts of healthy lives and harm done to self and others' social and personal lives, alcohol remains absent from the Strategy, a distinction embedded in the 1970 and 1971 debates on the Misuse of Drugs Bills. The current UK alcohol strategy dates from 2012. While contributing to much social and individual harm, alcohol's legal status, social acceptability and industry interests mean it is not subjected to the same scrutiny as illegal drugs.

References to interventions with children and young adults assume that early age primary prevention (stopping use before it starts) will lead to demand reduction in those individuals' later lives, reducing drug use generationally. This analysis ignores the causal factors behind drug use resulting from early childhood trauma and abuse, and socio-economic factors. The statements '*Drug use among children and young adults is particularly concerning…Drug use by young people risks worse immediate and long-term outcomes'* include proposals for school interventions, including a commitment that *'children will receive a comprehensive education about the dangers of drugs'* through the inclusion of drug education in mandatory school programmes of relationships, sex and health education, the renamed personal social and health education (Strategy, 49, 46, 4, 9). This proposal reverses previous dismissal of PSHE [25]. It also confuses education with prevention: information alone does not change behaviour. It is not clear if this requirement will extend to academies or be confined to local authority schools. The emphasis on prevention is made contrary to evidence of its limited effectiveness (Sumnall, 2022).

The statement *'The most effective and sustainable approach to reducing demand is building the resilience of young people through giving them a good start in life, the best education possible and keeping them safe, well and happy'* does not acknowledge the socio-economic factors which play a major part in '*giving them a good start in life'*. Schools are expected to promote children's economic, emotional and social well-being, without requisite funding or skills support. The claim that *'…there are a* [sic] *range of programmes in schools to identify and support children with vulnerabilities'* repeats the assertion of additional support in schools while ignoring the reality that such services have been lost to austerity. Promising *'new quantitative and qualitative research'* (Strategy, 50) repeats the disregard of existing research into the effectiveness and limitations of school-based education and prevention.

[25] The 2007-9 Brown government's Bill proposing making PSHE, including drug education, part of the mandatory school curriculum was abandoned by the incoming Conservative government in 2010.

The statement *'The UK is among the countries in Europe most affected by drugs'* is not explored, missing an opportunity to re-consider macro-economic policies which could play a role in reversing many of the UK's long-standing inequalities. That '*The UK is now Europe's largest heroin market and a target for international drug trafficking groups'* (Strategy, 11, 21) is similarly not explored, again avoiding opportunities to consider the impact of inequality, and the role of prohibition and illegality, in creating and sustaining the trade in illegal drugs. While the Strategy acknowledges that the global availability of illegal drugs is growing, this is not followed by consideration of the role existing policies have played in this situation. Lack of recognition of the power of the market and its role in illegal drug use is a significant policy failure, especially in the UK, where the ruling party has long been associated with pro-market ideology. There is no indication of recognition that the prohibition of drug use is itself a driver of organised crime and that rather than combatting illegal drug use prohibition consolidates it: *'once supply and demand are firmly established, their* [prohibitions'] *effects become counter productive…..Imposing harsh penalties on sales of an item increases its value on the illicit market'* (Jay, 2022); *'prohibition provides the conditions for illicit markets to exist in their current forms and vast scale'* (Bacon and Spicer, 2002, 4). The 2016 Psychoactive Substances Act will have extended the illegal market and increased the opportunities for organised crime groups.

While other jurisdictions are re-assessing drug policies to prioritise health and human rights, a term absent from the Strategy, which emphasise dignity, humanity, agency, justice and mutual caring, this Strategy does not signal a similar approach or consider the needs of disenfranchised and dehumanised groups: it objectifies people who use drugs. There is no indication that the Strategy has been written in consultation with user groups (Holland et. al., 2022, 5. For user perspectives on UK drugs policy see Southwell, 2021; Askew et al, 2022). The limited acknowledgement of the existence and needs of marginalised groups does not consider how commissioning and treatment professionals will be *"agile"* (Strategy, 36) to their needs and situations without consultation, involvement and representation.

Conclusion.

While predicated on evidence, new approaches and funding, the Strategy presents a narrow use of evidence and lack of consideration of the macro contexts of drug use. Alongside the refusal to acknowledge existing evidence there is a reluctance to consider and learn from experience and example: the promise of future evidence-based policy entails dismissal of evidence already known and available. There is no 'evidence' that evidence has been recognised and heeded in the past, or that it will be in the future: thinking about the future requires reflection on the present. The Strategy pays scant regard to reality and need, looks at 'what' rather than 'why', and adopts approaches long shown to be ineffective or counter-productive, while an evidence-based response to drug policy needs to include an awareness of history [26].

As others have observed, the Strategy contains no new thinking, approach or reform (Rolles, 2021; Winstock, Eastwood and Stevens, 2021, Finch, 2022; Bacon and Spicer, 2022; Holland et.al. 2022); lacks vision, enquiry and curiosity; and represents a non-scientific approach. Use of such terminology as *zero tolerance* and *tough* indicates a populist rather than professional approach. The outcome-claims are demonstrably false, and the pretence that the Strategy is in any way "*A new and bold approach"* shows an amnesia, disregard or ignorance of history, evidence and example, UK and international. The intention of *"cutting off the supply of drugs, preventing and reducing drug use"*

[26] Berridge, V: 2020: History and the future of addiction: *International Journal of Drug Policy*, 37, 117-121.

(Strategy, 47, 13), the Holy Grail of drug policy, repeats a failed ambition of UK and international policies over the past century. Bacon and Spicer (2022, 3) noted *'the new Drug Strategy contains numerous examples of unoriginal, unspecific and unachievable aims, with supply control measures arguably the greatest recipients of overblown rhetoric'.*

A Strategy strong on rhetoric but weak on analysis, which prioritises reducing drug use and availability above reducing drug deaths and harms, seems fated to join its predecessors in making little impact on drug availability, use and harms. Content, aims and delivery structures are similar to those of previous national strategies, prompting the question: why will this Strategy work when previous strategies have not? The Strategy substitutes wishful thinking for experience and evidence, with intentions presented as outcomes [27], compounding the failure to learn from previous strategies and, despite the pretensions, disregard of evidence.

The Strategy and its shortcomings form part of a wider pattern of a decline in UK governance and disarray in public sector services – staff training, recruitment and retention, the dilapidation of much physical infrastructure and hardware, failure to invest in, assess or plan current and future service provision. Much can be attributed to the failure of recent policy decisions, notably the impact of austerity. Ministers increasingly make personal, frequently ill-informed, statements, purporting to represent policy and even law. There has been a growing tendency to criticise constitutional, legal and political institutions, including the civil service and the devolved administrations, using increasingly dismissive language; and reports and commentaries from international agencies. This accompanies a decline in the standard and content of political discourse, also exposed by the UK Covid enquiry. In drugs policy, this is exemplified in the strategy's citing of CND and the INCB as international partners while diverging from those agencies' moves to less punitive, more health-focussed approaches.

There is no recognition that the world is entering a post war-on-drugs era, and no vision for the future. The Strategy is inherently backward looking, this at a time when the EMCDDA is strengthening its foresight programme, building anticipatory capability and collective intelligence – contingency planning - on future scenarios and possible responses [28]. Ambition without clear and unqualified adoption of ACMD and others' recommendations and evidence, or addressing socio-economic conditions, is unrealistic and unrealisable. This is heightened by the rejection and dismissal of evidence, thinking and practice which would benefit individuals and societal possibilities: accepting and regulating commercial markets for cocaine, heroin and cannabis, the use of psychedelic and psychoactive substances as medicines, including the use of cannabis-based medicines in paediatric medicine, rejection which inhibits research and scientific enquiry and the further development of evidence [29]. These factors lead to the conclusion that this Strategy exists outside history.

[27] Referring to overall government policy an editorial in The Guardian newspaper commented on *"…a failure to distinguish between the announcement of a plan and its enactment…There is little distinction between a slogan and a policy"*. https://www.theguardian.com/commentisfree/2022/may/04/the-guardian-view-on-government-drift-the-rot-starts-at-the-top

[28] EMCDDA webinar 'Preparing for the future' June 23 2022.

[29] For one overview of such developments see Berridge, 2013, 214 ff.

Addendum.

The House of Commons Home Affairs Committee report *'Drugs'* was published in the summer of 2023. (House of Commons Home Affairs Committee, 2023). It endorsed many of the criticisms which have been made of the Strategy. It emphasised the need for a public health response to drugs; recommended a review of existing UK drug laws; recommended the use of drug-checking at festivals and other events, including in the night-time economy; and recommended the establishment of a pilot drug consumption rooms project.

The government's response to this report was published on November 8. (House of Commons Home Affairs Committee, 2023). The Response asserted that harm reduction and public health approaches were prominent components of government drug policy. It rejected the HAC recommendations that current drugs legislation be reviewed, and the ACMD tasked to review exiting drug classification. The recommendations regarding drug testing were rejected as was the recommendation regarding drug consumption rooms, repeating previous arguments that drug consumption rooms are opposed *'due to the risk of these facilities condoning illicit drug use and encouraging the continued criminal supply of drugs to users'*. The arguments around the harm reduction and life-saving benefits of drug consumption rooms were not considered in the Response.

Curiously, this part of the Response continued to state that *"The UK government respects the independence of the Lord Advocate as Scotland's prosecutorial authority and will not interfere with plans to introduce a drug consumption room in Glasgow, providing these powers are lawfully executed"*. This may be an acknowledgement of an opportunity to gather evidence on the impact of drug consumption rooms from UK practice . It may also be a retreat from a potential further constitutional conflict with the Scottish devolved administration.

Without summarising its content, the Response rejected the HAC request for sight of an unpublished 2016 ACMD report which is reported to have recommended the decriminalisation of the possession of illegal drugs for personal use [30]. Government has consistently refused to publish this report, the only ACMD report not to have been published.

While a House of Commons report (House of Commons Public Accounts Committee 2024) acknowledged improved coordination of Strategy implementation and recruitment of drug workers, it noted that *'progress towards the strategy's aims of reducing drug use and related harms is less clear'* (House of Commons Public Accounts Committee, 2024, Summary). This Report noted that continued funding was not guaranteed and *'the £768 million of funding for treatment and recovery services has not replaced the funding decline seen over the last decade…Uncertainties over funding allocations has made it difficult for local authorities to commission and deliver the high-quality treatment and recovery services that are needed'* (House of Commons 2024, Recommendation 3, 6). Echoing the NAO in 2023, the Report emphasised lack of evidence and understanding of the factors influencing drug use and the neglect of socio-economic factors: '*Despite previous attempts to reduce the demand for illegal drugs, the Joint Combatting Drugs Unit and departments still do not understand how to change behaviours and prevent people from using drugs…long-term interventions must consider wider socio-economic factors. Vulnerability to illegal drug use is often linked to trauma and issues such as deprivation…'* (House of Commons 2024, 7).

[30] https://www.theguardian.com/politics/2023/sep/19/uk-drug-advisers-recommended-decriminalising-possession-in-2016-leak-reveals

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