THE FUTURES MARKET

Crime, heroin and poverty underpinned the growth of the sector. But with change happening at every turn, **Marcus Roberts** takes stock

A new Home Office research report by Nick Morgan considers *The heroin epidemic of the 1980s and 1990s and its effect upon crime trends – then and now*. It asks whether the 'significant drugs epidemic, or wave of epidemics, through the 1980s and early 1990s' can help to explain a rise and subsequent fall in crime for which 'no definitive explanation has been produced'. Morgan finds that 'the epidemic may have had a significant impact on acquisitive crime in England and Wales', helping to explain why crime rose in the 1980s and early 1990s and has been falling since the mid 1990s. He concludes that – even allowing for a declining and ageing population – 'OCUs (opiate and crack users) continue to have the biggest impact on acquisitive crime trends', and 'the potential for further crime reduction is large'. This argument is not heard as much in current debate about drug treatment, even though it was the dominant trope for the best part of a decade.

The latest drug treatment figures confirm that while the majority of people in drug treatment have problems with heroin, there has been a marked decline in heroin use among new entrants. In 2005-06 there were almost three times as many heroin users starting treatment for the first time as users of other drugs, by 2012-13 this had been reversed, with non-heroin users new to treatment outstripping heroin users by two to one.

DrugScope's former Chief Executive, Martin Barnes, argued at our last Annual Conference that this 'wave of epidemics' could be said to have given birth to the 'drug sector' itself. He also highlighted a further link with deprivation that is less prominent in Morgan's discussion: the influx of heroin in the late seventies and eighties corresponded with social dislocation, and it was in some of the worst hit areas that heroin did most damage, from the inner cities to the Welsh valleys.

THE RESHAPING OF A YOUNG SECTOR THAT HAS EMERGED...AT LEAST SINCE THE 1980S, ... IN RESPONSE TO THE IMPACT OF A PARTICULAR DRUG IN A PARTICULAR CONTEXT AND AT A PARTICULAR TIME

Before the 1980s, heroin was not widely available (while crack was unknown) and there was no comprehensive specialised treatment system. By 2012-13 there were over 190,000 adults in drug services in England, with a central funding pot of £570 million for community and prison services, topped up by significant local investment.

This growth was in response to 'problem drug use', defined as dependence on heroin and/or crack cocaine. From the late 1990s, the expansion of the sector was turbo charged by exactly the kinds of arguments rehearsed by Morgan, which spoke directly to New Labour's commitment to be 'tough on crime and tough on the *causes* of crime'. This configuration produced the National Treatment Agency (NTA), the National Drug Treatment Monitoring System, the pooled treatment budget, regular catch ups between the Chief Executive of the NTA and the Prime Minister in the Blair years and a concerted cross-Governmental programme of action, led by the Home Office and guided by national drug strategies. It also produced *the* evidence base. The formula that says that £1 spent on drug treatment produces £2.50 in savings is based on evidence for the impact of *certain* kinds of treatment on *problem* drug use and the bulk of that saving was a result of reduced crime (and so, for example, the National Audit Office's assessment of the impact of the 2008 Drug Strategy was called *Tackling problem drug use*).

It is possible, then, to trace a paradigm that – at least, politically – drove the birth and expansion of the drug sector

as we know it in the UK, with the key co-ordinates being: 'problem drug use' (heroin and/or crack), deprivation and offending.

This paradigm also produced a reaction, which has contributed to the reshaping of the sector. A recent report from the Recovery Committee of the Advisory Council on the Misuse of Drugs comments that the first New Labour drug strategy in 1998 led to 'a substantial expansion of treatment for those with heroin dependence and in particular an expansion in methadone and other opioid-assisted treatment in England and Scotland'. What was criticised in the late 2000s as an over-reliance on opiate substitute treatment reflected both the focus of the system on heroin and the attractions of a treatment approach that was evidence based. It also – arguably – provided a relatively inexpensive crime reduction tool, but was not being used widely enough as a platform for integration and recovery at that time. It is worth noting that New Labour's second Drug Strategy – *Drugs: protecting families and communities* (2008) – promised 'a radical new focus on services to help drug users to re-establish their lives', including housing and employment. With hindsight, it is striking that this was described as 'radical' and 'new' just over five years ago.

There have been a host of paradigm shaking developments since, particularly with the election of the coalition Government in May 2010, swiftly followed by the publication of a drug strategy – *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life*. These include changes that are philosophical and ideological (e.g. 'recovery' and 'localism'), institutional and structural (e.g. the replacement of the NTA by Public Health England), economic (e.g. 'austerity'), epidemiological (e.g. falls in demand for heroin treatment), composition of the sector (e.g. growth of big providers), trend and market changes (e.g. new psychoactive substances or NPS), club drugs, emerging drug issues (e.g. performance and image enhancing drugs or prescription and over-the-counter drugs), the equalities agenda (e.g. services for women or older people), legal developments and rumours of legal developments (e.g. the Home Office review of NPS or the increasing international interest in cannabis regulation) and new policy issues and agendas (e.g. drug and alcohol misuse as a dimension of 'multiple need' or 'multiple exclusion').

Above all, of course, there is a bringing together of responsibility and budgets for drugs, alcohol and tobacco within a broader public health framework. If the impact of drug treatment on crime secured unprecedented investment from the 1990s, the relocation of substance misuse issues in public health brings the costs associated with alcohol misuse (and tobacco) much more sharply into focus. It is estimated that alcohol-related harm has an overall cost to the NHS in England of £3.5 billion annually.

So what does all this mean? It is hardly news that we are in a period of wide-ranging and far-reaching change

affecting drug and alcohol policy and services. It is illuminating, however, to consider this as the reshaping of a young sector that has emerged and developed in the UK in the last 50 years and, to a significant degree, at least since the 1980s, has done so in response to the impact of a particular drug in a particular context and at a particular time. In this sense, these changes go to the foundations of the drug sector, and could amount to a fundamental shift in its co-ordinates and direction of travel. What follows are some reflections prompted by Morgan's analysis.

First, given the effectiveness of crime reduction arguments in levering in the political interest and investment that built the modern drug treatment system, and their salience to the priorities and concerns of local communities, it is tempting to mobilise a new analysis that suggests that the impact of treatment on crime may be sufficiently large to explain overall crime trends.

Less crime is a good thing and the contribution that drug services make to cutting crime brings huge benefits to communities, including some of the most deprived. But a disproportionate emphasis on this argument would feel a regressive step given the emergence of a recovery narrative that has started to shift the political debate about drug treatment beyond a deficit model that is exclusively about fear/risk, and towards an asset model that is also about hope/potential. If the principal argument for getting people into treatment services is that they are responsible for a lot of crime, then this will tend to reinforce the barriers to them moving out of treatment and on with their lives.

Another question is who an argument for investment to reduce crime should be addressed to. In the late 1990s it addressed a key priority for a Government that set national targets and ring-fenced budgets. It may have less direct and immediate purchase when pitched at a Director of Public Health or local Health and Wellbeing Board, given their focus and responsibilities (this is one reason why DrugScope has championed the involvement of Police and Crime Commissioners and other criminal justice representation on Health and Wellbeing Boards). Perhaps the point to be made here is partly that the impact of drug treatment on overall crime trends is so profound that this should be a priority for crime reduction policy and spending, over and above public health investment.

Second, the recent ACMD Recovery Committee report concluded that 'many people have periods of dependence or problematic use of alcohol or drugs in their lives that most overcome'. However, for people 'with little recovery capital or dependent on some types of drugs (especially heroin), recovery can be much more difficult and many will not be able to achieve substantial recovery outcomes'. Paradoxically, then, it may be that recovery is hardest to achieve for many of the problem drug users for whom the drug sector was primarily developed in the UK and largely achievable for the wider group of people experiencing alcohol or drug problems that it has more recently reached out to encompass. A practical conclusion is that the development of the recovery model needs to be balanced with models and interventions that provide the best possible support to enable those less likely to achieve 'substantial recovery outcomes' to realise their potential, particularly as many of this group move into older age.

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Third, the formation of the drug sector in the UK brought investment and support to excluded individuals, families and communities. There is widespread anxiety that a public health focus could divert money away from marginalised people with entrenched needs and towards population-wide interventions – this is particularly concerning with the pressures on public health budgets, particularly if drug and alcohol spend is a 'zero sum game'.

This is, of course, a concern. It should be noted, however, that there are a range of ways in which drug and alcohol use can contribute to exclusion, stigmatisation and marginalisation. DrugScope's work on 'multiple need' with the Making Every Adult Matter coalition illustrates this, with drug and alcohol issues figuring in the lives of people experiencing severe and multiple disadvantage in a variety of ways, often not involving problem drug use – with, incidentally, significant cost benefits for criminal justice services. This agenda is attracting significant investment (e.g. over £100 million through the Big Lottery Fund's 'Fulfilling Lives' programme) and increasing political interest (e.g. featuring in both the Government's Social Justice strategy and Institute of Public Policy Research's *Condition of Britain* report, which mapped out a policy agenda for Labour). In addition, drugs and alcohol may impact harmfully on other marginalised groups – such as sections of the LGBT community or elderly people – in ways that do not match the problem drug use pattern.

The long term future of drug and alcohol services is not being played for a fixed pot of money anyway (if only it were). The case that we develop today will affect the amount of investment available in five, ten or fifty years time. Looking at the bigger picture, there is a need to speak to both the crime reduction agenda and other issues and priorities that can engage the attention and commitment of local communities. Recent changes provide us with opportunities to position our sector by developing its offers and narratives both to challenge stigma and exclusion and to reach into all those areas of policy and practice to which drug and alcohol services and interventions are relevant – which is to say virtually everywhere, and including a better balance between early intervention and resolving chaos.

Finally, Morgan states that 'the other main policy conclusion is that preventing a future epidemic is crucial'. This is particularly pertinent at a time when new drugs and patterns of drug use are emerging all the time, but that isn't to say that an older problem can't become a new one again. Look no further than the United States, where a new heroin epidemic is being linked to misuse of prescription pain killers and an influx of cheap heroin, much of it from the Mexican drug cartels. In a recent BBC article, Jack Riley, a regional head working for the US Drug Enforcement Agency in the Chicago area, commented that 'heroin addiction is probably at its all-time high' in parts of America, adding 'I've been doing this for thirty years in virtually every corner of this country and if anything can be likened to a weapon of mass destruction in a family, on a community, on society, it's heroin'.

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