Drugs and Crime

THIRD EDITION

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Philip Bean

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For
Maryjane, Jodey,
Liam and Callan

Preface and acknowledgements

Writing in the late 1960s on drug taking and crime, I thought any link (such as there was) would be complex, and full of pitfalls for the unwary. I little realised how true this was, nor how many and deep were the pitfalls. Nor was I able to see that drugs and crime would dominate government thinking. In the 1960s questions were rarely asked about crime, but of over-prescribing, about the role of the medical profession, and how best to explain drug taking within the context of the social attitudes of the time.

In the last 40 years or so things have changed. Then drug users were rare; now they are commonplace. Then they were pitied; now they are likely to be scorned. Then there was no supply system except through the over-prescribing doctors; today cocaine comes from the Andes, heroin from Afghanistan, Turkey and South East Asia, and amphetamines, ecstasy and similar drugs are manufactured in Britain or on the continent. In the last five years or so the government has reacted to the drug problem – but whether always with the appropriate vision or in the right direction remains a matter for debate. Some of the policies seem right, but others (which have led to the Drug Treatment and Testing Order) and the dominant role given to Drug Action Teams are surely not. In addition, government-funded research is scanty, often promoting short-term, small, atheoretical, epidemiological studies. Large-scale longitudinal studies which would provide detailed information about the natural history of the phenomena have not been forthcoming. Nor do non-governmental agencies (NGOs) fare better, for they too rarely promote high-quality research.

I offer this book as a way of assessing what is broadly known about drugs and crime and related matters such as policing, drug testing and treatment. I have also made suggestions about how best to proceed. Inevitably the topics selected represent a personal interest, and no claim is made to suggest they produce a compendium of the drugs–crime debate. None the less, it is hoped enough areas have been covered to sustain the claim that this book includes most of what we mean when we talk of drugs and crime, especially as these affect Britain.

It is nearly seven years since I wrote the first edition. Things have moved on since then. In some ways not as fast as one would have liked, for we are still a long way from meeting and dealing with some of the more obvious structural difficulties. There has been no attempt to replace the Drug Treatment and Testing Orders (DTTOs), and nothing has been done about trying to get treatment and criminal justice agencies to work together more closely. Nor has there been an evaluation of the way the Drug Action Teams operate, with their budget of about £400 million per year. Might all this be an indication that inertia or the like is the dominating force? Perhaps so. Let us hope someone somewhere will provide the necessary political drive to move things forward.

I have made further changes to this the third edition. The tables and data relating to Chapter 1 and Chapter 3 have been updated, at least where possible. It has been mightily difficult to find appropriate data and it is not an exaggeration to say that the UK national system for data collection and retrieval is a shambles. Accordingly, not all the earlier tables have been updated. Where there is no information I have pointed this out and have left the tables as in the second edition. Joy Mott, formerly of the Home Office Research Unit, has undertaken the burdensome task of finding the data and updating accordingly. I wish to acknowledge the enormous assistance given by her in these chapters.

Some chapters have been left unaltered but others, particularly Chapter 6 and Chapter 7, have been rewritten to take account of additional material and to fill the gaps in earlier texts. For example, in Chapter 7 I have added a section on 'ice' and extended the section on police tactics to include 'stop and search', 'test purchase', and so on. In doing so, I hope to have strengthened these chapters, particularly through the inclusion of more British research. Chapter 10 is new and entirely devoted to the 'legalisation debate'. It was pointed out to me that a book on drugs and crime ought to deal with the questions surrounding legalisation if only because legalisation or prohibition

provides the basis from which almost all else follows. I have therefore tried to set out the main arguments in that debate in a manner which is informative without sitting on the fence, concluding that the case for legalisation in its full-blooded form has not been satisfactorily made. Chapter 11 (the old Chapter 10) has been amended in a way that I hope improves and strengthens my conclusion by setting out the arguments in a more systematic way. My aim throughout has been to produce a book which covers most of the central areas of the debate on what has always been an important and interesting subject.

There is no doubt that the 'drugs crime' problem remains central to criminology generally and government's thinking in particular. Sadly, I can see little in the way of government thinking which suggests that our elected leaders appear sufficiently concerned to get on top of the matter. There is much talk but little in the way of direct proposals aimed at turning a bleak situation around. Hopefully, this third edition will add to the debate and perhaps stimulate some new ideas.

I have burdened a number of people by asking them to comment on the chapter on legalisation and would wish to thank them for their assistance; Leo Goodman, Mike and Peach Partis, Philip McLean, Joy Mott and Teresa Nemitz. I am grateful to them and have welcomed their comments. I also wish to thank others too numerous to mention who have assisted me throughout, and especially my erstwhile colleagues at the University of Loughborough who did so much to make my time there stimulating and enjoyable. I also would repeat my thanks to Joy Mott who worked so valiantly on the data in Chapters 1 and 3. Needless to say the errors that remain are mine. Finally, I would thank publicly my friends and immediate family. That this book is dedicated to some close family members is a further indication of their importance.

Philip Bean

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Chapter 1

Drugs and crime: an overview

A great deal has been said about the links between drugs and crime and, in Britain, an increasing amount of resources is given to drug-crime prevention programmes. For example, the Criminal Justice and Court Services Act 2001 involves estimated costs for national implementation of the new drug-testing proposals of approximately £45.5 million (House of Commons 2000: 24). This is a small part of an ever increasing spiral of expenditure aimed at reducing drug use – rightly described as the scourge of our age – and the corresponding social and economic problems it brings.

For our purposes, 'drugs' are defined as those substances controlled by the Misuse of Drugs Act 1971 (henceforth the 1971 Act) of which there are a number. (The terms 'drug misuse', 'substance misuse' or 'drug abuse' will be used interchangeably.) Cannabis, amphetamines, heroin, cocaine, 'crack', LSD and ecstasy are, for these purposes, the most important, as they tend to be the most widely used illegally. Debates about what constitutes a drug, the moral connotations attached to the term and about how or under what circumstances certain substances are selected for control are important but not considered here. These are topics in their own right warranting more consideration than space permits. The task here is different: it is to examine some of the major criminological implications of the drugs-crime nexus, to determine how drugs and crime are linked and to assess the responses made to those links.

The drugs-crime debate extends beyond the legislation to include, *inter alia*, policing (whether on matters of interdiction – i.e. before drugs enter Britain – or local procedures, including the use of

informers) and the sentencing of drug offenders involving treatment programmes, whether as part of a sentence of the court or not. It can, and indeed should, include the impact of drug use on local communities – not least because of the deleterious effect drugs have upon them (Barton 2003).

To complicate things further, many of the substances controlled by the 1971 Act can be prescribed by selected physicians to substances misusers. Maintenance prescribing has a long tradition in British drug policy, going back at least to the Rolleston Committee in 1926 (Bean 1974; Spear 2002). Without going into the merits or defects of maintenance prescribing, one of its critics defined it as 'producing a maladaptive pattern of use manifested by recurrent and significant adverse consequences related to the repeated use of substances with clinically significant impairment or distress' (Ghodse 1995; 162). This should alert us to some of the complexities. If substances can be prescribed, the question must be: for what reason? Are they to assist the offender or to reduce crime? And what, after all, is a 'maladaptive pattern'? Or, how are we to talk of dangerous drugs when some prohibited substances are not dangerous, whilst others not included are? Moreover, what are the boundaries of the debate? Hopefully some of these questions will be answered here, but some remain elusive and difficult to unravel. We can begin, however, with a workable definition of what we mean by 'drugs'. For these purposes, and to avoid a lengthy and acrimonious debate, a pragmatic, circular definition has been used – 'drugs' are what are usually included in the debate about drugs.

Extent of drug use

Who, and how many, are the users? Drug misuse is largely an illegal activity, making it difficult to measure. Traditionally, national estimates have been based on a set of indicators which have included convictions for possession or supply, drug seizures by police and HM Customs and Excise, and notification to the Addicts Index where notification was required under the Misuse of Drug (Notification of and Supply to Addicts) Regulations 1973. Taken together they provided some evidence of trends of use throughout Britain. These standard indicators are still used, although to what effect remains unclear. The Addicts Index has been replaced by what is now called a 'starting agency episode'. This is where users are recorded when they first attend a selected drug treatment agency, or reattend after a

break of six months or more. Unfortunately data from these starting agency episodes are not comparable with that of the older Addicts Index, and of course seizures or possession offences in themselves are uncertain indicators, reflecting the activities of the police and HM Customs rather than measuring the extent of use. Accordingly I have selected some key indicators which, in their way, provide insights into the current position. The data come from large-scale, national, self-report surveys such as the British Crime Survey (BCS), from the National Treatment Agency for Substance Misuse, and from research projects commissioned by the Home Office.

Prevalence of the use of controlled drugs in the general population

First we have the surveys. The Home Office, the Scottish Executive and the Northern Ireland Office conduct regular household surveys of people's experience of crime which include questions about drug use (see Corkery 2003 for an excellent summary of this data up to 2002/03 and Northern Ireland Office 1999). These surveys provide a measure of the prevalence of drug misuse in the United Kingdom in the general population. (For a review of how survey methodology in this field has developed see Ramsay and Percy 1997).

In the three national surveys, more 16 to 24 year-olds report drug use last year and last month than people in other age groups and with more men than women doing so, with cannabis by far the most commonly used drug. Very few people in the general population admitted to heroin use (Frisher *et al.* 2007).

England and Wales

The British Crime Survey (BCS) covers people living in private households in England and Wales. Younger people, aged between 16 and 24, report higher levels of drug use than older people, with more men than women saying so. The proportions of people in the BCS from 1996 to 2005/06, who said they had used any controlled drug in the last year and last month, are shown in Table 1.1 below. While the proportion of 16 to 59 year-olds has remained constant (at 11–12% for last year use during the ten year period) there has been a significant drop in the proportion of 16 to 24 year-olds (from 30% to 25%, with a corresponding drop in last month use) from 19% to 15%.

Between the 2000 and 2005/6 BCS the estimated number of 16 to 24 year-olds who admitted to using one or other of certain controlled,

Table 1.1 England and Wales: use of any drug in the previous year and month (BCS 1996–2005/06 expressed as rounded percentages).

	Last year		Last month	
Age:	16–59	16–24	16–59	16–24
1996	11	30	7	19
1998	12	32	7	21
2000	12	30	7	19
2001/02	12	30	7	19
2002/03	12	29	7	18
2003/04	12	28	8	18
2004/05	11	27	7	16
2005/06	11	25	6	15

Source: Roe and Mann 2006.

drugs in the last year and the last month dropped, largely due to fewer people reporting use of cannabis. There was a significant increase in the number reporting their use of cocaine in powder form.

Scotland

The 2000 Scottish Crime Survey (SCS) found people aged 16 to 29 were most likely to report drug use in the last year and the last month (17% and 13% respectively) compared with those aged 30 to 59 (with 3% and 2% respectively). More 16 to 19 year-old women than men had used drugs in the last year (21% and 15% respectively) with less difference in the 20 to 24 age group (17% and 19% respectively) (see Fraser 2002). The 2003 SCS found this sex difference had reversed with more men than women reporting drug use in the last year in both age groups (27% and 20% respectively of 16 to 19 year-olds, and 33% and 25% respectively of 20 to 24 year-olds) (see Anderson and Frischer 1997; Murray and Harkins 2006).

Both the 2000 and 2003 SCS showed that cannabis was the most commonly used drug, with very small numbers of respondents reporting the use of any other. However, Corkery (2003) states that, in reality, heroin, crack and methadone are widely used – as is shown by the comparatively high numbers of deaths involving these drugs.

A superior data set comes from the University of Glasgow (self report studies such as from the Scottish Crime Survey notoriously under report drug misuse and drug users rarely complete

Table 1.2 Best estimates of numbers of people aged 16 to 24 in the population of England and Wales who had used selected drugs in the last year and the last month, 2000 and 2005/06 (thousands).

	Last year		Last month	
	2000	2005/06	2000	2005/06
Any cocaine	285	370	103	189
Cocaine powder	–	367	–	188
Crack	50	24	11	13
Heroin	46	10	18	4
Any Class A	533	526	275	251
Cannabis	1,503	1,338	959	810
Any drug	1,649	1,575	1,036	941

Source: Ramsay *et al.* 2001; Roe and Mann 2006.

questionnaires). The Centre for Drug Misuse, University of Glasgow, using a methodology which incorporated data from various sources including the police, has produced estimates of the prevalence of drug misuse in Scotland for the calendar year 2003, focusing on the 15 to 54 age group (Hay *et al.* 2005). They report that there were an estimated 51,582 individuals misusing opiates and/or benzodiazepines in the year 2003. This, they say, corresponds to 1.84% of the population aged between 15 and 54. The 95% confidence interval (CI) attached to the national estimate ranges from 51,456 to 56,379 (1,842.01%). The proportion estimated to be female is 31% and for males this is 69%. The age breakdown among males was 30% aged between 15 and 24, 45% between 25 and 34, and 25% aged between 35 and 54.

Somewhat surprisingly they found the highest prevalence of problem drug misuse within a DAAT area was in the Dundee City DAAT area, with a prevalence rate of 2.80% for those aged 15 to 54 (95% CI 2.51–3.22%), and not in Glasgow – although this was followed by Greater Glasgow with a prevalence of 2.64% for the 15 to 54 age range (95% CI 2.55–2.87%). In terms of drug injecting, it was estimated that 18,737 people were injecting opiates and/or benzodiazepines in 2003 (95% CI 17,731 to 20,289). The highest drug-injecting prevalence rates were identified in the Argyll & Clyde, Greater Glasgow and Grampian NHS Board areas; in each of these areas it was estimated that just under 1% of the population was injecting drugs (Hay *et al.* 2006).

Table 1.3 2003 Scottish Crime Survey: people reporting the use of selected drugs last year and last month by age (rounded percentages)

	Last year			Last month		
Aged:	16–59	16–19	20–24	16–59	16–19	20–24
Any cocaine	1	3	5	*	1	1
Crack	*	0	1	*	0	1
Heroin	*	0	1	*	0	1
Cannabis	8	21	25	5	14	15
Any drug	10	24	28	5	15	17

*less than 1%

Source: Murray and Harkins 2006.

To repeat an earlier point: these are the best available data in the UK and accordingly comparisons with data for England and Wales are not likely to be worthwhile.

Northern Ireland

The Northern Ireland Crime Surveys between 2001 and 2005 showed a significant drop in the proportion of 16 to 24 year-olds reporting any drug use last year or last month, largely accounted for by a drop in cannabis use (McMullan and Ruddy 2006; NACD and DAIRU 2003).

As in England, Wales and Scotland, cannabis was the drug most commonly used last year and last month in the 2001, 2003/04 and 2005 Northern Ireland surveys. Very few people of any age reported the use of cocaine, crack or heroin (Hague *et al.* 2000).

Estimates of the prevalence of problem drug use in England and Wales

Problem drug users are less likely to be reached by surveys of the general population because they may not be living in private households or, if they do, may not be willing to be interviewed. Sophisticated statistical methods (capture/recapture and multiple indicator) have been used to estimate the prevalence of 'problem drug use' in England in 2004/05 (Hay *et al.* 2006), and also in Scotland.

Problem drug use was defined as those who used opiates (heroin, methadone or other opiates) and/or crack cocaine. It was estimated that in 2004/05 there were 327,466 problem drug users in England and Wales, of whom 281,320 used an opiate drug and 192,999 used

Table 1.4 Northern Ireland Crime Survey: people reporting any drug use last year and last month by age, 2001–2005 (rounded percentages)

	Last year		Last month	
Aged:	16–59	16–24	16–59	16–24
2001	11	28	7	19
2003/04	10	24	6	16
2005	8	19	5	11

Source: McMullan and Ruddy 2006.

Table 1.5 2005 Northern Ireland Crime Survey: people reporting use of selected drugs last year and last month by age (rounded percentages)

	Last year		Last month	
Aged:	16–59	16–24	16–59	16–24
Cocaine	1	3	*	*
Crack	*	0	0	0
Heroin	*	1	0	0
Cannabis	6	16	3	9
Any drug	8	19	5	11
*less than 1%				

Source: McMullan and Ruddy 2006.

crack cocaine. Estimates of the number of problem drug users in the government office regions showed the highest number in London (74,417), followed by the North West (51,110), with the lowest number in the North East (15,853). In terms of population rates, London had the highest rate of 14 per 1,000 people, followed by the Northwest with 11 per 1,000 people, with the lowest rate in the South East at six per 1,000 people.

Prevalence of drug use by arrested people in England and Wales

The first nationally representative survey of drug use by arrestees in England and Wales was carried out in 2003/04 (Boreham *et al.* 2006). Since only 23% of eligible arrestees agreed to be interviewed or to provide oral fluid samples for analysis, these findings can only be

Table 1.6 Main drug of misuse by age at triage for NDTMS clients 2004/05*

Aged:	under 18		18 and over		Total**	
	N	%	N	%	N	%
Heroin	1,048	14	79,061	67	80,274	64
Other opiates	58	1	10,410	9	10,480	8
Cocaine	231	3	5,117	4	5,354	4
Crack	144	2	6,909	6	7,061	8
Cannabis	5,033	67	8,312	7	13,408	11
Other drugs***	994	13	8,178	7	8,455	7
Total (100%)	7,508		117,987		125,791	
Missing data	83		1,594		1,710	
Grand total	7,591		119,581		127,501	

*excludes clients treated in the North West Region
**includes 329 clients with no age recorded at triage
***includes solvents
Source: Statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2004 to 31 March 2005 (Table 4.3.1).

regarded as indicative. They showed that 57% of those interviewed reported having used a controlled drug in the last month, with 46% using cannabis, 18% using heroin and 10% using powder cocaine. The youngest age group was most likely to report use of cannabis in the last month (57% of 17 to 24 year-olds compared with 28% of the over 35 year-olds) and with similar figures for cocaine use (14% and 5% respectively). Heroin use in the last month was most common by 25 to 34 year-olds (28%) compared with 17 to 24 year-olds (15%) and those aged over 35 (10%). On a measure of drug dependence 85% of those who has used heroin in the last year were dependent, of those who had used crack 52% were dependent and of those who had used cocaine powder 23% were dependent.

Numbers of drug users in treatment in England

Between 1990 and 2001, information on drug users attending a drug treatment agency for the first time or after a break of six months or more was collected by regional drug misuse databases, and national (six-monthly) statistics of people 'starting agency episodes' were published by the Department of Health from March 1993 until March

2001. These figures replaced annual statistics taken from the Addicts Index of addicts notified by doctors to the Home Office for the first time (or renotified) that was published annually between 1973 and 1996.

On 1 April 2001, the regional drug misuse databases in England were replaced with the National Drug Treatment Monitoring System (NDTMS) which collects data on all clients in touch with drug treatment services in each of the government's regional office areas. Responsibility for managing the NDTMS was transferred from the Department of Health to the National Treatment Agency for Substance Misuse (NTA) in 2003. The NDTMS has implemented a monthly data collection process since 2005/06 and annual statistics are published (NTA 2006). In Wales, Scotland and Northern Ireland drug misuse databases continue to operate and six-monthly statistics are published.

In 2004/05 the NDTMS identified 160,453 clients attending drug treatment services. The median age of clients on 30 September 2004 was 30 years and men outnumbered women by almost 3 to 1. Two thirds of the clients aged under 18 reported cannabis as their main drug of misuse, while three quarters of those aged 18 or older reported heroin or another opiate drug as their main drug of misuse.

Estimates from data collected by the Regional Drug Misuse Databases from 2000/01 until 2002/03 and the National Drug Treatment Monitoring System for 2003/04 and 2004/05 of the number of individuals in contact with drug treatment services show that the numbers in contact with treatment services had more than doubled in this five-year period.

Table 1.7 Trends in the estimated or projected number of individuals in contact with drug treatment servides from 2001/01 to 2004/05

Year	Reported number	% increase from previous year
2000/01	99,000*	9
2001/02	116,000*	17
2002/03	115,500*	0
2003/04	125,545	9
2004/05	160,453	28
*estimated		

Source: Statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2004 to 31 March 2005 (Table 7.1).

An assessment

- Young people in England and Wales, Scotland and Northern Ireland aged 16 to 29 reported the highest level of drug misuse and 50% indicated they had taken a prohibited drug at some time. Only 25% of 16 to 29 year-olds had taken drugs within the last year, with just 16% having done so within the last month.
- Levels of drug misuse were relatively stable across England and Wales between 1994 and 1996. This stability generally persisted between 1996 and 1998. The overall level of drug use did not change between 1998 and 2000. However, there were some changes in the use of individual drugs.
- Cannabis was still the most widely consumed prohibited drug. There was a significant increase between 1996 and 1998 in the use of this drug by young men aged 16 to 29, whose prevalence rate for the last year had risen from 25% to 29%. However, this fell to 23% in 2000. The equivalent rate for females rose from 10% to 12%.
- There has been continued (but possibly decelerating) growth in the use of cocaine across all age groups, including 16 to 19 year-olds. Amongst this group, last year use increased from 1% in 1994 to 4% in 2000.
- The use of amphetamines, LSD and 'poppers' fell in 2000. Use of any drug by 16 to 19 year-olds fell from about one-third in 1994 to just over a quarter in 2000.
- Levels of use have remained fairly stable except amongst males aged 25 to 29, where there was a significant rise in 2000.
- In 2001/02 34% of 16 to 59-year olds reported they had used an illicit drug at some time and 12% in the last year (equating to around four million users). Last year use remained at this level in 2002/03. Cannabis was the most frequently used drug in the last year for this age group in both of these survey years (11%). Last year use of amphetamines, LSD, magic mushrooms and steroids has decreased significantly since 1998. Cocaine and crack use had increased significantly over the same time period, while ecstasy use had risen significantly up until 2001/02 but had fallen slightly in 2002/3.

- People aged 16 to 24 are significantly more likely to have used drugs in the last year and last month than older people. The use of Class A drugs by this age group has not changed significantly since 1994. Last year use of amphetamines, LSD, magic mushrooms, methadone and solvents has decreased significantly since 1998 – but cocaine and crack use has risen significantly. A fall in the use of ecstasy was noted in 2002/03.
- In 2001/02 the mean age of first use of cannabis was 15.5 years, compared to heroin at 17.4 and cocaine at 18.2.
- The 16 to 24 age group reported that cannabis was the easiest drug to obtain, followed by ecstasy, amphetamines and cocaine.
- The 2002/03 BCS estimated that 62% of 16 to 24 year-old drug users had used only one drug in the last year and nearly three-quarters had used just one drug in the last month. This is slightly lower than the rates for the survey sample as a whole.

In 1994 the BCS came up with what it described as 'best estimates' of the number of people aged 16 to 59 in England and Wales who had tried four specific substances (heroin, cocaine, cannabis and amphetamine) (see Ramsay and Percy 1997, Table 4.5).

An historical approach to theories linking drugs to crime

Michael Tonry (Tonry and Wilson 1990) says of American drug research that 'the literature is scant, much of it fugitive, the research community fragmented, and too much of the research is poor in quality and weak in design' (p. 2) He adds that for a number of central questions very little systematic knowledge is available from methodologically rigorous research (*ibid*. p. 2). If this is so of America, how much more is it so of Britain?

At this point I want to provide a brief overview of some of the major theoretical developments in the drugs crime scene before looking at part of the research in more detail in the next chapter. I should like to do this by relating these theories to a 40-year period, i.e. from about the mid 1960s to the present day.

Early British literature on drugs and crime was dominated by epidemiological considerations aimed at establishing the extent of drug use in a particular cohort, or showing that drug taking and crime go together, whether before or after the user is arrested. There

was little by way of theoretical development. The literature was mainly concerned with trying to determine what drug users were up to: establishing links with existing sociological theory or other theoretical propositions was much too heady. Occasionally the odd theory was offered – I remember in 1965 being particularly taken by one which linked drug taking to the aristocrats of eighteenth century France. It was founded on the presumption that a lack of social obligation led to experimentation. In eighteenth century France the nobility were financially independent and they eschewed any responsibility for the less fortunate. During that time experimentation developed in sexual practices, which in turn took the form of sado-masochism. Parallels were drawn with the drug users in Britain in the 1960s: they were economically independent, with few social obligations, and they likewise experimented, but this time with drugs not sex. I do not know how much credence I would now give to such a theory as it fails to account for the experimentation in drugs rather than elsewhere, but it was interesting nonetheless. It was one of the few attempts to explain the sudden increase in drug use, and then (as now) to try to account for its continued use.

Throughout the period under review, and speaking very generally, it is possible to see a number of stages – each dominated by a set of paradigms, each lasting about a decade. We can begin with the 1960s when drug taking first became recognised as a problem (although of course the Rolleston Committee had debated the matter in the 1920s), although drug use as we now know it began in about 1957 when some London clubs were frequented by cannabis users who openly proselytised its use (see Bean 1974). Joy Mott (1994) has described established heroin addicts in the London of the late 1950s and early 1960s as 'jazz junkies', who often came from comfortable middle-class homes and belonged to a drug-using subculture that shared an interest in jazz (many were musicians), art and poetry, and also identified with the United States addict subculture of the USA by using American drug argot. By the late 1960s London's heroin addicts were wheedling, cheating and extorting excessive supplies of heroin from their physicians, and selling any surplus to supplement their unemployment benefits, maintaining a style of life without work and consistent with the values of their subculture (Young 1971).

Explanations were then mainly concerned with the pathologies of the users, and they concentrated on heroin addicts. Here the psychiatric paradigm dominated, which was not surprising as this was the period of psychiatric dominance generally and psychiatric explanations were offered for all new and existing problems. (Britain was not alone

in this. Other countries appear to have followed a similar pattern – which is that in the first stages of a drug epidemic, psychiatric explanations overshadow all others.) Sociological explanations were rare in or around the late 1960s, and economic ones unheard of. Amongst psychiatrists (Freudian), psychoanalytical explanations often held sway, linking drug use to nascent experiences, to narcissism (through the process of injecting), or to other ontogenetic factors. Note that this was following the era when that type of psychiatric influence was at its height.

By the mid-1970s drug taking, or rather heroin addiction, began to arouse less attention although the number of users continued to increase. For example, the number of new addicts notified to the Home Office was 663 in 1967 and rose slightly to 984 in 1976. By 1986 this figure had risen five-fold to 5,325, and was to increase significantly again during the following decade to 18,281. This represents a 28-fold increase in 30 years. In spite of this mammoth increase the 1970s were the latency period, or simply the second period where little attention was given, sociologically or otherwise. If anything the drug taker was seen increasingly as the product of the deprivation of inner city poverty, drug taking was being transferred from psychopathology to a form of social pathology. Sometimes there was concern about alcohol use and glue sniffing, but heroin addicts remained the major preoccupation. In addition, there was a continuing debate about the role of cannabis and amphetamines as gateway drugs – that is, as drugs leading to heroin use. The other preoccupation, however, was of the over-prescribing physician as the supplier of drugs and especially of heroin. Treatment centres had just begun to open, in 1968, and the 'British system', which had earlier allowed any physician to prescribe maintenance doses to addicts, was now amended. Only licensed doctors/physicians could prescribe heroin as a maintenance drug (Spear 2002).

By the 1990s the emphasis had shifted again. Theoretical interest had broadened and a wider range of models began to emerge. Economic explanations also began to be offered. Slowly a socio-economic model emerged, underpinned by the premise that drugs were commodities that were bought and sold in markets and like other commodities governed by the laws of supply and demand. The economic market model emphasised the centrality of drug prices (Wagstaff and Maynard 1988). That is to say, it was recognised that price affects consumption whether in terms of the quantity consumed, who uses the drugs, or how the drugs are used (Reuter and Kleiman 1986; Caulkins and Reuter 1996). Price was also seen to

affect entry into treatment (i.e. the user enters treatment when he or she can no longer afford the drugs). Similarly, the incentive to remain in treatment may weaken if the price declines.

It was also recognised that the extent of use is also affected by price – e.g. reductions in the price of heroin in Britain have almost always led to a sharp increase in the numbers of users. Clearly, this model can be used also to explain other forms of criminality. For example, drugs have an enormously valuable per unit weight, allowing ease of transportation. If transactions are huge the incentives to protect those markets will likewise be huge. Caulkins and Reuter (*ibid*.) show how price also affects levels of corruption, whether of police or other authorities. High prices provide the incentive for corruption, and the incentives for organised crime are also affected by price and quantity (*ibid*. p. 1262).

The economic model is not a single model: in fact, it is not a model at all and more a paradigm of the type suggested above. There are numerous subdivisions within this model; for example there is a Marxist, a neo-Marxist, a socio-demographic, and a laissez-faire market model such as that offered by the Rand Corporation (*ibid*.) More recently others have emerged. Mike Hough (1996: 8) has identified three which he says have begun to dominate. They are

1. The *coping* model or self-medication model which tries to explain why drug misuse goes hand in hand with social deprivation. Drug taking is seen as a palliative to the poor quality of economic and social life.
2. The *structure* model which emphasises that those denied legitimate opportunity to achieve society's economic and social goals do so by achieving them through illegitimate routes.
3. The *status* model develops opportunity theory, identifying status and identity associated with economic exclusion. It identifies the positive social pay-offs from drug use in subcultures which respect anti-authoritarian macho, risk-taking and entrepreneurial activities.

These three models are neither mutually exclusive nor exhaustive. In the few years since Hough described them they have already become largely redundant having been superseded by new theories (of which eco systems theory and social capital are but two) alongside integrated theory, general theory and life course transitions

theory. Briefly, eco systems theory (which incidentally is more of an organising framework than a theory) calls for an active awareness that the interaction of biology, entrepreneurial relationships, culture, and legal, economic organisational and political forces affects an individual's behaviour (McBride *et al.* 2002: 14). Social capital theory is defined 'as the quality and depth of relationships between people in a family and community, or the stock of networks (relationships between individuals) that are used to produce goods and services in society' (*ibid*. p. 15). These new theories are in the early stages of development, with social capital likely to emerge as the dominant one.

Returning to the three models described by Hough, it is interesting that they have developed outside the main theories of the sociology of deviance and almost as if earlier theories had never existed. For example, control theory is not mentioned and nor is labelling or differential association. Neither is anomie, which for many years (at least up to the late 1960s) was the dominant theory of deviance (Merton 1957). In anomie theory, drug taking was a deviant adaptation to anomie and itself created as a mismatch between culture goals and legitimate means. That adaptation was described by Merton as 'retreatism', where the substance misuser (mainly alcoholism then) no longer accepted or strived for the culture goals of success nor accepted the legitimate means to achieve them. Anomie theory depicts the user as an escapist, a passive respondent to the world around him. This gave way to subcultural theory which in turn gave way to labelling theory where the user was either labelled as a drug user, (the important factor here being the manner in which the label was applied) or responded to and took on board the effect of the label. As I have said previously, it is surprising that none of these is mentioned in the listed theories above.[1]

Why should this be so? I suspect it is because those earlier sociological theories fail to consider the social reality of the drug user. Take for example the first model, the coping model. It emphasises the social and economic poverty that so often mars and blights drug users earlier lives. It shows how drug use is heavily concentrated in the deprived areas of cities, and although this is not exclusively so, it is often enough to be more than coincidental. That community is invariably a poor neighbourhood (Advisory Council on the Misuse of Drugs 1998). In her description of Bladon in north east England, Janet Foster (2000) portrays it as containing 'drug abuse and crime combined with a debilitating range of other social problems, high levels of truancy, poor health and pervasive unemployment (about

50%) where exclusion and deprivation are very much in evidence'. Her thesis is to link social exclusion and social deprivation to drug taking; a view that echoes other British studies but does not appear to resonate with those earlier sociological theories of deviance. Her solution? A more inclusive society – but in this she is pessimistic. She fears that many of Bladon's residents dare not hope for a better tomorrow, and for those accustomed to living on the margins it is for them a long and impossible path back (p. 327). Coping in this environment requires strength of character – for those who fail drug taking is the palliative they need in order to survive.

Consider the third model, which is closely associated with *structure* in that it emphasises the use of entrepreneurial skills and adds in the positive pay-offs associated with dealing. This model draws heavily on some carefully focused ethnographic descriptions of drug users which do not show the drug user as 'a man on his back'. Rather, they see him as an active participant in the life of the community who, if not a 'mover and shaker', then at least is someone who acquires status from drug dealing. The descriptions of local outbreaks of heroin use in the early to mid-1980s in some towns and cities in north west England (users started by smoking illicitly imported supplies which had not been previously available) provided strong evidence that economic factors rather than ideology, or the attractions of the addict subculture, played a large part in their development and created a stronger link with acquisitive crime. Heroin use was found to be most prevalent in the most socially and economically deprived areas with high rates of youthful unemployment, where the busy lifestyle of 'thieving and scoring' provided occupation during the long, workless days and user-dealers enjoyed considerable status (Pearson 1987; Parker 1988).

The defining research on this came from Preble and Casey (1969):

> Their behaviour is anything but an escape from life. They are actively engaged in meaningful activities and relationships seven days a week. The brief moments of euphoria after each administration of a small amount of heroin constitute a small fraction of their daily lives. The rest of the time they are aggressively pursuing a career that is exciting, challenging, adventurous, and rewarding. They are always on the move and must be alert, flexible, and resourceful. The surest way to identify heroin users in a slum neighbourhood is to observe the way people walk. The heroin user walks with a fast, purposeful stride, as if late for an important appointment – indeed he is. He

> is hustling trying to sell stolen goods, avoiding the police looking for a heroin dealer. He is in short taking care of business. (p. 14)

The key phrase here is 'taking care of business'. The heroin user, according to Preble and Casey, is busy and purposeful and an important figure to those who live in the drug areas of our cities. He has status, power and influence; certainly not a 'double failure' or someone to be ignored. There is empirical evidence to support this for the highest concentrations of drug abuse tend to be in rundown, derelict, inner city areas. Blotting out the awfulness and hopelessness is an understandable reaction and trying to assert and claim status, albeit through drug dealing, is an obvious reaction.

That, however, is only one aspect of the problem. How to explain the drug use of the more successful middle classes whose lives have not been economically and socially blighted? What of them? (See Ramsay and Spiller (1997), and the ACMD Report on drugs and the environment (1998).) Clearly, drug taking is not a palliative for them, or to the neverending stream of celebrities who appear daily at expensive treatment centres. Their lives are as different as could be. Must we then have different explanations based on class or status? Presumably yes, in which case we are back to that age-old problem in criminology – how to account for middle-class delinquency? No satisfactory theories exist to answer this question.

Creating distance from mainstream sociological theory may turn out to be an error: control theory, alongside others in the sociology of deviance, have much to contribute. Centring the debate on ethnography is too narrow, but that is the currently fashionable direction for research. In my view, we can take much from small ethnographic studies but they need to be set against others which take account of the natural history of the problem, i.e. longitudinal studies or those which are concerned with users' social development. I am thinking here of that earlier, and now much neglected, theory of Alfred Lindesmith who began with the central premise that addiction means the addict recognises his addiction. This recognition comes from an earlier acceptance that there are cravings for a drug (Lindesmith 1965). Lindesmith anchors his theory firmly in sociological territory, having no time for the current fashion to expand the definition of addiction to include dependency or habituation, or such matters as excessive gambling, in a definition of addiction.

In the next chapter I want to look more closely at the links with crime and give more attention to research which has tried to unravel the various strands of the drugs/crime nexus.

Note

1 The second of Hough's models, the structure model, can be said to be based loosely on an earlier theory derived from the Cloward and Ohlin thesis but in an amended form. It modifies or rather removes one of the main features of Cloward and Ohlin's argument, that of the emergence of the retreatist subculture. Cloward and Ohlin (1961) posited the user as facing two opportunity structures, the legitimate and illegitimate. In their terms the drug user fails at both; he is a double failure having failed as a non offender and as an offender. Drug abuse is the retreat from both opportunity structures. However, the structure model does not see the drug user as a double failure but someone who is still striving to achieve success goals, albeit by illegitimate means. He has not retreated; he may not be a successful entrepreneur in the legitimate sense but he is still trying to make it illegitimately. Indeed the very nature of modern drug markets is that buying and selling, along with 'hustling' in all its forms, are *sina qua non* of contemporary existence.

Chapter 2

Drugs and crime: theoretical assumptions

Introduction

Crime is one of, if not *the* major, attendant problems of drug misuse. At one level drugs and crime are linked if only because it is an offence to possess certain substances unlawfully. However, at another level, where drugs are said to cause, influence or be associated with crime, matters are less clear. For whilst there is considerable anecdotal evidence, aided by some research that drug use causes crime, the closer we get to establishing a causal connection, the more difficult things become.

If we are to make progress towards solving the drugs–crime problem we need to determine effective responses (Brownstein and Crossland 2002). That means developing an appropriate research agenda, and tackling the central issues of the drugs–crime link – or 'unpacking' it, to use the modern phrase. Is the link a matter of cause and effect or is it something more complex (*ibid*.: 1)? And in which direction does it go? Do drugs lead to crime, or crime to drugs? Or perhaps there is no connection after all and the one remains separate from the other?[1]

Confusion arises where there is a tendency to explain the drugs–crime nexus using terms that are too wide or that include a range of behaviours, some of which are criminal, some not. Or sometimes we simply settle for supposed commonsense explanations offered by the media. Consider two psychological explanations: one suggests criminality is as much a product of the drugs as the need for the drugs; and the other that drugs change the drug user's personality. In the first users are said to be 'enslaved' by the drug and, in the second, act in ways that are 'out of character' – i.e. behave in ways unlike anything before.

Where drug users are said to be 'enslaved', the assumption is of users being unable to offset the impact of the drug. Offences are committed with little or no control over actions or consideration for anyone, let alone the victim. 'Enslavement' means behaving in ways which satisfy the craving – which is close to a mild version of the economic necessity model. The second, the 'out of character' model, overlaps with the 'enslavement' model, for being 'out of character' means behaving in a different way than hitherto. It might involve abusing close family members, not showing concern about personal appearance or hygiene or committing offences to satisfy a habit. In extreme circumstances these offences may be over and above that needed to pay for the drugs (i.e. the user may become violent or damage property in a way alien to his or her erstwhile character).

In both models similar psychological mechanisms seem to be at work, except that the 'enslaved' users are more powerfully driven by the demand for the drug, whilst the 'out of character' user behaves in ways that may be highly unusual (this may or may not include crime). Unfortunately, being 'enslaved' or acting 'out of character' merely offers a series of character statements which permit only wide generalisations to be made. If 'enslaved', then is the drug user unable to exercise control over his or her behaviour and thus caught in an unwinding pattern as a prisoner of the drug? Or similarly for the 'out of character' drug user, how many crimes are committed as a direct result of this condition? Even if that could be established, will they always be of the same order, of the same amount and type irrespective of the drug user's previous experiences? How is there a causal (sufficient) connection between the drug and the criminality in these two models? And the answer is that it is difficult, almost impossible, to determine or establish such contingent influences. MacCoun *et al*. (2002) say that there is little evidence that drug use per se causes people to commit crime in some direct and unconditional manner, or that criminality per se causes someone to use drugs: 'The drug crime link varies across individuals, over time within an individual's development, across situations, and possibly over time periods (as a function of the dynamics of drug epidemics and, possibly drug control policies)' (p. 2).

Or consider the view, often portrayed by the media, that drug users commit crimes to fund their habit – not an unreasonable position and one with considerably more strength than being enslaved or acting out of character. Support for this comes from a number of studies. Ethnographic and longitudinal studies of drug-abusing criminals, many in the USA, show that high levels of drug use are associated with high levels of crime; similarly, low levels of drug use are associated with low levels of crime (Chaiken and Chaiken 1990: 235). Heroin users, more than any others,

conform to this pattern; less so for those using other drugs – except perhaps cocaine (*ibid*.). Moreover, predatory offenders persistently and frequently use large amounts of multiple types of drugs – i.e. polyaddicts or polyusers – and commit crimes at significantly higher rates over longer periods than less drug-involved criminals. Predatory offenders commit fewer crimes during periods in which they use no heroin (*ibid*.). An out-of-control male drug user is likely to commit between 80 and 100 serious property offences per year, or a female may resort to prostitution to pay for the drugs (*ibid*.).

Similarly in Britain, the National Criminal Intelligence Service (NCIS) estimate that, in 2001, the street market in crack cocaine was worth £1.8 billion. Users fund at least 48% of that (£864 million) by stealing goods which are sold on the black market for between 20 and 25% of their real value (i.e crack users are stealing at least £3.45 billion of property each year) (*Guardian* 22 May 2003). Other British studies give a similar picture. Studies of heroin users in Merseyside show how burglary rates increase when heroin use increases (Parker and Newcombe 1987). The Shadow Home Secretary in 1996 produced evidence which he subsequently used to introduce the Drug Treatment and Testing Order (or DTTO), showing that the growth in the rate of crime was accompanied by a similar growth in the rate of substance abuse (Labour Party 1996).

Yet matters are not so clear cut. Most drug users are not otherwise criminally active, and the vast majority of drug-using incidents neither cause nor accompany other forms of criminality (MacCoun *et al*. 2002). Large numbers of drug users do not commit property offences and have no convictions except perhaps for illegal possession. The use of illicit drugs does not appear to cause (sufficient condition) participation in predatory crime. Moreover, that some drug users *are* criminal should not lead to the conclusion that they are criminal because of their drug use. Some offenders might commit more crimes as a result of their drug use – and this would be a reasonable conclusion to draw – but how many and which offences are causally (sufficiently) linked cannot be known (see particularly Hammersley *et al*. 1989 for a useful discussion on this). Similarly, some otherwise non-offenders might be drawn into committing offences, and some offenders drawn to non-offending. It is reasonable to infer there are links with drug taking and crime (necessary conditions) but what they are, how they affect crime rates and how offending might be reduced are not always easy to establish.

One of the many problems is that self-report studies support the idea that crime is committed to fund a habit. Offenders will often say they committed their crime to feed their habit, implying that, were they not drug users, they would not be offenders. But many were burglars

anyway. The question is how to disaggregate the crimes committed *qua* offending and the crimes committed because of drug taking. What is required, and almost impossible to achieve, is a means by which those offences committed as a result of drug taking could be separated from those which would have been committed anyway. Drug users might believe, or want us to believe, their claims that they were somehow forced into criminality to fund their habit. This might produce a less serious condemnation. They might even suggest the fault lies elsewhere – e.g. with the government for not making drugs legal or with the dealer for raising the prices. (This incidentally might turn out to be a risky strategy which could backfire with an unsympathetic judge or magistrate and lead to a longer spell in prison. None the less, some offenders might see this as a useful ploy.) Their aim would be to convince all and sundry that they committed offences only because of their habit, not because they were burglars or whatever.

Also, most studies go no further than establishing a correlation or say that drug use is *associated* with criminality. For example, in Trevor Bennett's research offenders seen at the police station often tested positive for drugs (Bennett 1998). Or as with Chaiken and Chaiken (1990: 231), drug addicts who have entered treatment commit fewer crimes during the period of treatment than when they were addicted. In both cases there is a statistical correlation which, in the latter study, is rather more pronounced than in the former, but even so it is not a causal connection.

To establish a cause, or to say an event has a cause, is to establish that there are universal laws which, together with statements about initial conditions prevailing at particular times, will, when taken together, allow a prediction to be made. That prediction will be of an event called an effect. So, under certain conditions water will freeze and, given that those conditions exist, we can predict the effect of temperature upon water. Here we have a typical causal relationship and those conditions are regarded as sufficient to explain the event. It is also a causal explanation (Benn and Peters 1975: 199).

Social scientists talk of 'links' with crime or create the impression of the user being trapped in certain social or psychological circumstances so that no other course is open, either to become a drug user or, when that is so, to become an offender. It is better to offer something less deterministic – that is, use the term 'cause' in its weakest sense where there are no sufficient conditions but there may be necessary ones. So to say drugs cause crime would be to say drug use is associated with criminal behaviour.

Little has been said of some of the methodological problems within drug research which should lead to even greater levels of caution when

it comes to interpreting results. For example, rarely do the studies have a control group of non-drug users to make comparisons. A lack of a control group is a common failing in drug research, linked incidentally to another failing – the small sample size. Studies involving interviews with 20 or 30 drug users are commonplace. Too often samples are taken from offender populations, so it is likely that criminality features heavily in the results and equally likely that criminality could be seen as being caused by the drug abuse. Were the samples to be taken from a non- offender group, say 'clubbers', then criminality would be less prominent (Release 1998).

There is evidence to suggest that some types of drugs are more associated with crime than others, but that might have more to do with the background and personal circumstances of the user than anything else. For example, whilst there are links with alcohol and crime (Mott 1987), ecstasy (MDMA) use is not usually associated with crime. This may be due to the sociodemographic features of the population taking it – i.e. ecstasy users are more likely to be occasional drug users, to be employed, of higher social class and are not multiple drug users (i.e. taking similar types of drugs but not the heavy end of the drug scene). Nor are they likely to have a criminal history or a subsequent criminal career. This in contrast to the heroin user, who is usually working class, unemployed (probably unemployable having never had a job), homeless and a polyaddict (taking heavy amounts of all drugs, including cocaine). Drugs and crime are strongly associated with this group, especially if a street user, but, again, their sociodemographic background puts them at a higher risk of criminality in the first place.

To summarise: all this suggests that we should be wary of trying to establish causal (sufficient) links of the type which state that those who take drugs are compelled in some way to commit crime. At best the term 'cause' can be used as a necessary condition offering a weak form of explanation, which does not imply much more than a statistical correlation or association. Moreover, extracting causal explanations (of whatever sort) from the available data is a risky business given that we know so little about the types of behaviour we are examining, whether before or after drug taking. The general conclusion, therefore, of over four decades of research on the relationship between drugs and crime is that, whilst there is a clear and significant statistical relationship, causal connections are more difficult to establish (McBride *et al.* 2002).

The three major explanatory models

There are three major models that examine the drugs–crime link. That:

1 drug use leads to crime;
2 crime leads to drug use; and
3 drug use and crimes have a common aetiology.

Although of interest academically these models also have important practical consequences. If drugs cause crime (or lead to crime, for these purposes the distinction is of less importance) then treatment for drug abuse should be expected to lead to a reduction in crime rates. Conversely if crime causes drug abuse then drug treatment will not affect crime rates, in which case the appropriate response is to treat the criminality. And if drugs and crime are not linked then treatment (or punishment) will not necessarily result in a reduction of the other as neither addresses the behaviours.

1. *Drugs cause crime*

This first model (i.e. that drugs cause crime) is the most popular, whether in the media or elsewhere. Sometimes the relationship is presented in direct causal terms, sometimes more by association. MacCoun *et al*. (2002) argue that the link is now so strong in the public mind it will be difficult to dislodge it. They say there is considerable research evidence in the USA, Britain and Europe to support it but no conclusive evidence of a direct causal link and, as will be shown later, other explanatory models retain their influence.

Four major studies have been selected to provide a background to this model:

1 The Criminal Justice and Court Services Act 2000 gave the police the power to test detainees in police custody and courts the power to order the drug testing of offenders under the supervision of the probation service. The testing was restricted to heroin and cocaine and in three sites throughout the UK. In total 1,835 tests were undertaken: the positive test results were London (Hackney) 63%; Nottingham 58%; Stafford and Cannock 47%. For those on probation (106 individuals), over half tested positive (Mallender *et al*. 2002).

2 The study by Trevor Bennett and Rae Sibbitt between 1997 and 1999 in two sites in England entitled *Drug Use among Arrestees* (2000) showed that 69% tested positive for at least one drug (excluding alcohol), with 29% testing positive for opiates and 20% for cocaine.

3 A later study, the NEW-ADAM programme (New English and Welsh Drug Abuse Monitoring), was designed to investigate drug use

among arrestees currently held in police custody sites in 16 locations in England and Wales. It showed similar results (Bennett 2000).

4 Joy Mott for the Home Office examined the proportion of acquisitive crimes which could be attributed to dependent heroin users in England and Wales in 1987; she said this was between 6 and 24% of all burglaries; between 6 and 22% of all thefts; and between 0.8 and 8% of all shoplifting offences. Using this methodology, the government estimated that the costs of all acquisitive crime committed by drug users was, for 1992, between £58 million and £864 million (Mott 1992).

Other studies elsewhere show roughly similar results. For example, in the Drug Use Monitoring programme (DUMA) in Australia, Makkai and McGregor (2002) looked at those users detained and brought to a police station. The data taken from four sites refer to about 2,000 detainees. These show that 57% had a prior arrest in the past 12 months, excluding the current arrest and, of those, 52% tested positive for heroin, amphetamine or cocaine. In terms of imprisonment, 20% had been in prison in the last 12 months and of these 59% tested positive to heroin, amphetamine or cocaine.

However, when one looks more closely at these studies, or most others for that matter, the position is less clear cut. In a later survey with a sample size of 5,440 (males 4,472; females 421), 3,141 provided a urine sample. Toni Makkai (2002) found that the extent of drug use varied enormously for, whilst over two thirds had tried a 'hard' drug, around 60% had not used any drug in the past 30 days, nor did they test positive, and 70% said they were not dependent. The initial conclusions of the study are that not all offenders use illicit drugs, not all offenders who use illicit drugs are dependent, not all dependent offenders necessarily commit crime to support a drug habit and illicit use varies by location (i.e. by drug markets across different sites) and across time (Makkai 2002 pers. comm.).

These factors have implications for an evidence-based policy and drug/crime prevention strategies. To have prevention strategies, it is necessary to know who is the target and what is to be achieved. Is the aim to reduce all crime or specific crime? Or just drug-related crime? Targets may be different in different places; they may change, and new ones may emerge.

Paul Goldstein (1985) has provided a tripartite framework for analysing the drugs–violence connection, but it can be adapted to fit other crimes. It has been described as 'a boon to research reviewers – it is invaluable as an organising scheme' (MacCoun *et al*. 2002: 4). Even so, the number

of studies using this framework is small: 'We are struck by the relative rarity of actual empirical applications' (*ibid*.). None the less, the Goldstein framework provides a taxonomic scheme, which can be expanded and refined without changing the basic elements. The three features are as follows:

1 *Psychopharmacological*: crime due to the direct acute effects of a psychoactive drug on the user.
2 *Economic-compulsive*: crime committed intermittently to generate money to purchase drugs.
3 *Systemic*: crime associated with the marketing of illicit drugs, such as disputes over contracts, territory, markets, etc.

Goldstein *et al*. (1992) applied the framework to homicides in New York in 1984 and 1988. In 1984, before the onset of the crack epidemic, they found that 42% of homicides were drug related. After the crack epidemic it had risen to 53% (out of 414). In terms of the features listed above, Goldstein *et al*. found in 1984 that 59% of the homicides were classified as psychopharmacological, 3% were economic-compulsive and 21% systemic. In 1988 this had changed to 14% psychopharmacological, 4% economic-compulsive and a massive 74% systemic. Almost certainly changes in the nature and composition of the markets account for the differences – but so too might the geography, as the study area changed from New York State to New York City. Some critics have complained that the Goldstein categories are not mutually exclusive (Parker and Auerhahn 1998), and say the framework is 'not … a set of testable propositions but … a set of assumptions about the nature of drug and drug related [crime]'. Others see it as providing one of the most useful ways of analysing the 'drugs leads to crime' model (Bean 2001a).

The Goldstein model is not free of notions of causality – there is an implication that drugs lead to crime. It none the less allows assessments to be made of varying crimes and provides guidance for future research. There are three parts to the framework or, in Goldstein's terms, there are three possible ways in which drugs and crime are related: the psychopharmacological, the economically compulsive and the systemic. These are ideal types and, whilst recognising that they may overlap, Goldstein believes this does not detract from their heuristic value. These ideal types are largely derived from role theory, although not acknowledged by Goldstein as such, and presumably are not exhaustive; others could be added as and when required.

Psychopharmacological crime

Looking at the three features in turn and dealing first with psychopharmacological crime (which accounted for 59% of homicides in 1984 and 14% in 1988 in New York), this category covers those crimes which result from the ingestion of specific substances where the user may become excitable, irrational or exhibit criminal (violent) behaviour. For homicides, Goldstein regards the most relevant substances as alcohol, stimulants, barbiturates and PCP, recognising too that heroin or cocaine may also be relevant.

Whilst it is important to include these psychopharmacological effects, it is not easy to determine their impact. The drugs, the need to raise money to buy drugs or the nature of illicit markets may stimulate or augment a great deal of criminal behaviour. But this is a long way from saying the drug causes the crime. The prevailing view, according to MacCoun *et al*. (2002), is that, where crimes exist, and we are talking mostly of violence, violence is attributable more to alcohol than illicit drugs. They note that Goldstein rated only 14% of drug-related homicides as psychopharmacological in 1988, but add that even so 'one in seven is hardly a trivial fraction' (p. 6).

Again, the question centres on the term 'cause'. Whilst MacCoun *et al*. (2002) say that 'no drug may be sufficient to produce aggression in isolation from psychological and situational factors, [none the less] some drugs such as alcohol can amplify the psychological and situational facilitators of aggression' (p. 6). Others, however, are more circumspect. Jeffrey Fagan (1990: 243) noted that the link between intoxication and aggression is less certain:

> Research on the nexus of aggression and substance use has consistently found a complex relationship mediated by personality and expectancy factors, situational factors and socio-cultural factors that channel the arousal effects of substance use into behaviour types which may or may not involve personal aggression ... Accordingly, there is only a limited evidence that consumption of alcohol, cocaine, heroin or other substances is a direct pharmacologically based cause of crime.

Others agree. Parker and Auerhahn (1998: 306) say that 'Our review of the literature finds a great deal of evidence that the social environment is a much more powerful contributor to the outcome of violent behaviour than are pharmacological factors'. Brownstein and Goldstein (1990), however, list case histories where they claim the connection is more

certain. These include domestic disputes, such as a boyfriend/husband killing a girlfriend/wife or vice versa where the assailant had been high on cannabis or cocaine. Others, such as family members or neighbours, may also be part of that dispute. A few involved killing a complete stranger as with the case of 'a 38 year old white man who was causing problems in a bar. He had been kicked out repeatedly. After the fourth time he returned with a handgun and fired shots into the bar. A 27 year old white man, an innocent bystander, was shot and killed' (*ibid*.: 180).

A major problem in identifying the impact of a single drug is that multiple use is common. It is clear, too, that the extent of violence is affected by the amounts consumed, the patterns of use, the length of use and the psychological condition of the user (Bean 2001a: 226). With alcohol, those with a history of violence will need only small amounts for high levels of violence to occur. Stimulant drugs (such as amphetamines) produce different effects according to different doses. Low-level doses, often found in ecstasy users (MDMA), tend not to produce violent or aggressive behaviour but, with other amphetamines, low-level doses produce increased levels of competition. High-level doses, on the other hand, can produce psychosis and violence but, again, this depends on the user's personal history: those with a violent history or unstable personality tend to be more violent after chronic stimulant use (see also Fagan 1990).[2]

Cocaine is often taken with heroin, making its effects difficult to determine. None the less its impact has been the subject of much debate. It was noticed in Nottingham in 1993 whilst conducting research into cocaine supply systems that the researchers were often told that some local 'pimps' had given up using cocaine as it made them too violent (Bean 1995a). Goldstein (1985) says users describe the cocaine 'crash' (going down from the high) as a period of anxiety and depression in which external stimuli may be reacted to in a violent form. However, other studies (Reiss and Roth 1993: 194) report no difference in the frequency of violent acts between institutionalised cocaine users and violent patients.

The hallucinogenic group, which includes cannabis and LSD, is clinically diverse. These drugs have received considerable attention. Five major reviews of the research literature on cannabis concluded that violent behaviour either decreased or was unaffected by use. In animal studies, acute doses promote submissiveness or flight, and large doses inhibit attack or threatening behaviour (Reiss and Roth 1993). LSD does not appear to trigger violent behaviour but it can aggravate the effects of a pre-existing pathology, which can promote violent outbursts in those already prone to violence (Bean 2001: 227).

Morphine, heroin and other opiates appear to reduce aggression and violent behaviour, albeit temporarily and in the early stages of use. Again, it is difficult to identify the impact of a single drug such as heroin, which is often taken with others such as cocaine. Users who are in various stages of withdrawal are, however, prone to violence and are demanding and threatening. They seek money or drugs to ward off withdrawal symptoms.

Fagan (1993) sees violence as occurring when the substances produce change or impair cognition, when they intensify states or when they disrupt hormonal or psychological functions that motivate or restrain violence. However, these studies cannot be considered in isolation. Some of the violence is ritualistic; where alcohol is consumed in settings that give approval to male violence, violent incidents become part of a considered demonstration of masculine authority. Moreover, not all who take alcohol become violent, even in those settings where violence is approved. Most alcohol consumption is socially functional, achieving the desired convivial non-criminal results. The research emphasis should be on locations and contexts: 'This analytical focus shifts attention from persons to events, and emphasises locations as the critical intervening construct in the occurrence of violence' (*ibid.:* 76).

Teasing out the situational and social factors – examining the events in which crimes occur (which may involve ways in which some people turn away from a potentially violent situation while others do not) – is one way forward (Mott 1987). Psychopharmacological effects may turn out to be less important; violence and other crimes may be contrived and not the result of the drug's effects. Some researchers believe that the evidence for the psychopharmacological effects of alcohol on crime is much higher than for other drugs (Pihl and Peterson 1995 cited in McBride *et al*. 2002: 8), but this may be an artefact, as this type of research has been more extensive. Goldstein (1995) says that the psychopharmacological model suggests that some individuals, as a result of short or long-term ingestion of specific substances, may become excitable and irrational and may exhibit violent behaviour. He regards the most relevant substances as alcohol, stimulants, barbiturates and PCP – although he recognises that others (such as cocaine and heroin) could be added, heroin being of relevance during the period of withdrawal. Goldstein (*ibid*.) says it is impossible to assess the extent of psychological violence because most cases go unreported or, if reported, then no record is made of the physical or psychological state of the offender. He believes that victims 'can be just about anybody' as this type of violence 'occurs in the home, on the streets, in the workplace, in bars and so on' (*ibid*.: 257).

Although Goldstein restricts this model to the study of violence, it can

include other offences. For example, the psychopharmacological impact of a substance can presumably lead to offences such as vandalism or to other property offences. Or it could lead to a mental disorder (the problem of dual diagnosis is a real one; see Bean 1998) which, in turn, could lead to other deviant activities, including crime.

Interestingly, Goldstein (1995: 256) sees drug use as 'having a reverse psychopharmacological effect by being able to ameliorate violent tendencies'; that is, acting as a crime reduction agent. Heroin and other tranquillisers dampen down violent impulses or make it difficult to commit property offences whilst under the influence of the drugs. Heroin typically produces a soporific effect – 'going on the nod' is how the users describe it. It removes aggressive impulses and takes away initiatives. Goldstein does not give examples or cite evidence of the impact of drugs on crime rates or how often the so-called reverse psychopharmacological effect operates, but its impact is likely to be small. It is also likely to be offset by the violence commonly associated with the withdrawal stage of addiction where the urgency to obtain supplies can easily lead to further crime – e.g. property offences or violence, domestic or otherwise. (Goldstein (*ibid.*) gives examples of prostitutes in the withdrawal stage robbing potential clients of their money to purchase sufficient heroin to 'get straight'.)

Goldstein also talks of victim-precipitated psychopharmacological crime: drug use may alter a person's behaviour in such a manner as to bring about victimisation. For example, the alcohol-intoxicated man or woman may have his or her wallet or purse stolen by being an easy target for street property offenders, the drugged pedestrian may become a victim of the dangerous driver or the drugged/drunken householder may leave his or her property unattended, thereby encouraging or assisting the burglar. These and numerous other examples illustrate the general point that drugs or alcohol can promote high rates of victimisation.

Economic-compulsive crime

The more common and publicly accepted feature of the 'drugs lead to crime' link is the so-called economic-compulsive model. Here drug users are said to engage in economically motivated crime in order to support an expensive drug habit (Goldstein 1995: 257). As heroin and cocaine are the most expensive drugs, so they produce the greatest pressure on the users – one of them, heroin, is addictive, and the other (cocaine) produces intense pleasure that adds to that pressure.

Popular perceptions of the links between drugs and crime support Goldstein's thesis. Evidence from the British Crime Survey (BCS) shows that more people see drugs as the main cause of crime; poor parental

discipline came second. The Home Office requested the Office for National Statistics to include questions on perceptions of illegal drug misuse and drug-related crime in their February 1997 Omnibus Survey (Charles 1998). Random samples of 1,585 people aged 16 years or over were interviewed in England. They were asked how much of a problem they felt illegal drug use and drug-related crime to be, whether locally or nationally. Drug-related crime included stealing to buy drugs, offering drugs for sale and committing crimes under the influence of drugs. In the sample, 23% saw drugs as the main cause of crime – slightly higher for those living in the north of England (25%) than in the south (21%) (Ramsey and Percy 1996).

The Home Office findings (*ibid*.) show that a third of those questioned said they or a number of their household had been the victim of a property crime in the previous two years. Of those who had been victimised, 15% believed they were the victims of a drug-related crime, but 26% were not sure. It is not clear how victims came to this conclusion as few could have had direct contact with an offender or could have known of his or her drug habits, but this was the general perception of the causes of crime. Moreover, about a third of respondents felt that stealing for drugs was a 'very big' or 'fairly high' problem in their local area (*ibid*.: 3) – but, again, how could they know this? Perceptions of the causes of property crime remained steady: 29% in 1997 compared with 28% in 1996.

These perceptions find support in research. For example, what we know of property offences generally and burglary in particular is that the offenders rarely move out of their own neighbourhood. Areas with high drug abuse will mean that the drug users who commit offences do so against those living in their immediate locality – and that includes other drug users. In our Nottingham study we found that drug users were active burglars, but were just as often victims of burglary (Bean and Wilkinson 1988). They stole from others and were stolen from. Similarly, Trevor Bennett (1998) found that nearly half the arrestees who reported taking drugs within the last year said their drug use was connected to their offending. Amongst the various factors emphasised was the need for money to buy drugs, where an estimated 32% of all income was spent on purchasing heroin or crack cocaine. Coid *et al*. (2000) also note that most subjects in their study (85%) reported that they committed offences to buy drugs, the most common offences being shoplifting, fraud, deception and drug dealing. Following treatment, theft decreased by 52% and those who spent longest in treatment showed the greatest reduction in daily expenditure on illicit drugs.

Joy Mott for the Home Office (1987) estimated the proportion of various types of acquisitive crime attributed to heroin users in England and Wales in 1987 to be between 6 and 24% of all burglaries, between 6 and

23% of thefts from the person and between 0.6 and 8% of all shoplifting. These calculations were based on a tentative set of assumptions – for example, about the number of heroin users at the time, the frequency of offending, the extent of their habit, etc. Small changes to these parameters would affect substantially the final figures – if the extent of the drugs used is greater or less than estimated, the rate of burglaries will change accordingly. Mott kept the confidence intervals wide, and rightly so (1987; see also ACMD 1994).

Some authorities (MacCoun *et al*. 2002) suggest that the commonsense understanding and interpretation of economic compulsive crime ought to evolve as a greater level of understanding develops. They think the simple notion that the demand for the drug automatically leads to a property crime is at last being challenged. For example, Lesner (1997: 45–6 cited in MacCoun *et al*.) puts the assumptions this way: 'The more dramatic the physical withdrawal symptoms, the more serious or dangerous the drug must be. This thinking is outdated.' Lesner goes on to say that many of the addictive and dangerous drugs do not produce severe physical symptoms upon withdrawal. What is important is whether the drug promotes compulsive drug seeking and use, even in the face of negative health and consequences. Yet, even so, users of a drug such as heroin which, on the face of it, would appear to promote 'compulsive drug seeking and use, etc.' are not insensitive to price and are not wholly enslaved by the drug. Peter Reuter and Mark Kleiman have shown that heroin use is not subject to an inelastic demand – that is, price increases can reduce daily consumption and lead to a proportionate reduction in intake (1986: 300). If addicts were relatively insensitive to price, price increases would expect to produce increased levels of economic–compulsive crime. Yet Reuter and Kleiman show that the elasticity of demand for heroin is about –1 for heavy users, and even then some heavy users cease consumption with a change in price.

The quotation above emphasises the importance of heroin addiction – which includes other narcotics. Research results suggest that crime rates, including those for robbery, are higher once the offender is a regular user or is addicted to heroin. Data supporting this version of the drug–crime link are conclusive, especially for street heroin users. The crime rate drops dramatically once the user enters treatment. Chaiken and Chaiken (1990) report that crime rates are strongly related to addiction; non-addicted users commit fewer crimes, yet street heroin users commit the most. Inciardi's study of drug-abusing populations (1991) also shows that narcotic users commit more robberies per year than other drug users. If we include crack dealing, Inciardi says that 'those more proximal to the crack distribution were more involved in violent crime, especially the

dealers'. Anglin and Hser (1990) reviewed the literature and showed that the frequency of criminal activity tends to vary with periods of intense use. Addicts significantly reduce their criminality during periods of methadone maintenance.

Goldstein *et al*. (1991), however, produce much lower figures. They see economic crime as consisting of only about 2% of the drug-related crimes. In their study of 414 homicides in New York, 8% were classified as psychopharmacological and only 2% economic. However, the criteria used were more stringent than most. For example, they did not include a robbery of drugs from a dealer in which the user and dealer were killed. This was seen as systemic crime (i.e. about crimes within drug markets). This low rate of economic crime is extraordinary, although Reiss and Roth (1993: 200) report that there were differences between the assessment by the police and the researchers in this study, the police regarding more crime as economic.

Almost certainly offenders help to promote the view that they commit offences to buy drugs, and their explanation (or excuse, depending on how one sees it) has been largely accepted. Differences, however, are not just of passing interest: if criminal justice policy is based on the assumption that economic factors are the major driving force, and they are not, then resources will be directed inappropriately. These perceptions have been bolstered by the media – and media comments have often been copied by the drug users themselves to justify their own activities. MacCoun *et al*. (2002: 10) put it this way: 'Arrested and incarcerated offenders report that they committed their offences to raise money to purchase drugs. Of course this might be a convenient rationalisation or excuse for anti-social behaviour.' They go on to ask 'Should we believe them?' And the reply is that 'At least for heroin addiction the answer is probably yes' (p. 10).

Linking drugs to crime through an economic necessity model would appear to be rather more difficult than it seems. It is all too easy to slip into the criminal addict paradigm and accept media-type interpretations of behaviour. As Korf *et al*. say (1998: 4), 'The familiar theory that addiction to illicit drugs inevitably leads to property crime therefore does not hold water'. Many drug users do not have a history of criminal behaviour prior to drug use and many do not commit crimes after drug use, and after heroin use. Future studies may reveal the amount of crimes committed by drug users (other than drug dealing or illicit use), and may find it is lower than described in conventional and popular media circles. More likely, research will show a normal distribution with a bell-shaped curve where a few users at one end commit many crimes – almost certainly the street heroin addicts – and an equal number at the other end who commit none. Those in the middle, comprising the bulk of the users, commit

relatively few crimes. This bell-shaped curve could, it is hypothesised, be for all drugs, not just heroin.

Systemic crime

Systemic crime arises out of drug markets and drug distribution networks. It occurs mainly between dealers and users but extends into other areas such as police corruption. Goldstein (1985) regards systemic crime as the most common. He refers to systemic crime in a narrow way, interpreting it as involving struggles for competitive advantage. In contrast, MacCoun *et al*. (2002) see it more generally, as the way markets generate crime which, they say, occurs in a variety of ways and over time and place (p. 12). The wider definition seems more appropriate: it opens up new ways of thinking and a corresponding range of new opportunities for research on the pervasive impact of the drug problem. An interesting avenue would be to determine how and why systemic crime varies between drug markets, and between drug markets for different drugs and in different cities (cannabis markets, for example, tend to be less violent).

Reiss and Roth (1993: 202) say systemic crime can take three distinct paths, but to these might be added a fourth which can include money laundering, or what can be called secondary forms of systemic crime. These are as follows:

1 Organisational crime, which involves territorial disputes over drug distribution rights, the enforcement of organisation rules, informers and battles with police.
2 Transaction-related crime, which involves theft of drugs or monies from the buyer or seller, debt collection and the resolution of disputes over the quality of drugs.
3 Third-party-related crime, which involves bystanders to drug disputes in related markets such as prostitution, protection or firearms.
4 Secondary forms, which are a consequence of the development and growth of drug markets.

Studies of organisational crime are rare, especially outside the USA. Organisational crime involves territorial disputes over drug distribution rights, the enforcement of organisational rules (such as prohibitions against drug use whilst selling or trafficking), battles with the police and the punishment of informers or anti-drug vigilantes (questions surrounding informers are dealt with below). Crime in drugs markets

with high profit levels where few skills are required to enter as an entrepreneur, and where the ease of transportation of a commodity that has an enormously valuable per-unit weight is likely to be attractive at whatever level. The protection of those markets requires high levels of corruption, whether of senior politicians, business people or low-level bank tellers. It also requires organisational skills to hold on to that part of the market in which they operate. The tensions within that market are always likely to make it unstable. One senior British police officer notes how the drug scene is imbued with treachery; the problem for the police is not to obtain information but to cope with the enormous amount given to them by dealers informing on other dealers (Grieve 1992). Levels of violence associated with the cocaine market greatly exceed those for other drug markets. Whether this is a result of a tradition of violence emanating from South America no one knows.

Secondly there is transaction crime. This refers to crime involving interpersonal relationships between dealer and dealer, or dealer and user. Drugs, like any other commodity, are bought and sold in markets (Bean 2002: 124). There are, of course, differences: unlike most other commodities, drug markets are characterised by a high degree of immeasurable risk, by the inability to enforce contracts in a court of law and by a lack of quality control of the product (Rydell *et al.* 1996). Drugs markets operate without the usual protections offered by the civil tort or court system. The state, instead of attempting to facilitate transactions, aims to disrupt them. Yet within those markets debts need to be collected and property rights need to be established, alongside countless other arrangements that need to be undertaken in any business transaction. Dealers have to secure financial transactions in an otherwise crooked world, with no one else to enforce the contracts. Protecting these transactions takes up most of their time.

Most will find it necessary to employ those familiar with intimidation or violence in order to collect debts and enforce discipline. Dorn *et al.* (1992) describe how a new breed of criminal was attracted to the drugs world. Whether this was a new breed or an old breed attracted by the possibility of offering their services is not known. Whatever the reason, the overall effect is to make drugs markets violent places where dealers become more frightened of other dealers than of the police. Dealers collect debts in a number of ways: one is to use violence; another is by burglary, where they take from other dealers or users to pay off their debts (Bean and Wilkinson 1988). The easy recourse to violence was a *sine qua non* of all dealings, for disciplines had to be asserted and debts collected – the system ran on some sort of credit which needed to be overhauled at regular intervals.

Third-party-related crime is less common. There are also very few studies of this type of crime, but prostitution and protection rackets, etc. are common to all drugs markets without necessarily being part of them. How and under what circumstances they mesh into the system is far from understood, but it is thought that they operate at the perimeter and may well be more important in the scheme of things than is believed.

The fourth type of systemic crime is less directly concerned with the operation of the drugs trade but remains dependent on it. Important forms of this type of crime include police corruption, especially when associated with informers (Clarke 2001). Police corruption may take many forms and develop in different ways, but it always includes personal gain for the officers. It may occur when the police decide not to enforce drugs laws or not prosecute drug offenders. Or it may occur where police officers become dealers or assist other dealers. Police corruption is likely to flourish where the police work with informers, where quantities of drugs are available and where informers are granted 'a licence to deal' in return for information (Skolnick 1967; Bean 2001c). Skolnick (1967) reminds us that, whilst the police can arrest drug users by cruising in unmarked cars looking for those tell tale signs of dealing, the apprehension of one small-time dealer does not constitute a good 'bust' (pp. 120–1). The police officer wants Mr Big and for that he or she needs the help of informers. These informers come from the addict populations, consume large quantities of heroin and are invariably unstable. The best informers are paradoxically the most heavily involved in crime, for they then know the local drugs scene. Handling these informers is a skilful operation requiring delicate judgement. It requires the police officer to know how far the informers should be allowed to go, criminally speaking, and at what point the informer should be 'busted'.

Money laundering is part of this secondary crime. It is defined as the concealment of illicit income and its conversion to other assets to disguise its source or use (Bean 2001a: 112). Drugs and money are but two sides of the same coin – a point increasingly recognised by governments. Money laundering and the police use of informers are discussed elsewhere; they are mentioned here for completeness sake.

A note on violence

Goldstein (1995) was particularly concerned with violent offenders where, he says, research has consistently found strong connections between drugs and violence (p. 255). For these purposes, violence can be defined as behaviour by persons against others that intentionally threatens, attempts or actually inflicts physical harm (Reiss and Roth 1993: 35). It does not include self-inflicted harm as in suicide, unintentional harm, or

harassment or psychological humiliation in which trauma may occur. In Britain as elsewhere, the introduction of drugs such as crack cocaine in the late 1980s and early 1990s made people realise that drugs markets could be violent places where death was increasingly commonplace and violence a standard feature of drug dealing (Bean 2001a).

Violent people involved in drug misuse are neither a subset of violent offenders nor a specific subset of offenders generally. The evidence suggests a measure of convergence has occurred – that is, substance misusers and other criminals have become one and the same. Drug-selling organisations frequently recruit those with previous histories of violence, or those who are comfortable with violence, and ask them to fulfil roles within the organisation (Johnson *et al*. 1990: 35). These roles can include intimidating ordinary citizens who may refuse to co-operate with their demands (*ibid*.: 35–6).

As with other forms of crime, there has been much research linking the ingestion of drugs with violence, especially alcohol. Jeffrey Fagan (1990) concludes that there is no empirical evidence for asserting a strong causal relationship between intoxication and aggression, regardless of the type of substances, and, in any case, conditional factors make causal connections difficult to demonstrate. For example, interpersonal violence occurs more frequently in some bars than others, and violence in sports stadiums occurs more frequently in some than in others. In Britain violence is more likely at football matches than cricket or rugby matches, yet more alcohol is consumed at cricket or rugby matches than at football matches.

As a general rule, violence is greater when drug dealing takes place at street level, and is even greater where the seller has less control over access to the purchaser. For example, Reiss and Roth (1993) confirm that call-girl operations are less violent than open-air street walking: 'Similarly in drug markets, runner-beeper delivery systems may entail less violence than open air markets, while heavily fortified crack houses experience still less risk' (p. 18). In our Nottingham study we thought that levels of street violence decreased in amount and changed in form and quality once control of the profits was taken over by an outside organisation, thereby making the financial system more organised. Then, as with high-level dealing, violence becomes more focused and instrumental and is used to enforce discipline and collect debts (Bean and Wilkinson 1988). Violence is not likely to be random or haphazard. At the very highest level of dealing, violence is entirely instrumental and focused, aimed at taking out the opposition or removing internal disagreements. It occurs according to a prearranged set of signals which almost always involve co-offending (i.e. with two or more offenders against one victim), based on a scale of punishments determined in advance.

Male violence in domestic situations is often ritualised – that is alcohol is consumed in settings which give approval to male violence where violent incidents occur as part of a considered demonstration of masculine authority. In contrast, female violence in domestic settings does not have the association with alcohol found with male violence. Nor is female violence associated with other drugs, as is common with male violence. In our Nottingham study we found that female drug dealers were prepared to use violence and did so as often as their male counterparts, either to enforce discipline or to collect, but they tended not to do it themselves; male partners had to do it for them. Incidentally, they changed partners regularly when existing partners failed to deliver as required (Bean and Wilkinson 1988). Similarly, Incardi *et al*. (1993), in their study of women heroin and cocaine users in Miami, found that, like their male counterparts, female users offended in similar ways – except that over half (54%) of their offences were for prostitution – and the heavier the drug use, the more likely was the use of violence.

Fagan (1990: 261) shows that male violence associated with substance misuse is no different from other forms of criminality in the sense that it has the same antecedents, i.e. family pathology and early childhood victimisation experiences. Early childhood aggressiveness and alcoholism as an adult were found to interact and predict the highest levels of interpersonal violence. Violent men under the influence of a substance (including alcohol) were violent men when not under the influence of those substances.

Sadly, one of the most important changes in the British drugs scene has been the increasing use of firearms on the streets, where low-level crack dealers display firearms openly in areas where firearms were hitherto unknown. No one knows now many homicides in Britain are drug related but the police believe they are increasing annually. McBride and Swartz (1991) in America note that, in addition to the willingness to use lethal weapons, there has been a significant increase in the lethality of the weapons used: machine-guns and semi-automatic weapons had significantly increased in use and scope in the 1980s during the increase in crack cocaine use (p. 160). The large profits and the way in which coca growing and distribution in Central and South America have become increasingly intertwined with political revolutionary groups (*ibid*.: 161) may help to explain the growing levels of violence associated with drugs. So too must be the recruitment of violent individuals to drug trafficking, and the approval given to violence in those situations.

2. *Crime leads to drug use*

The research literature surrounding and providing support to this model is scanty by comparison. Conversely, speculation is greater. Moreover, as stated earlier, the debate is more than of academic interest. If crime leads to drugs there will be no reduction in criminality even with the successful treatment of the drugs problem. If crime leads to drugs then treatment should be directed at reducing the criminality, and the drug problem will be correspondingly reduced (Hammersley *et al*. 1989).

As with all models, there are problems with the quality of the data. At the simplest level, researchers have been interested in determining which came first: the drug abuse or the criminality. The results are equivocal. Early British studies found that about 50% of heroin addicts were antecedently delinquent but, of course, 50% were not (Bean 1971). Later studies have shown similar findings, but to what extent they point to evidence of directionality is difficult to say.

The problem is also a methodological one; it depends on the subset or where one takes the sample. As noted above, if the sample is taken from an offender group it is likely that criminality would feature heavily in the results – and in this case equally likely that criminality would be first. If, however, the sample was taken from a non-offender group (say, a group of young middle-class ecstasy 'clubbers'), criminality would be less prominent (Release 1998). And, of course, it is the presence of those drug users who are not criminals and not likely to be so that poses so many of the problems for this debate (Hammersley *et al*. 1989).

Some researchers are more certain than others. Korf *et al*. (1998) say there is empirical support for the theory that prior criminal involvement increases one's chances of getting into drugs. They say that 'Many current addicts have set out on a criminal path at an early age and *before* their first dose of heroin. These pre-drug criminals turn out to be the group most likely to generate their income from property crime' (p. 4, emphasis in original).

Those supporting this model usually explain it in one of three ways: either in terms of a subcultural theory, by using a situational crime model perspective or as a form of self-medication.

Subcultural theory

Criminal activity in subcultures provides 'the content, the reference group and the definitions of a situation that are conclusive to subsequent involvement in drugs' (White 1990: 223). The evidence for this comes from a small number of studies, quoted by White, where she says the

individual is placed in an environment which is supportive of drug use. It is the desire for subcultural status rather than a need for a drug which leads the individual to commit crimes. Drug use arises and flourishes within the deprived ghetto areas of inner cities, where subcultural values sustain it and, if not actually promoting it, then they do not resist it. Drug use provides status in an otherwise low-status society. It identifies the positive payoffs where respect, anti-authoritarianism, macho lifestyles, risk taking and entrepreneuralism are given esteem (Hough 1996: 8). In Chapter 1, Janet Foster's (2000) discussion of Bladon in northeast England was outlined. Coping in this environment requires strength of character – drug use is both a palliative and a status-promoting mechanism. However, White (1990) concludes that the evidence for this is not conclusive. Whilst it is likely that crime leads to drug use under these conditions, a direct causal path from crime to drugs using this type of subcultural explanation is not likely to reflect the dominant patterns of behaviour (*ibid*.: 223).

Situational control theory

A second form of explanation is through situational crime control theory, whose earliest and most important exponent is Ron Clarke. Clarke (1980: 136) sets out the basis of his position as follows:

> Criminological theories have been little concerned with the situational determinants of crime. Instead the main object of these theories (whether biological, psychological or sociological in orientation) has been to show that some people are born with or come to acquire a 'disposition' to behave in a consistently criminal manner. This 'dispositional' bias of theory has been identified as a defining characteristic of 'positivist' criminology. In fact a dispositional bias is presented through the social sciences.

Situational crime theory concentrates on the opportunities to commit crime and the risks attached to criminal activity. Essentially, the offender is seen as exercising a rational choice – that is, working out the cost-benefits of offending. This would be so for the addicted drug user as for the recreational user. In popular fiction the addicted offender might be portrayed as 'enslaved' by the drug but, to the situational theorist, this is over-dramatic. Rational choice theory (which, incidentally, is being increasingly accepted within criminological circles) has three main strands or subtheories:

1 Routine activities theory, which relates criminal opportunities to the routine activities of suitable victims and the characteristics and locations of suitable targets.

2 Environmental criminology, which explores spatial and temporal aspects of offending, such as crime hotspots and other policies of crime, as well as the routine activities of offenders.

3 Defensible space, crime prevention through environmental design, strategic crime analyses and situational crime prevention where the aim is to prevent crime by modifying the physical environment itself or by changing the activities of people inhabiting the settings within which crimes are likely to occur (Cornish 2001: 306).

The development of situational crime prevention has been such as to lead its exponents to develop a new branch of criminology (or perhaps a new subject altogether) which they call 'crime science'. They subject all types of crime to this analysis. Drug taking and its associated criminality can be made subject to the same cost-benefit analysis as other drugs. Supporters of situational crime prevention would say that crime leads to drug taking so that, by modifying crime 'hotspots' and the environment, and by dealing with the characteristics and location of suitable targets, drug taking can be reduced.

In a celebrated essay entitled '*Broken windows*', James Wilson and George Kelling (1982) identified what they saw as the visible signs of an area in decay. These broken windows were accompanied by graffiti, malicious damage to property and litter, all linked in the public mind to disorder, crime and fear of crime (Downes and Rock 1998: 254). Wilson and Kelling (cited in *ibid*.) described the situation thus: 'Families move out, unattached adults move in. Teenagers gather in front of the corner store. The merchants ask them to move; they refuse. Fights occur, litter accumulates.' 'Broken windows' is a phase in the natural history of communal disorganisation (*ibid*.). The links with drug abuse centre on the manner in which the police and others deal with the broken windows environment and the associated hotspots that develop. Policing these hotspots means dealing with the accompanying incivilities: the beggars, the squeegee artists, those producing litter and graffiti. Intervening in the cycle of deterioration is expected to reverse neighbourhood decline and bring about a reduction in the rates of crime. Successes include the reclamation of the New York subway system and neighbourhood improvements elsewhere.

Critics talk of the displacement of crime to other areas of cities and suggest that crimes committed by drug users are more likely to be displaced. The evidence for displacement is, however, limited: drug users do not always displace. In the King's Cross project in London (using a situational crime prevention approach), rates of novice drug users were certainly reduced, and not displaced as a result of increased police activity (nor were some dealers). Of course some were, but the strength of situational crime prevention is paradoxically that it does not claim to be able to eliminate all crime but to regulate it (Downes and Rock 1998: 257). Moreover, to invoke a displacement argument is to assume forms and types of motivation which the situational crime theorists would eschew.

Cornish again:

> Claims that offences prevented will inevitably result in displacement or escalation, that technological advances in crime prevention will create 'arms races', or that so called 'expressive' crimes such as sex and violence cannot be prevented by situational strategies often draw their persuasiveness from hidden assumptions about offenders as essentially pathologically motivated and hence undeterrable. (2001: 306)

(*Note*: 'expressive' crimes include drug taking.)

There is little doubt that situational crime prevention has much to offer, and will continue to offer an explanation of the links between crime and drugs. It promotes a new perspective and a new way of thinking. Its message is straightforward; reducing crime leads to a reduction in drug use, and policing hotspots has an impact on the quality of life in a neighbourhood – including reducing incivilities, prostitution and drug dealing.

Self-medication

The third way in which crime leads to drugs is through self-medication. Again, there are not many data for this model but there is some evidence to suggest that individuals with deviant lifestyles or personalities may also use substances for the purposes of self-medication. These include the so-called 'dual diagnoses' patients – i.e. where drug users also suffer from forms of mental disorder. ('Dual diagnosis' is not a satisfactory term; some drug users have been found to have a number of morbidities including AIDS/HIV, but the term has now been accepted in general usage and has acquired a measure of general recognition.)

It is thought that about 50% of drug users have dual conditions, with a smaller number having multiple conditions including alcohol addiction and HIV (Swanson *et al*. 1994). It has been suggested that dual diagnosis patients are more violent than those with a single diagnosis, but the data are not straightforward. Although respondents with dual diagnosis had a greater risk, it was only slightly greater than that for single diagnosis respondents – i.e. among drug users the presence of mental disorder increased the risk of violence but not significantly (*ibid*.: 113).

Diagnosing these patients is complex and misdiagnosis common: one condition may mask or mimic the others; hence the difficulty in obtaining data. In this model, the link between drug abuse and mental disorder operates as follows:

- **M**ental **I**llness* → **C**hemical **A**buse (MICA).
- **C**hemical **A**buse → **M**ental **I**llness* (CAMI).

(*Note:* *The term 'mental illness' has been substituted for 'mental disorder'.)

With MICAs the mental illness leads to chemical abuse; with CAMIs the reverse is so. In the first, those with mental illness may find themselves accepted within the drugs community in a way they had not been accepted elsewhere, although this acceptance may be superficial. It is more likely that they are being exploited by drug users, who ask them to 'stash' and 'run' for them. None the less, their deviant lifestyle (mental disorder) and/or personality lead them into a drugs subculture. Once attached to this they may begin to self-medicate, either to dampen down their symptoms of mental illness or to use substances to offset the unpleasant side-effects of their psychiatric treatment. In most cases of self-medication the drug of choice seems to be heroin, although for some inexplicable reason schizophrenics will also use cocaine, which has the opposite effect of damping down their condition. (There is much speculation why this should be so. One theory is that schizophrenia produces a cold, detached feeling. At least with cocaine the opposite is true.) None the less, self-medication seems to be a fairly common activity amongst MICAs.

For CAMIs there is a much less clear-cut relationship but there is evidence to suggest they, too, self-medicate. Long-term heroin use leads to depression (as does long-term alcohol use), and the relief of depression through stimulants is one possibility. The use of LSD, cannabis and other hallucinogenics may also produce mental disorders (amphetamine or other stimulants such as cocaine produce psychosis), and self-medication may be a way of relieving symptoms.

These activities provide further examples of the confusing and confused patterns or directions of the links between substance abuse and crime (or vice versa). The clinical evidence, however, alongside increasing research evidence on dual diagnosis, points to an important avenue for future research where the links with crime become blurred by the additional complexity of the mental disorder.

3. *A common aetiology*

White and Gorman (2000: 151) concluded that 'one single model cannot account for the drug crime relationship. Rather the drug using… population is heterogeneous, and there are multiple paths that lead to drug use and crime'. Others have rejected the simple causal explanatory model where one (drugs or crime) leads to the other (crime or drugs). The relationship is said to be too complex (McBride *et al.* 2002: 11).

Within this 'coincidental' or 'common cause' model there are a number of different sub-models:

1. Common origin – that is drug taking and crime have the same antecedent history of behaviours where there is a behaviour syndrome (or clusters) which, in this case is deviant.
2. Reciprocal model – that is, the relationship is bi-directional.
3. Spurious model or co-morbidity model – that is, both morbidities occur simultaneously.
4. Policy and prohibition model – that is, public policy shapes the drugs – crime link.

Common origin

One approach is to talk of a common origin – that is, drugs and crime may emerge from the same contextual milieu. They may share the same anecdotal variables, such as poor social support systems with difficulties at school and membership of a deviant peer group (McBride 1999: 11). As will be shown later, much of the research on juvenile drug users emphasises these features, especially that of poor parenting alongside family and domestic violence. Another approach is less certain; it is simply to talk of a set of co-morbidities – i.e. simply occurring alongside and without pointing to any causal link. In the former the family or social environment is seen as the unifying factor; in the latter, no attempts are made to believe or suggest a unifying factor exists.

The search for a common origin has tended to centre on the background of the drug user, especially where there is an early dysfunctional lifestyle,

or what David Farrington (1997: 363) calls the 'anti-social syndrome' and Charles Murray (1990) refers to as an 'underclass'. Farrington argues that, whilst acts might be defined as heterogeneous, nevertheless it still makes sense to investigate the characteristics of the offenders. He cites evidence to suggest that people who commit one type of offence have a significant tendency to commit other types – i.e. to display an anti-social syndrome (1997: 363). That anti-social syndrome is linked to low social class or socioeconomic deprivation. Charles Murray, in his research on low-class welfare-dependent families, argues that new divisions are appearing in the traditional social classes, especially in Social Class 5. Traditional two-parent families are increasingly leaving working-class housing estates, which are being populated by an underclass predominantly consisting of dysfunctional single-parent families, and where unemployment, child neglect and crime and, most importantly, alcohol and drug use are prevalent (Murray 1990). Farrington, however, using a 'criminal career' model, concludes that 'offending is one element of a larger syndrome of anti-social behaviour that arises in childhood and tends to persist in adulthood with numerous different behavioural manifestations' (1997: 399). One such manifestation would be crime; another would be drug taking, but all stem from the common origin of a dysfunctional lifestyle.

Reciprocal

The reciprocal model postulates that the relationship between the drug user and crime is bi-directional (White 1990: 223) – that is, drug abuse and crime are causally linked and mutually reinforcing. White quotes Goldstein (1981) who, she says, offered some support for the reciprocity model (even though in this review Goldstein has been seen to support a drugs-cause-crime link) when he suggested that the relationship moves in both directions even for the same individuals. When a heroin addict can easily obtain money illegally, he or she will engage in crime and then buy drugs, not out of compulsion but out of consumer expenditure. Conversely when the need for drugs is great, users will commit crime to buy drugs (White: 223). White argues that, whilst reciprocity is only a recently developed area, it may hold a promise for clarifying causal relationships.

There is other evidence for reciprocity. Chaiken and Chaiken (1990) say that high-frequency drug users are also likely to be high-rate predators and to commit many different types of crimes, including violent crimes, and to use many different types of drugs (p. 213). They say this is true for adolescents and adults, independent of race and across countries. The exception are females who use drugs frequently but are less likely to commit violent crimes than males, and are more likely to resort to

shoplifting, prostitution and similar covert non-violent crimes (*ibid*.). They add that, although sustained drug use cannot be considered a key variable in predatory crime, none the less serious forms of drug use enhance the continuation and seriousness of a predatory career (*ibid*.).

A major difficulty with the reciprocity model is that it can easily become nothing more than a drugs-cause-crime model (or vice versa) in that it may be saying nothing more than one (drugs or crime) moves in the same direction as the other (crime or drugs). For the model to be effective, it needs to be established that the two are 'mutually reinforcing', and this is difficult.

Spurious or co-morbidity

This model centres on the proposition that drugs and crime are simply two features of a person's life: they may be connected but there is no reason to believe this is so. The link, such as there is, may be coincidental but, more likely, features are simply clustered together – perhaps as a result of a wide range of behaviour that developed during adolescence, but perhaps not.

Too often, the spurious model merges with the common cause model so that a 'behaviour syndrome' is presented as the explanation. Klein (1989 cited in White 1990: 228) avoids this and offers support for the spurious model when he says that the relationship between drug use and crime is the result of patterns of simultaneous activity described as 'cafeteria-style delinquency'. That is to say, adolescents engage in a variety of delinquent behaviours, of which drug use and crime are but two. Cafeteria-style delinquency is dominated by fashion, peer group influences and a general dislike of all authority symbols; that which is illegal will be taken. If a 'common cause' exists, it is peer influences (Fagan 1990) which remain one of the strongest predictors of delinquency, and of which drug use is a part. White (1990: 238) looked at groups of adolescents who were delinquents and compared those who used drugs and those who did not. She found that serious drug users and delinquents were not necessarily concentrated in a homogeneous group but that each group or subgroup represented a unique set of individuals whose levels of drug use and delinquency were different.

Promising though these avenues might be, little research has been conducted on them and they remain largely unexplored. Parallels in the mental health field, where studies of co-morbidities (usually drug use and mental disorder) are much more developed, suggest this is promising area of research, but few drug researchers have taken up the challenge. As a result, the spurious model remains a minority interest.

Policy

McBride *et al*. (2002) argue that efforts to address the drugs–crime relationship must incorporate a realisation of how the development of policy and law has contributed to that relationship (p. 2). They go on to say that 'each time policy shifts the act of drug use takes on a slightly different character in relation to crime' (p. 3). They recognise that little research has been conducted in this matter but see it as a fruitful area of inquiry. They see American drug policy as having passed through the following three phrases:

1 *Libertarianism*. The individual should be allowed to do what he or she likes provided it does not harm others.

2 O*pen markets*. A nineteenth-century policy orientation that limited government interference in the production and distribution of goods and services.

3 *Puritan moralism*. Individual behaviour with the potential to harm the community was seen as a community problem, with the legitimate purview of community action.

These three approaches have had, and retain, an impact on the relationship between drugs and crime. It is part of McBride *et al*.'s argument (2002) that we are in the Puritan moralist worldview, which led to the 'War on Drugs' and the subsequent demands for severe penalties for dealers and users. 'Puritan moralism' has a number of different forms, of which five subdivisions can be identified:

1 Prohibition – which emphasises severe penalties.
2 Risk reduction – which emphasises a public health approach.
3 Medicalisation – which calls for physicians to treat drug use.
4 Legalisation/regulation – which encourages increased access as permitted by the government.
5 Decriminalisation – which calls for an end to the use of criminal law and for a return to libertarianism.

These five subdivisions, although not mutually exclusive nor complete have been subject to considerable debate but not always within the framework defined by McBride *et al*. (2002). It is the wider, more general point about the way policy shifts and its subsequent impact on crime which is important; the research possibilities are considerable. What were, say, the effects of establishing treatment centres on crime, or restricting

prescription to licensed doctors? And what are the effects on crime of allowing heroin to be prescribed under certain conditions? We simply do not know. And therein lies one of the many problems.

An overview

Few would dispute that there are links between drug taking and crime – irrespective of the mere fact that possession of selected substances is itself a crime. The problem is to determine the precise nature of that link. As noted above, establishing causal connections (sufficient conditions) is additionally difficult; the best that can be done is to make a weak causal link (necessary condition) and begin from there. The main problem is that many drug users would have been offenders anyway, so that determining those offenders whose offences relate to drugs and those that do not is almost impossible.

None the less the research points to some important conclusions. First it shows that the links with crime are strongest amongst street heroin users than for almost any other group of users and for any other drug. And even within this group the rates of crime tend to be reduced when drug users are in treatment. This also supports the data on the link with crime amongst this group of users. However, as a general rule, research suggests less of a direct causal link and more of an association – a necessary rather than sufficient condition. At best many data sources establish a correlation. One of the main problems in establishing a causal link is that many drug users are not offenders, and the vast majority of drug-using incidents neither cause nor accompany criminality. None the less there is strong research evidence that drugs play a strong probabilistic role in some property offences and in some incidents of violence.

The Goldstein tripartite framework has been a boon to drug researchers, providing an invaluable organising scheme. Particularly interesting is the suggestion that the psychopharmacological properties of the drug should be identified as being linked to crime, although the evidence for this remains weak. Also interesting is to see the drug user as victim. These apart, Goldstein's concept of systemic crime (which grows out of the development of drugs markets) provides the most useful area of research and leads to a greater understanding of the drugs–crime nexus. Systemic crime, which involves the protection of drugs markets, can be extended to include those aspects which are related but at one remove. For example, systemic crime can include police corruption and those quasi-legitimate activities where local economies grow and develop as a

result of drugs markets (i.e. where property owners let out their property to dealers, prostitutes, etc.).

Whilst the Goldstein framework is useful, it is time to go beyond this. Earlier theories are losing ground and are being replaced by modern theories, such as integrated theory, life-course transitions and eco-systems theory. Subgroups need to be examined especially those who are not lower class – i.e. the so-called celebrity users – and we need to look more closely at drug users' patterns of criminality, concentrating too on the extent to which drug use lessens crime.

The direct empirical evidence for the 'crime leads to drugs' model is less than for 'drugs-causes-crime'. None the less, some is available and sufficient to suggest that those who support this are on firm ground for they are able to draw on empirical data as well as on other theoretical models, including situational crime control, alongside an expanding area of research related to dual diagnosis. They may not have the popular appeal of the 'drugs-cause-crime' model, but so be it – there is support from basic empirical data, notably that about 50% of drug users were criminal before drug taking. The situational crime model, which suggests that crime leads to drugs where offenders have surplus money from crime to start and continue their habit, is as plausible as the notion that drugs lead to crime.

Where the relationship is purely coincidental or based on a common origin, there are a number of submodels. Four have been identified: where drug taking and crime have the same antecedent history of behaviours; where the relationship is bi-directional; where the morbidities occur simultaneously; and where public policy shapes the crime link.

Numerous theories of drug use have provided useful and interesting areas of research but, for these purposes, a wider framework is required. For example the supply networks, particularly those within Britain, and the attempts to police them (and the corresponding drugs markets, whether local or otherwise), require attention.

Bruce Johnson *et al*. (1990) make the point that, whilst a few upper-level suppliers make 'crazy money' from cocaine and heroin sales, the vast majority of inner-city youths who enter this world rarely improve their economic positions. Instead the regular use of heroin, cocaine and crack frequently brings impoverishment (p. 43). The oft-heard lament from ex-dealers was 'dealing doesn't last' (Bean and Wilkinson 1988); they made their pile of 'crazy money'. Invariably, they lost it as quickly, whether from their own drug use or through burglary by other dealers, or simply by being 'busted' by the police, usually on a tip-off from an informer.

There is also the impact on the community – which is an under-researched area. Anecdotally, the impact could be devastating, especially amongst some ethnic minority groups where community structures are fragile. When a 15-year-old dealer taunts others with his new-found wealth, what does this do to a community where unemployment is high and job prospects limited? How do parents tell children that hard work and effort will lead to rewards, ten or 20 years hence, when the rewards are available now, with few entrepreneurial skills required and little by way of education? Or how do you cope with some of the more ill-considered comments from drug researchers who claim that drug use in Britain is 'normal'? Statistically this may be so, but how do parents tell their children not to take drugs when their response is that it is normal to do so? We do not have to live with high rates of drug abuse; there are things we can do, and one of these is to lay the appropriate foundations and then secure the political will to meet the task.

Notes

1 This literature review inevitably draws heavily on American sources. In an analysis of addiction abstracts from 1994 to 2000 taking over 5,000 abstracts from 30 specialist journals and 120 general journals, the National Treatment Agency in Britain found that the USA dominates. Over 50% of the abstracts were from American authors. Next was the UK with about 12% of all abstracts. About one third of those from Britain were on interventions (i.e. treatment and policy), one sixth on prevalence and one fifth on health behaviour, which includes co-morbidity and physical and psychological health matters. Furthermore, even in the UK it was found that a few research centres dominated, with little collaboration between them, and there was substantial variation and duplication. London provided the most (NTA pers. comm.). Clearly this leads to enormous gaps in the literature as well as in the planning and development of research programmes. In the UK for example, there is little research on drugs and ethnicity, and little with an international perspective (examining developing countries) or on drugs and older people (for these purposes those aged 35+). Nor is there much research on the links with policy.

2 Nothing has been said about contaminated drugs. In a study undertaken in Nottingham in 1993, we examined a small number of ecstasy tablets purchased in the street. The quality of the product was not related to price, to where they were purchased (club or street) or to the recommendation of the dealer. Most contained no ecstasy at all. Some were caffeine pills sold as ecstasy. Others contained small amounts of LSD or MDEA (a slightly different compound). For those who thought they purchased MDMA when it was caffeine, presumably they experienced a placebo effect.

Chapter 3

Sentencing drug offenders

In this chapter I want to look at the ways courts deal with drug offenders, or rather with those charged with drug offences under the 1971 Act. There are two major types of offences; first possession, that is illegally possessing one of the prohibited drugs, and second supply, that is giving or selling one of those prohibited drugs. Of course the 1971 Act is more extensive than this but these are the main types of offences. There will of course be numerous users charged with an index offence other than a drug offence. Unfortunately no official national data are available for this group even though they may be in the majority. The research undertaken by Trevor Bennett (1998) is important in this respect.

Producing the data

The data on drug offenders appearing before the Courts in England and Wales was described by John Corkery from the Home Office in 1999 as 'very complicated, old fashioned and time consuming' (Corkery 1999). Unfortunately not much has changed since then and if anything the situation has worsened. At best it means the data relate to a period some 12 to 18 months earlier, but at worst it means the data are either not collected or if actually collected turn out to be largely invalid. Inevitably there will be a delay: this is expected if only because of the time it takes for offenders to come before the Courts, and for any subsequent Appeal, but even so a greater sense of urgency would be welcomed (*ibid*.). At present (2007) much of the

latest available data are for 2003, e.g. for drug offenders in England and Wales and for drug seizures.

That the data are 'very complicated' is clear from the method by which they are recorded. At present the data are compiled from a Crimsec 38 form which is used throughout England and Wales. It is apparently very simple to complete and can contain some basic information i.e., police force, date of seizure, drug involved, the type and quantity, and whether it was sent for forensic analysis (Corkery 1999). Increasingly more and more of the 43 police forces in England and Wales, plus the British Transport Police, submit data electronically, and steps are under way to encourage other forces to do so (*ibid*.). In April 2003 28 out of the 43 forces in England and Wales were supplying seizure data electronically (Corkery, pers. com.).

By contrast, the form used in Scotland and Northern Ireland is even worse. The Crimsec 19 in this case is a two-sheet, partly-carbonated form. The top sheet is completed when a drug seizure is made. This is sent to the Home Office once the substance has been forensically tested. In addition to the information outlined as being required by the Crimsec 38, other fields have to be completed e.g. place of seizure and by whom. Details of the suspect(s) are entered onto the form and these are copied through to the second sheet. This part of the form is supposed to be completed when the results of any police or court decision are known (*ibid*.).

The in-built delay concerning the time which cases take to come before the courts is further complicated in Scotland because the courts there tend to 'roll up' offences. This means that when an offender appears before the court, all offences of whatever nature are dealt with together. This makes it difficult for the police to then decide on what action was specifically taken for drug offences and hence what to enter on the Crimsec 19. These difficulties appear to have led to a significant shortfall in the number of forms being received by the Home Office, especially between 1994–6. The second part of the Crimsec 19 form gives details of the date of offence, date of the disposal (e.g. court appearance), the action taken (court sentence, amount of fine, and so on) and the drug(s) involved. All this is in addition to the basic socio-demographic data such as offender's name, age, and so on, as well as the court and police force area (*ibid*.).

To complicate matters even further since 1995, instead of supplying data in a format compatible with the Crimsec 19, HM Customs and Excise have provided further data on seizures and on offenders involved in unlawful import and export offences (although almost exclusively the former). Unfortunately, there is a fundamental

difference between their data and that provided by the police and the courts – the drugs seized by HM Customs and Excise are not attributable to individual suspects or offenders (*ibid*.). One wonders of course why these variations persist, and why it takes so long to introduce a coherent system, but there it is.

However, the Centre for Drug Misuse, University of Glasgow, using a method known as capture/recapture has been able to provide general estimates of the prevalence of drug misuse in Scotland (Hay *et al.* 2005) (The capture/recapture method is used to describe the pattern of overlap between different sources of data. For a description of this method see Gemmell *et al.* 2004).) These estimates were derived using four separate sources of data; treatment, hospital admissions, police and social work. Of course the quality of the data determines the quality of output and if the former is weak no amount of sophisticated analysis will compensate for this. None the less, the Scottish data are the best in the UK.

'Old fashioned' also means that it is not as automated as it could be (Corkery, pers. com.). Some of the information on court disposals still comes from the police who retrieve it from court records and this is true for the whole of Scotland as well as parts of England and Wales. Forms have been found lurking in the back of cupboards in some Scottish police forces (Corkery 1997). Timeliness of data both in terms of submission to the Home Office and as regards publication, is a major issue. Accordingly, the data presented below may well be the best available, but should be seen as having obvious limitations.

There are two separate matters here. First there are the limitations imposed by the data; that is where data on drug offenders gives but a partial picture. For example, many drug-using offenders may be charged with a non-drug offence. How best to interpret this? Or, how to interpret data on drug seizures? These limitations occur not as a result of defects in the data, but because the data are not sufficiently comprehensive.

An independent review of drug seizure and offender statistics was undertaken in 2002/03 by the late Rodney Taylor. Doubtless it was prompted by the absence of a central collection of drug-related offenders statistics since 1979, which although important is only part of the problem, albeit an important part. Data were collected originally by the Home Office Drugs Inspectorate and then by the Home Office Statistics Department. This information formed part of the data submitted by HM Government in its annual report on drugs to the League of Nations and later the United Nations (see Bean 1974). The Addicts Index, part of this data base, has long since

gone, and we have no satisfactory replacement. We have the National Drug Treatment Monitoring system, and the Drug Misuse database in Northern Ireland, but they both fall seriously short of what is required.

The second matter relates more to the validity and reliability of the data and directly to the collection of the data itself. Take for example the accuracy of published data on drug trafficking and related crime in London which comes from the Metropolitan Police. Some Metropolitan Police Staff (MPS), especially in the Strategic Intelligence Unit (SIU), share these concerns – and with good reason. Since 1998, the SIU Drug Desk Staff have been monitoring drug trafficking crime in London. Analyses of CRIS reports leave no doubt that MPS data are seriously flawed and present a distorted picture of drug trafficking. Geoff Monaghan (1999, pers. comm.) analysed drug trafficking offences involving Class A drugs. He found that nearly one third (or 31%) had been incorrectly classified. In a few cases 'Possession of Cannabis' had been incorrectly classified as 'Production of Cannabis' (a drug trafficking offence). Important fields in CRIS (e.g. nationality, place of birth, drug type and amount) were all too often left blank. In our later study of MPS records (Bean and Nemitz (2000) mimeo), we also found numerous errors, such as 'drug trafficking offences' listed without any supporting evidence. The results of our study supported fully those found by Geoff Monaghan. Clearly, the situation is worrying. How can it be that the data are so poor, and why has so little attention been given to this fact?

An overview of the legal position

Before looking at some of the data available a brief overview is required of the legislation. The Misuse of Drugs Act divides the drugs it controls into three main categories which determine the maximum penalties for possession supply and other offences.

> *Class A*. This is the highest class and includes heroin, methadone, cocaine, LSD, cannabinols and Ecstasy. The maximum penalty for possession by a Crown Court is seven years imprisonment and/or an unlimited fine, and in a Magistrates Court this is six months imprisonment and/or a £2,500 fine. For supplying (i.e trafficking and dealing) the offence in a Crown Court carries a maximum life sentence, and an unlimited fine.

Class B. The drugs included here are amphetamines (cannabis was a Class B drug but now downgraded to a Class C as from 29 January 2004). In a Crown Court possession carries a maximum five years imprisonment and/or an unlimited fine, and in a Magistrates Court three months imprisonment and/or a £2,500 fine. For supplying in a Crown Court the maximum is 14 years imprisonment and/or an unlimited fine, and in a Magistrates Court it is six months imprisonment and/or a £2,500 fine.

Class C. The drugs included here are benzodiazepenes, some synthetic opiates and cannabis. The maximum Crown Court penalty for possession is two years imprisonment and/or an unlimited fine and in a Magistrates Court three months imprisonment and/or a £1,000 fine. Supply carries a maximum of five years imprisonment in a Crown Court and an unlimited fine. (Note that the possession of cannabis is still an offence. Where small amounts are discovered and thought to be for personal use it is likely the user will simply be cautioned but the drug itself will be confiscated.)

In addition, the Customs and Excise Management Act 1979 prohibits the import and export of controlled drugs except for approved purposes, i.e. medicinal or research. The 1994 Drug Trafficking Act creates further offences in respect of money laundering and gives courts powers to order the confiscation of assets obtained through drug trafficking.

Drug seizures

Now we turn to the data. First we will look at drug seizures – a useful but not wholly reliable or valid indicator of the extent of illegal use, or of the extent of criminality associated with drug trafficking, except of course the longest prison sentences are reserved for traffickers, especially large-scale international traffickers. John Corkery (2003) notes that the number of seizures within the UK involving Class A drugs increased by 10.3% in 2000, against the target set of 10%. Drugs with a street value of £789 million were seized by law enforcement agencies in 2000.

Data on seizures of controlled drugs 1970–2001 are given below. The totals for each drug in the respective years will not add up to the subtotal, nor will the subtotals add up to the main total, as some seizures will be recorded more than once, and the categories are not discrete. Some seizures include both possession and trafficking. However, from Table 3.1 below it is clear that seizures have increased

Table 3.1 Number of seizures* of Class A, Class B, and Class C drugs, by drug type and year (England and Wales)

Drug type	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Cocaine	1250	1760	2400	3470	4670	5400	5400	6530	5750	6910
Crack	1320	1440	1340	1680	2470	2470	2640	3580	4150	4760
Heroin	3840	5600	8570	10500	12680	12730	13140	14630	12630	10570
LSD	1910	970	920	710	530	400	240	150	50	120
Ectasy-type	3010	4720	4870	4240	4050	5410	7990	8600	6660	6110
Methadone	690	890	1240	1450	1460	1090	1010	900	720	530
Morphine	0	0	0	0	0	0	0	0	0	0
Other Class A	810	800	670	700	760	740	730	640	870	690
All Class A	11770	14920	18700	21260	24740	26920	28920	32280	28540	30000
Class B										
Amphet	11450	13720	15980	16210	16320	11560	6120	6010	5850	5860
All Cannabis	71790	73860	74270	87370	93190	80020	76410	77480	83510	78520
Other Class B	130	110	210	240	210	290	310	310	260	200
All Class B	79710	83470	85930	98760	105770	89680	80030	80830	88520	83700
Class C										
All Class C	830	1070	1440	1710	1860	1620	1250	1390	1300	1380
All Drugs	88420	94510	100740	116990	126490	112410	107620	111930	114550	109410

Source: Mwenda *et al.* (2005).
Notes: Totals are rounded to the nearest 10.
*A seizure can involve more than one drug; individual drugs figures cannot be added together to produce totals.
1. Seizures of unspecified quantities are not included.
2. MDMA prior to 1996.
3. Includes opium and pethidine.

for almost all drugs in the last 20 years or so. Scant data were available before 1967.

Using Table 3.1 and incorporating all drugs, the number of drug seizures in 2003 involving the police and HM Revenue and Customs in England and Wales were 109,410: this was 4% fewer than in the previous year (114,550). For Class A drugs there were 30,000 seizures in England and Wales in 2003 (5% more than in 2002). Heroin was the most commonly seized class A drug in 2003. There were 10,570 seizures, down 16% since 2002, followed by cocaine (6,910 seizures, up 20%), Ecstasy (6,110) seizures, down 8% since 2002 and crack (4,760 seizures, up 15%). A small number of seizures involved methadone and LSD (530 and 120 seizures respectively).

For Class B drugs there were 83,700 seizures, a 5% reduction over 2002 with the majority of seizures being for cannabis (94%). This was offset by a similar increase in Class C seizures – up from 1300 in 2002 to 1380 in 2003. Clearly, the quantity seized has increased dramatically over a 30 year period, and that is the case for all drugs with the exception of LSD. Nowhere is this better illustrated than with amphetamines – 5kg was seized in 1980 compared with 1.5 tonnes seized in 2003. The increase in the numbers and quantity of heroin seizures is disturbing, in 2003 standing at three times the number in 1994. Cannabis still represented the largest number of seizures, as shown in Table 3.1 above: in 2003 this stood at 78,520 out of a total of 109,410.

Figure 3.1 below puts the position of cannabis more clearly and it is fascinating for a number of reasons. It shows how seizures of

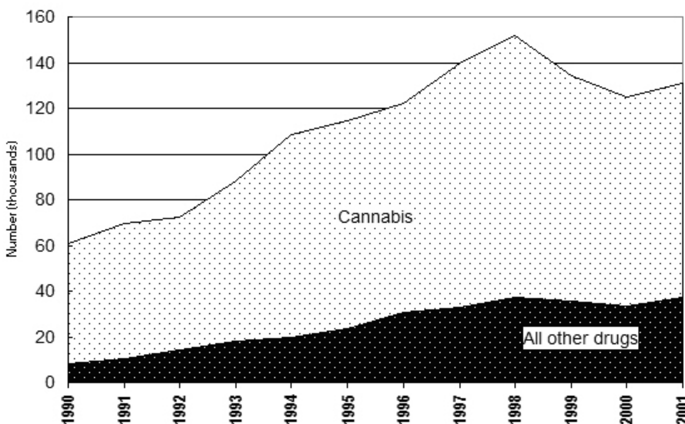


Figure 3.1 All seizures compared with seizures of cannabis, United Kingdom, 1990–2001
Source: Derwed from Corkery (2002: Figure 1): Corkery and Airs (2003) cited in Corkery 2003

cannabis account for about 73% of all seizures. It shows too how cannabis seizures follow the same trends as for the combined seizures of all other drugs, and suggests that there may be a link between cannabis seizures and those which take place generally. As we do not know details of the seizures, i.e. where they occurred and the circumstances in which they occurred, we are left to speculate. Of course some of these seizures would have been large scale, but I suspect most were not. My guess is that many did not come about as a result of the police targeting small-scale cannabis users, whether in the street or their homes, but took place in the police station. The typical scenario would be something like this: an offender is brought into the police station charged with a property offence, made to turn out his pockets and then cannabis is discovered. If I am right then the accusation that the police target otherwise non-criminal young people who happen to be cannabis users is false. I suspect the police are already 'on the back foot' when it comes to coping with drug offenders and therefore small-time cannabis users are not a priority. Small-scale cannabis seizures will generally occur through serendipity rather than design.

At one level seizure data can provide a useful indicator about the extent of use, in that it is reasonable to suppose that an increase in seizures is reflected in use. This is clear from seizures of heroin: an increase in seizures occurred alongside an increase in use, whilst the opposite occurred with LSD. Data on seizures are also useful in possibly alerting us to a new development or pattern of use (as with, say, 'ice'). Yet seizures provide only a crude measure of use, if only because no one knows the extent to which the drugs seized relate to the total consumed.

A more interesting, and perhaps more useful, feature is to relate seizure data to price. Take for example heroin and cocaine. Currently, it seems that while seizures of heroin and cocaine have risen, the cost of these drugs has actually fallen. Conventional wisdom often assumes that users of illicit drugs, especially dependent users, are insensitive to price. However, as MacCoun and Reuter (1998) point out this is not so. If the price increases demand falls and *vice versa.* So, if seizures increase, whether in quantity or numbers, and the price does not rise we can assume that seizures are but a small part of a larger market, or in Peter Reuter's terms 'seizures constitute little more than a random tax collection' (Reuter 2001: 22). On the other hand, were seizures to increase and prices increase (as with the famous 'Operation Julie' for LSD i.e. where the seizure led to a massive price increase), it would be reasonable to assume seizures

were part of a smaller market. Therefore, if law enforcement aims at reducing availability, then it must aim to increase the price, preferably to the point where the cost of drugs almost makes them impossible to obtain (MacCoun and Reuter 1998: 214). Unfortunately, it seems we are a long way from realising those aims.

The seizures for Scotland are given in Table 3.2 on page 60. Comparisons with those in England and Wales are interesting, in that although there has been an increase in seizures for Class A drugs from 1994 to 2003 that increase is far below that for England and Wales. There are similarities however. There has been a reduction in seizures for Class B drugs, and the largest percentage of seizures for Class C is for cannabis (82% for Scotland, 94% for England and Wales). Scotland, incidentally, is able to provide more up-to-date information than England and Wales.

Drug offenders

Second, drug offenders. As stated previously, one limitation of the official data is that these relate only to those convicted of offences against the principal Act, which in Britain is the 1971 Misuse of Drugs Act. They do not include those convicted for a different index offence who are nonetheless drug users. For those where the index offence is a drug offence, the numbers appearing before courts in the UK from 1994 to 2003 are given in Table 3.3 below. (The term 'offender' will be used in this and subsequent chapters, although legally an offender must have been convicted of an offence: here the term is used, when a person may have been found not guilty or may not as yet have been convicted.)

As the same person may be found guilty, cautioned, or dealt with by compounding for offences involving more than one drug, cells cannot be added together to produce subtotals or totals. From Table 3.2, the data shows a relentless rise in the number of drug offenders over the period from 1994 to 2003, i.e. from 82,890 in 1994 to 110,400 in 2003. (From 1990 the figure has gone up from 44,942 to 110,400, i.e. more than doubled in ten years.) It also shows a massive increase in the number of heroin offenders, especially if 1994 is compared to 2003, and an equally large increase in crack and cocaine offenders in the same period. However, if the data are broken down in terms of offence, then those for possession constitute the bulk of the drug-offending population.

Any hope, such as there may be, came originally from the Home Office Bulletin (2000). Comparing 1999 with 2000, the number of

Table 3.2 The number and percentage of seizures of controlled drugs by class of drug and year (Scotland)

Seizure year	1995/ 1996	1996/ 1997	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003	2003/ 2004	2004/ 2005	2006/ 2007
Numbers											
Class A	1,729	2,707	2,714	3,497	3,787	4,589	5,124	4,529	3,984	4,995	5,270
Class B	1,811	2,303	2,356	2,341	1,486	874	995	1,301	1,094	1,149	1,205
Class C	11,098	11,781	13,539	14,823	13,109	12,447	15,153	18,040	18,471	20,546	20,353
Total	13,223	14,787	16,595	18,261	16,425	16,040	19,350	21,739	21,768	24,897	24,941
Percentage of total seizures											
Class A	13	18	16	19	23	29	26	21	18	20	21
Class B	14	16	14	13	9	5	5	6	5	5	5
Class C	84	80	82	81	80	78	78	83	85	83	

Source: Drug Seizures by Scottish Police Forces 2004/2005 and 2005/2006 (The Scottish Government).

Table 3.3 Number of known drug offenders by type of drug in England and Wales 1994 to 2003

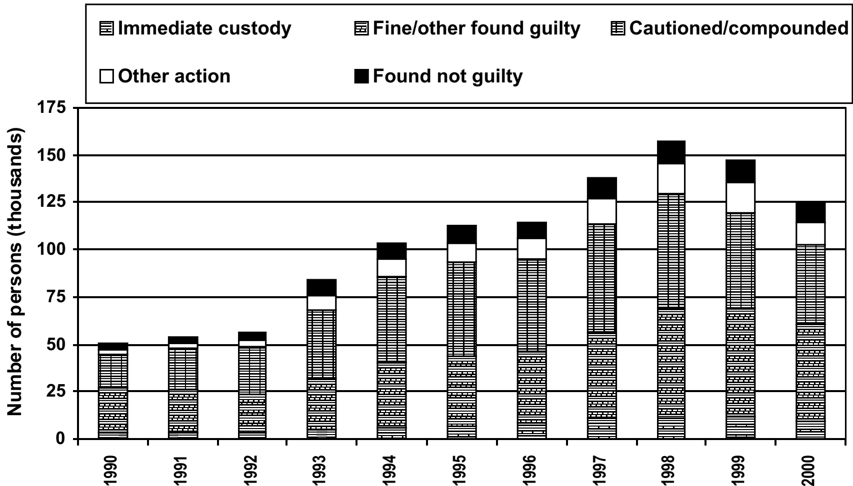
Type of drug	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Class A										
Cocaine	1570	1840	2170	2880	3980	4620	4240	4690	5780	6970
Crack	370	520	480	530	910	1130	1210	1460	1800	2260
Heroin	2750	3930	5660	8200	10060	10790	10680	11100	10670	10520
LSD	1660	1140	780	660	510	410	230	170	120	150
Ecstasy	1760	3080	3680	3710	2750	3800	5910	6800	6050	5530
Methadone	10	20	390	670	720	630	540	540	450	430
Class B										
Amphet.	7800	9650	12270	12410	13200	10620	5880	4620	5550	5940
Cannabis	67180	71950	69070	80910	90480	81090	70160	66410	78050	82060
Class C										
Steroids	0	0	20	30	30	30	10	370	640	570
Other	3670	7340	7870	9020	8810	8270	6920	7180	7710	7440
All Drugs	82890	90640	91230	107500	122440	112780	99060	96520	106640	110400

Source: Mwenda and Kumari (2005).

'drug offenders' actually fell – by 14% to 99060 in 2000, and again in 2001. This relief was short-lived: an increase followed in 2002 and another in 2003.

The sentencing and treatment of drug offenders

Next we look at sentences. The ways such offenders were sentenced over the last ten years are produced below. Figure 3.2 produces that data in percentage terms. This gives a different slant on it for, *inter alia*, it shows how the numbers of those sent to immediate imprisonment may have risen yet the percentage has remained roughly the same, or if anything fallen. It also shows how fines have lost ground, almost certainly to cautions. The caution is not a court disposal but a police one in England, Wales or Northern Ireland. Reprimands and final warnings are counted as cautions in the published statistics – these would include the use of informal warnings for cannabis possession (as in the Lambeth pilot project). There has been an increase also in those sentenced to 'Other found guilty'; probably this means being sentenced to probation community service or to a combination order. This shows that the proportion found 'not guilty' remained fairly stable.



Source: Corkery (2003: Figure 10).

Figure 3.2 Persons dealt with by action taken, United Kingdom, 1990–2000

Table 3.4 below updates the information for 2003 showing that the greatest likelihood of receiving a custodial sentence falls to dealers in crack/cocaine or heroin, although lengthy sentences were given to import/export offences, presumably committed by international traffickers.

This broad overview of the number of offenders and the manner in which they were sentenced sets the scene for a wider discussion on the sentencing practices of the courts, where, as shown above, only about 10% of drug offenders are sentenced to immediate custody and about the same number are placed on probation, with rather more (but falling) being fined. What these tables do not show is that most drug offenders never appear in court but are cautioned by the police, having admitted their offence. Here I want to look at the four major court sentences – probation, a fine, a caution, and imprisonment – to determine their contribution to drugs crime reduction. For these purposes a caution will be termed a 'sentence'.

First of all I will examine probation, which accounted for about 8% of drug offenders in 1997 and was the least implemented of the four major sentences. On the face of it, a probation order would seem an obvious method of dealing with a drug offender. It is primarily

Table 3.4 Custodial sentences awarded for drug offences by type of drug in England and Wales in 2003

	Number sentenced to custody	% of offences receiving a custodial sentence	Mean sentence length in months
Cocaine	1270	16	36
Crack	560	25	31
Heroin	3010	28	28
Ecstasy type	740	13	26
Cannabis	1810	2	8
All drug offences of which	10,120	9	29
Possession	4020	4	4
Dealing	6370	60	37
Production	240	9	20
Import/export	1090	93	67

Source: Mwenda and Kumari (2005).

rehabilitative in approach, concerned with assisting in the welfare of offenders, with facilities to aid treatment and officers who have knowledge of local facilities. In practice, probation orders appear not to work well with drug users; supervision can be patchy and the type of treatment offered does not always appear to have much impact. For example, in a study on the Inner London Probation Service the results were anything but clear cut or favourable towards the probation service. When asked what had been the greatest help overall in tackling drug use, most of the offenders in the population who were on probation mentioned factors other than probation. However, in doing so most of those interviewed felt their probation officer had played a part in securing this help (Hearnden and Haracopos 2000). And further to this, over two thirds of respondents felt that the probation service's relationship with drug users could be improved. Many judged their individual officer to have little understanding of drug issues and terminology, so that probationers who were not prepared to fully discuss or divulge drug use said it was easy to mislead their probation officer – a matter which will be of deep significance when we later come to discuss the Drug Treatment and Testing Order. On the other hand those interviewed said that they did not necessarily think their officer's knowledge needed improving, regarding it as sufficient that their probation officer could refer them on to a drugs specialist, either within the probation service or elsewhere (*ibid*. p. 3). There was some success in reducing drug use whilst on probation, but it seemed all too often that the demands of the drugs were more powerful than the demands of any probation officer.

There is little doubt that the probation service is in the front line when it comes to dealing with drug offenders. The study quoted above shows that a significant minority of the Inner London Probation Service (ILPS) caseload has consistently been identified as consisting of problem drug users. Data from the ILPS Drug and Alcohol Demonstration unit suggested that in 1989 around 1,800 (or 20% of the caseload) fell into this category (*ibid*.). In a (1993) study by Claire Nee and Rae Sibbitt for the Home Office the conclusions were depressingly similar, namely that there was substantial variation among probation services in terms of the kind of response made, the effectiveness of the responses, the number and range of drug agencies available, and the relationship with these agencies. Nee and Sibbitt say 'in many ways the responses appeared inadequate; probation officers had not been trained to recognise drug misuse and drug programmes did not always have the support of management' (1993). Of significance in matters relating to the conditions of treatment that can be attached to

a probation order. Nee and Sibbitt say 'once they had made a referral probation officers were usually unable to get feedback from drug agencies as a result of the agencies' policies on confidentiality' (*ibid*. p. iv).

Within the probation service there remains ambivalence about the need to control drug users. A casework approach mingled with a harm reduction approach is sometimes seen as more appropriate than one based on abstinence and control. This ambivalence produces problems and uncertainties when it comes to securing and enforcing treatment. Many of the criticisms levelled at probation officers ought to be directed at those providing treatment: these providers often fail to cooperate with the probation service. It is strongly suspected that they do not do so because they do not want to be involved in court proceedings, or worse because they do not want to inform probation officers of patients' failings, as this 'might damage their relationship with the treatment provider'. To which the obvious retort would be that the relationship is not that strong if it cannot stand that measure of honesty.

A probation order with a condition of treatment attached offers the best opportunities. Briefly, the Powers of the Criminal Courts Act 1973 permit a court to attach a condition of treatment to a probation order, which may be as an inpatient or outpatient, if that court is satisfied on the evidence of a duly qualified medical practitioner that an offender's condition is such that it requires and may be susceptible to treatment, but is not such as to warrant detention in hospital under the Mental Health Act. (There is an apparent confusion here which may be resolved thus: a person on a probation order with a condition of treatment can be detained in a hospital, but unlike those patients detained under the Mental Health Act his condition will not be as severe, and whilst on probation he has the same rights whilst in hospital as an outpatient to refuse treatment and discharge himself. That, of course, may lead to a breach of their probation, but if a refusal to undergo treatment is reasonable, having regard to all the circumstances (Section 6(7) Powers of Civil Courts Act 1973) no breach would be implied.) The main advantages of this type of probation order are that this can be employed in cases which do not warrant detention in a hospital (perhaps under the Mental Health Act 1983) and it is also able to provide treatment in conditions which fall outside the Mental Health Act's definitions of mental disorder, e.g. because they can include alcohol and drug misuse.

There seems to be general agreement that what is commonly called the 'psychiatric probation order' – or more accurately a probation

order with a condition of psychiatric treatment, as essentially determined by Section 3 of the Powers of Criminal Courts Act 1973 – is under-used, under-valued and under-researched. As far as can be seen, the high point of such orders was in the mid 1970s when approximately 1,000 outpatient and 500 inpatient orders were made – 'approximately', because surprisingly there are few accurate national statistics on the orders made. By 1987 it appears that the figures had dipped to 870 and 150 respectively, and by the late 1990s these had dropped even further. Of course these figures are not just for drug offenders, but for all offenders under a probation order with a condition of treatment, some of whom may not use drugs.

It is difficult to explain this lack of interest. It may have something to do with a general reluctance on behalf of psychiatrists to accept patients on an order, and a similar reluctance by the probation service to negotiate with psychiatrists about resolving existing tensions. The courts too seem to have lost interest, or perhaps have simply gone along with the prevailing climate. No one seems to know. Only one detailed research study has been undertaken, and that was many years ago (Lewis 1980). This study looked at the use and effectiveness of such orders. The conclusions were generally favourable, with Lewis arguing for greater use, especially amongst the less severely mentally disordered. Sadly, the study produced little general interest and has hardly been referred to again.

The 1991 Criminal Justice Act attempted to revive things by placing community treatments at the centre of the criminal justice system. For example Section 9 allowed courts to require offenders to comply, during the whole period on probation or part of it, with such requirements as a court considered desirable. The 1991 Act, however, seems not to have improved things, with this decline continuing. It is difficult to know how it can be reversed.

In addition there are bail and arrest referral schemes which strictly speaking are not part of the probation service's remit but are often run by them. These are available when an offender requires early assessment or treatment which can be provided through a bail scheme. Bail schemes may also involve the services of a consultant psychiatrist. The accommodation is usually in local bail hostels – the West Midlands Probation Service in Birmingham has one such hostel. If an offender is on police bail, the police may choose not to prosecute if that offender is being successfully diverted into treatment: sometimes the police will refer the case to the CPS for advice (NACRO 1993: 15).

There are various types of arrest referral schemes. Some may

involve nothing more than supplying an offender with an address to seek assistance or accommodation, others have agencies attending police stations offering advice on treatment. Some offer incentives contingent on receiving treatment. Much is made of these schemes with the potential for diverting drug offenders out of the criminal justice system, but there is little information on the number of such schemes or on their effectiveness, and without this it is difficult to evaluate them.

One study by Sondhi *et al.* (2002) showed that in the period from October 2000 to September 2001 those who make a treatment demand are broadly similar to problematic users presenting for treatment elsewhere. Males accounted for 81% of those screened. The average age was 27 years (range 10 to 66) and 90% were 'White'. The percentage reporting use in the last month were, in descending order: heroin 56%; cannabis 34%; alcohol 27%; crack 22%; benzodiazepines 14%; methadone 11%; cocaine, amphetamines and Ecstasy each 6%. Nearly half (47%) had injected in the last month. What appears to be happening is that of offenders offered treatment about 30% accept it, but whether these provide a representative sample of drug users is difficult to say.

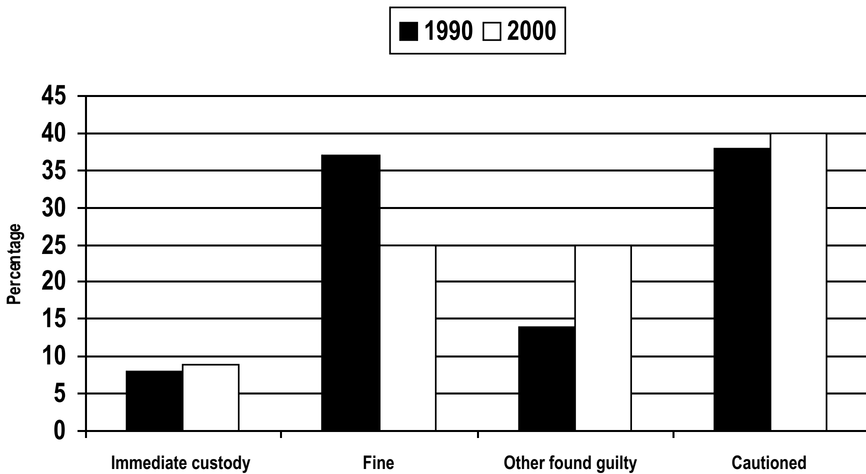
What is more important, however, is to see what happens to them afterwards. Are they accepted for treatment, and if so, do they stay? No one seems to know, although anecdotal evidence suggests only a small number make contact with the treatment services, and an equally small number stay in treatment. Sometimes this is due to a lack of treatment facilities, in which case it is all very well offering treatment, or rather suggesting offenders go into treatment, but if the services are not available, or there is no requirement to remain in treatment, we should not be surprised if the long-term results turn out to be poor. The other possibility is that offenders may lack the motivation to succeed in treatment.

A key point here will be developed in the final chapter, but the opportunity arises here to flag it up, as it were. And it is this. A major problem with all arrest referral schemes is they can only offer treatment to offenders; the Bail Act does not permit treatment to be a condition of bail and arrest referral schemes operate at the point where an offender is arrested and then bailed. Everything we know about treatment tells us that drug users are at their most vulnerable, and therefore at their most susceptible to treatment, when arrested. Yet offering treatment is never enough – at best, most will accept one or two appointments and then relapse. Treatment for offender populations works best when there is a compulsion to remain in

treatment, supported by mandatory drug testing and a period of treatment lasting at least 60 days. Anything less than that and one should expect failure. Arrest referral schemes may pick up one or two offenders who are ready for treatment and sufficiently motivated to succeed, but these are in a small minority. To catch the majority we need much more.

There are, in addition, fines. Figure 3.3 shows that the use of fines has fallen in the last decade from just under 40% to a little above 20%. In 2003 fines were used with 23% of offenders charged with the possession of heroin, and 35% for the possession of crack (Mwenda and Kumari (2005). It was rarely used for offences involving dealing. That it was used at all remains a mystery. It has no place for street junkies whose lifestyle makes them unsuitable for that type of sentence, or for the serious trafficker. I suspect that it could have more of a place for minor possession offences where the drug involved is Class B or C, but surely not for the possession of heroin. Yet here in 2003 it was used in 23% of cases for possessing heroin, 35% for possessing crack and 31% for possessing cocaine.

There is no information currently available as to the effectiveness of fines for drug offenders, either in terms of reconviction rates or as to whether fines were paid. Compounding (which is a fine in every respect save that it does not involve a court appearance and can be



Source: Mwenda *et al.* (2005).

Figure 3.3 Action taken against drug offenders (for principal drugs offences), United Kingdom, 1990 and 2000

imposed by HM Customs and Excise) has remained steady over the ten years from 1987. There is still no information on its effectiveness, but payment is made direct to the Customs Service at the time drugs are discovered. The number of offenders given a fiscal fine (for Scotland only) was comparatively small. A fine carries no treatment requirements.

Then there is the caution. Figure 3.3 above shows that as the use of fines has declined so that of the caution has increased, in such proportions that it is reasonable to suppose that cautioning has replaced fining at this lower end of the sentencing tariff. But not entirely, of course. Briefly, there are two types of cautions, the informal and the formal. The first is given in the form of a warning, with no record made of the incident and no further action taken. (Presumably this was given to many cannabis users after 29 January 2004.) The formal caution is different. It arose in the late 1940s with the police in Liverpool, where it was found that children who were made subject to the juvenile court's proceedings did rather worse in terms of reconviction than those who do not go to court. Hence they developed the formal caution, usually given by a senior police officer, but without the involvement of the court. It is a pragmatic device, aimed at cutting down court appearances and avoiding reconvictions. It is also a peculiarly British device, hardly used outside of these islands, but cheap, effective and thought to be especially useful with juveniles, although it is increasingly being used with adults. Formal cautions, like informal cautions, carry no treatment provisions, although there is nothing to stop the police from advising those cautioned where they can receive treatment should they so wish.

Figure 3.3 shows how the use of the caution for drug users has increased dramatically in the decade 1987–1997. Almost half of drug offenders were cautioned in 1997 – up from about 25% in 1987. The Advisory Council on the Misuse of Drugs (ACMD) saw cautioning as a 'particularly appropriate way of dealing with minor drug offences' (1994: para 7.6), adding that 'the effect of cautioning in reducing re-offending remains in question', although for most first offenders the likelihood of reoffending appears no greater than after conviction by a court (*ibid*.). It defined cautioning thus:

> In England and Wales the police may formally caution an arrested offender instead of initiating prosecution by the Crown Prosecution Service. The procedure is not used in

> Scotland. Although the practice of formal caution has statutory recognition it is nowhere defined in legislation, and is essentially an administrative act based on the discretion the police have in whether or not to prosecute offenders. (ACMD 1994: para. 7.2)

A major problem is the variation in the rates of cautioning throughout Britain. Some police forces caution only for a first offence, others would not caution if an offender had a previous drug offence, and some would not caution for supply. At one level, of course, this offends our principles of natural justice – equals should be treated equally. At another level, a national policy might be quite inappropriate and has been recognised as such by many police forces who have stated that they want to operate a policy specifically related to the conditions in their area. So, for example, they would not want to give a caution to a drug user in an area where drug use is rare as it would send the wrong message to others and potential users, but where drug use is common a caution might be more appropriate. Home Office Circular 18/1994 encourages greater consistency between various police forces and tries to meet the other criticism that cautions are a soft option: the Circular discourages the use of cautions for the most serious offences (ACMD para 7.36). To what extent such advice is heeded remains difficult to say, but the ACMD were correct in saying that they were convinced of the value of cautions in dealing with drug offenders (*ibid.* para. 7.1), and accordingly we can expect their use to continue.

The sentencing patterns for Ecstasy are interesting. Although a Class A drug, 62% of all possession offences were dealt with by a fine or caution as compared with 37% for heroin and 35% for crack (Mwenda and Kumari 2005.) Moreover, only 6% of those charged with possession of Ecstasy were sentenced to immediate imprisonment, a smaller proportion than for other Class A offences. So too for dealing; 81% of dealers in heroin received immediate custody, and 69% for crack, but the figure was 61% for Ecstasy. The courts it seems do not treat Ecstasy as a Class A drug, or rather they treat it as a special Class A drug.

Finally, there is imprisonment. Its use remained relatively steady over the previous decade, and in 1998 ran at about 9% or 10% of total drug offenders.[1] This was an increase of 4% over 1997 compared with a 19% increase over 1996.[2] These increases do not affect the proportion of drug offenders sentenced to immediate custody as they match the rise in drug offenders generally. Imprisonment is less used for possession and more often for trafficking offences, defined in terms

of the production of drugs, the unlawful supply and possession with intent to supply unlawfully, and unlawful import and export. The longest sentences are awarded to the most serious traffickers.

Generally, the main aims of imprisonment are to punish according to individual and general deterrence, retribution and rehabilitation. Treatment is part of a rehabilitative framework and is provided in prisons alongside mandatory drug testing. The latter, which was introduced in all penal establishments in England and Wales by March 1996, is primarily a deterrent against using whilst in prison, but if provided alongside a treatment programme it can be beneficial (Duke 2000).

There are three main reasons why treatment programmes should be run in prisons. First, to provide treatment and especially for those who want it: prison provides an opportunity to give treatment, and that opportunity should not be missed. Second, treatment programmes help reduce the extent of drug use in prisons generally, which is widespread. Third, treatment in prison also provides a means by which drug users can plan for their release, most relapses occur soon after an offender leaves. Determining the effect of these programmes is impossible with the current data sets as there are no measures of the numbers of drug users in prison generally, so it is not possible to estimate the impact of the programmes let alone compare one programme with another. Nor is it clear what criteria should be used to measure the impact of programmes, or to determine to what extent incarceration itself is of greater importance than the treatment available. Reconviction, and perhaps continuing drug use, are the only measures generally available, but these are not always valid measures and rarely prove reliable.

The range of programmes for prisoners must, of necessity, be limited, whether due to the available facilities or the length of stay of prisoners (treatment programmes in whatever setting should last at least three months). In an American study of over 100 jails providing treatment it was found that few had comprehensive services, most had poor screening facilities and few were linked in any systematic way to community agencies on an offender's release. The services provided, which varied greatly in content (and one suspects also in quality), were only available to a small proportion of those inmates who should have been receiving them (Peters 1993: 47–49; Weinman and Lockwood 1993). Most of the treatment consisted of a mixture of group therapy and psycho-educational approaches within therapeutic community settings, determined often by the interests and qualifications of the staff and the amount of time they were prepared

to allocate to this form of treatment rather than other requirements. Similar results were found in prisons in Britain, with John Burrows *et al.* (2000) reporting that the provision of drug services throughout prison establishments was uneven, and prisoners stating that the treatment offered often depended on what was available rather than what was appropriate to their needs (*ibid*. p. 3).

There is little doubt that treatment services are necessary. John Burrows *et al.* (2000) reported that drug taking amongst prison populations prior to incarceration was high, with use in the 12 months before entering prison ranging from 40% to about 70%, and in addition findings from self-report studies show that many people continue to use drugs whilst in custody. Numerous prisoners (66%) cited heroin as their main drug, and had used it everyday in the 30 days before being sentenced. A third said they took crack and half took cannabis. Overall, most were polyusers (*ibid*. p. 2). The researchers also noted that the primary means of identifying prisoners with drug problems was when they themselves seek help. However many are reluctant to do this, as it means the authorities will know they are drug users and thus prisoners fear they will be targeted during their sentence (for additional searches and the like). These are some of the impediments to receiving prison treatment. Add in the increasing numbers of substance abuse prisoners with a coexisting mental disorder, or dual diagnosis (about 11% in US jails according to the US Department of Health and Human Services 1998), and the problem becomes huge.

The Office of National Statistics (ONS) carried out a survey of inmates in English and Welsh prisons during 1997 (Singleton *et al.* 1998). It revealed that nearly half of sentenced males and a third of sentenced females reported using drugs during that current prison term. Cannabis use was reported by 46% of males and 31% of females who had been sentenced. However, women were just as likely as men to report the use of heroin. Around two-fifths of both male (43%) and female (41%) inmates reported a dependence on drugs, somewhat lower than the rates for remand prisoners (51% and 54% of males and females respectively). Females reported higher levels of dependence on heroin and non-prescribed methadone. By the end of March 1996, John Corkery reported that Mandatory Drug Testing (MDT) had been introduced into all penal establishments in England and Wales. Results for these countries show that while there was an overall decrease in the proportion of inmates testing positive for cannabis (from 10.2% in 1999/2000 to 6.8% in 2001/2), there were rises in the use of opiates and benzodiazepines (Home Office 2001; 2003). The proportion using opiates rose from 4.3% to 4.7%, and that for

benzodiazepines from 1.1% to 1.3% in 2000/01, but fell slightly in 2001/02. Of note here is that 1.5% of inmates in some establishments in the north east of England tested positive in 2000/01 (and 1.2% in 2001/02) for buprenorphine which is becoming more widely used in the treatment of opiate dependence (Corkery 2003).

What is particularly disturbing is that some prisoners reported that their detection and punishment had not affected their use. In a sample of 148 prisoners from five establishments, Edgar and O'Donnell (1998) found that 37 claimed they did not use drugs while in prison. However, of the remainder (111) almost half (53) said they had not changed their drug taking while in prison, four said they had tried heroin for the first time and had cut down on cannabis use, seven had reported altering their pattern of consumption taking less cannabis but continuing to use heroin), and 17 out of the 111 said they had reduced their consumption, i.e. that had not stopped using. An outcome of MDT is that many prisoners will spend longer in custody at a significant cost to the prison service. Edgar and O'Donnell reported that in 1997 about 159,000 days were added to prisoners sentences as a direct result of MDT (or roughly equivalent to 360 prisoner years, or about £7m in additional running costs) (*ibid*. p. 4). A criticism of MDT, at least from the prisoners' point of view, was that not enough attention was given to identifying serious drug use and directing prisoners to treatment, and rather too much was directed at deterrence.

The US Department of Health and Human Services talk of what they describe as 'Obstacles to Effective Post Release Transitions', – in other words, problems around providing adequate throughcare facilities. The obstacles, they say, are substantial, with most coming from the structure of public sector systems, such as fragmentation of the criminal justice system, community providers' lack of attention to offender issues and funding barriers (US Department of Health and Human Services 1998: 4). John Burrows *et al.* (2000) paint an equally dismal picture for Britain when they say 'Drugs throughcare provision is characterised by structural impediments where delivery is restricted by disputes over professional boundaries, areas of responsibility and fragile funding. Successful schemes are typically the product of one or two charismatic individuals and unusually strong interagency partnerships'. Yet without adequate throughcare the inevitable will happen: prisoners will return to drugs, as most appear to do, and will do so speedily upon release.

The prison service are clearly alive to the problem and its 1998 strategy was aimed at providing an equitable provision of

basic and enhanced specialist services to meet low level, moderate, and severe drug problems. In practice this means developing what is called a Counselling, Assessment, Referral Advice and Throughcare Service (CARATS) within and across the prison service, with greater emphasis on inputs by the treatment services. At the same time, security is being strengthened and drug testing continues – the usual mixture of carrot and stick is thus in evidence (Home Office 1998b).

The problems posed by drug users in prison are immense. Some offenders are unlikely to be drug users (such as those convicted for trafficking), and users are more likely to come from the organised crime syndicates described below. They pose particular control problems, with their sentence being wholly for retributive or for deterrence reasons and likely to be lengthy. Rehabilitation, whatever that might mean to drug offenders generally, is not likely to be available for this group and nor will there be treatment for these traffickers while in prison. Yet there are many other drug offenders where the principles of rehabilitation do apply – treatment is needed and supervision is required.

No one wants to underestimate the difficulties. Some drug offenders are reluctant to disclose their drug use when first taken to a police station or subject to a report from a probation officer, believing it may result in a longer sentence (especially if they are a female and certainly if they are also pregnant). Nor are they the most rewarding offenders to deal with. For some the concept of rehabilitation does not apply, not because they are unworthy candidates for a rehabilitative approach, but because rehabilitation assumes that they were once habilitated and that assumption may be unwarranted. They may have never received the basic skills – social, technical, or otherwise – in the first place. Many are unemployable, reaching their mid-twenties never having had a proper job. Their life experiences will have largely been shaped by periods in prison and on the drug scene, where inter personal violence and the demands for instant rewards are commonplace. Supervising these offenders is always going to be difficult, whether inside prison or on discharge, even monumental. Yet all too often these are the offenders that cause enormous expense to the criminal justice system and take up a disproportionate amount of resources.

Some concluding comments

Looking at the numbers of drug offenders and the number and length of sentences passed tells us little about sentencing policy, about changes in policy or the practices of the courts. There are three reasons for saying this. First, the data are so poor and so defective that, at best, we can talk only of general trends. Noted above that there was about a 33% error in MPS data sent to the Home Office, at it is from this that the Home Office constructs its reports. 'Rubbish in, rubbish out' was how one senior police officer described it.

Second, drug offenders as defined above are only a small proportion of offenders appearing before the criminal justice system who have a drug habit. Countless others, where the Index offence is not a drug offence, regularly appear and for some the court will not know there is a problem. If it does, it is not clear whether or not courts consider this when passing sentences. Third, even if we knew of all the drug offenders the number of offenders sentenced to each specific sentence is insufficient to identify a sentencing policy: at the very least, we would need to be told the ratio of sentences to offences, i.e. we would need to know the years of prison time, or the amount of the fine, the period of probation, and so on, imposed as a result of drug taking. Even then, any answers would only give a crude figure, as it would also need to take account of previous convictions, amount of drugs involved, and so on. We are left, therefore, with little more than a general description of the sentences themselves, examining the changes over time, and can only infer likely trends.

The principal rationales for sentencing apply equally to drug offenders as to others. There are no special defences for drug offenders and no particular reasons to deal with drug offenders outside the usual justifications for imposing sentences on any other offender. Sentencing involves a mixture of legal principles, moral assertions, theoretical justifications and legal precedents which can occasionally be reduced to the notion of a tariff, that is a rough and ready guide based on a common law tradition about what a particular crime is worth as far as a sentence goes. To say that one crime is worth a more severe sentence than another is to invoke a multitude of arguments about proportionality, deterrence and rehabilitation, plus a mixture of mitigating circumstances which can include the nature of the offence, the way it was committed and the character of the defendant. In this respect, sentencing drug offenders is no different to sentencing other

offenders. The sentence will contain the following components: there will be a need to deter others from committing the offence; to deter the individual from committing the offence again; to sentence the offender because he has committed an offence and therefore deserves to be punished; and to offer a form of rehabilitation while being punished. The final decision will also take account of the mitigating circumstances, which may include the offender's dependence on drugs, but this may not always work to the offender's advantage as a court may think this is a self-inflicted condition and justifies a heavier sentence than would otherwise be handed down.

However, in one respect drug offenders *are* different. It is increasingly being recognised that they need to be sentenced according to principles of rehabilitation, rather than deterrence or retribution. This has occurred because of the links with treatment – 'Treatment works' is a recurring theme to be found in later chapters. Rehabilitation was a dominant philosophy of the 1960s and 1970s, but has since been discredited and replaced by a just desserts model, which draws on retribution as its intellectual inspiration. The basis of a rehabilitative philosophy is that offenders require help not punishment and where help is usually provided through some therapeutic intervention, or by medical services. It was criticised for being too soft on offenders and too concerned with their welfare, at the expense of victims, while at the same time viewed as too harsh because it permitted detention until the offender was cured, which may be longer than would have been the case had a retributive sentence been passed.

The paradox of the present position is evident. The treatment of drug offenders resurrects the theory of rehabilitation and with it all those arguments which were left behind when the just desserts philosophy became dominant. Rehabilitation does have within it a set of apparent contradictions: it can be regarded as too soft when drug offenders are given treatment in the community, rather than sent to prison, and can be regarded as too harsh when they are detained in prison for treatment longer than they would have served them otherwise. For those conducting treatments, rehabilitation promotes them to an increasingly powerful position, as they will be asked to decide when a drug offender is ready to be discharged. They will also be asked who will be given treatment, what kind will be given, the cost involved, the length of time this is likely to take, and above all who is suitable? They will also have their say as to who is to be let into treatment and who is to be excluded.

At the moment, rehabilitation as a dominant theory of sentencing is being held back by a shortage of treatment services which are

currently scarce and poorly developed. There are today about 500 drug treatment agencies in England and Wales (Royal College of Psychiatrists 2000), but these have a relatively minor part to play within the criminal justice system. Rehabilitation could change that, and indeed in later chapters I argue that there should be a greater level of coordination between the criminal justice system and treatment services. In saying this I recognise that I am advocating a return to a rehabilitative philosophy with all its attendant problems, but in doing so I am also suggesting that it be resurrected in a form which avoids past failings. It should still have an impact on the sentencing practices of the courts and will exert an influence, but must do this in ways less destructive to those of earlier years. The extent of such rehabilitative influence will become increasingly apparent as the demands for treatment increase.

At present, most of our energies in Britain seem to be taken up with less important pursuits such as whether drugs (mostly cannabis) should change from one class to another, typically from Class B to Class C, or whether Ecstasy should change to Class B from Class A. The argument for doing so is that a more accurate 'hierarchy of harm' will help to target policing prevention and treatment resources more effectively. Whether that will be so remains to be seen for as will be shown later policing drug offenders is more haphazard than this with most prosecutions, especially for cannabis, occurring when an offender is arrested for a non-drugs offence and is found to be in possession of same. Few offenders are targeted for possessing cannabis, although more may be for the possession of Ecstasy, but reclassifying the latter to a Class B drug is not likely to make much difference as far as policing is concerned. Moreover, as shown in this chapter, most of those offenders charged with a possession offence are given a caution or a fine and this is irrespective of the Class of drug involved. More likely the reclassification argument is part of a wider demand for decriminalisation or legalisation and has little to do with sentencing, policing or public policy.

Of the many aspects of sentencing which are important there are two which need to be emphasised, and at the risk of being repetitive, as being likely to become significant in the future. First that drug offenders in Britain are not likely to go to prison for a possession offence, but are very likely to do so for illicit supply. Second that the links with treatment make sentencing closely aligned to a rehabilitative philosophy. In the first case the development of treatment facilities must become increasingly important. The nature and extent of drug misuse in the United Kingdom – official statistics,

surveys and studies of sentencing – will need to be considered, if only to avoid the previous defects of rehabilitation which were glaringly obvious when rehabilitation last assumed a measure of dominance. I shall refer to these points again in later chapters.

Notes

1 A survey of Scottish prisoners conducted in 1998 found that 44% of prisoners had used drugs while in prison during the previous six months (Wozniak *et al.* 1998). Nearly two-fifths (39%) had used cannabis and the rates for other drugs were heroin 31%; diazepam 16%; dihydrocodeine 14%; Ecstasy 9%; amphetamines 8%; methadone 4%; and other opiate-based drugs e.g. Temgesic (buprenorphine) 23%. There was a significant increase in the use of heroin between 1994 and 1998, from 9% to 31%. Levels of drug use reported by inmates varied from 11% in Peterhead to 59% in Glenochil. Drug use was more likely among young offenders, especially males. On average, 5% reported injecting drugs in prison and again this varied from prison to prison, reaching 19% in Aberdeen. About four-fifths (82%) of injectors reported sharing injecting equipment. Remand prisoners and long term-prisoners nearing the end of their sentences are less likely to have these practices.

The 2001 sweep of this survey found that 38% reported having used drugs in prison in the previous month (SPS 2001). Of these, opiates were reported by 76%, cannabis 70% (see Table 16). Four per cent of this drug-using group reported injecting, and of these 77% had shared their 'works'. Drug use ever in prison was reported by 58%, of whom 43% had received help, such as counselling or prescriptions, while in prison. Three-quarters said that their drug use had changed during their current period inside: for 80% use had decreased, but 12% reported more use, and 8% had used different drugs. The latest sweep (SPS 2002) indicated that while the use of opiates and Temgesic had fallen since 2001, there have been increases in a range of other drugs (see Table 18). These changes have been accompanied by a doubling (to 8%) in the proportion reporting injecting drugs, and a higher proportion of these sharing (92%). However, the percentage of those receiving help for their drug problems had risen to 50%. Other patterns remained similar to 2001.

2 MDT results for Scotland show that the proportion of positive tests for any drug fell from 36% in 1996/97 to 21% in 2000/01 before rising to 22% in 2001/02 (ISD 2002: 152 and 2003: 165). The rates for cannabis and opiates fell most from 29% to 9% and from 16% to 11% respectively. The rate for benzodiazepines fell from 9% to 4%. The rate of detection for Temgesic has ranged between 1 and 3%.

The levels of drug use amongst prisoners at reception increased in Scotland from 73% in 1998/99 to 77% in 2001, but fell to 75% in 2001/02

(ISD 2003:164). The use of cannabis rose from 49% to 63% in 2001, but fell to 45% in 2001/02 as well as benzodiazepines (from 43% to 52%). Methadone use increased from 8% to 12% before falling to 10% in 2001/02, probably reflecting its wider use in the treatment of dependence. Opiate use varied between 34% and 44%, and amphetamines between 2% and 4%. Cocaine use rose from 4% to 9%.

These results relate mainly to prison establishments in Aberdeen and Perth. A study in October 2000 found that there were substantial geographical differences in the use of all types of drug (ISD 2002: 151). For example, cannabis use ranged from 29% in Inverness to 93% in Perth; opiates from 11% in Polmont to 61% in Cornton Vale (a female establishment); and benzodiazepines from 12% in Dumfries to 84% in Aberdeen.

Chapter 4

Coercive treatment and mandatory drug testing

In the previous chapter an overview was given of the facilities available within the criminal justice system for dealing with drug offenders. In this chapter the aim is to look more closely at treatment within the criminal justice system which, for these purposes, means coercive or enforced treatment. This examination will take place alongside a look at mandatory drug testing (for a more detailed discussion on treatment generally, see Bean and Nemitz 2004).

From the mid-1990s onwards, British governments have shown an increasing willingness to fund and thereby increase the range of treatment facilities for substance abusers and, correspondingly, have shown a willingness to increase drug testing. They have done so because they recognise that treatment provides one of the few options for containing the drug problem, coupled with a belief that it breaks the link with crime. Drug testing is included because it is thought that, without that backup, treatment will fail. Drug testing is the building block of treatment within the criminal justice system.

Briefly, the background to the various government initiatives is as follows. In 1995, *Tackling Drugs Together: A Strategy for England 1995–8* was produced for England; that for Wales and Scotland followed soon afterwards (Ministerial Drugs Task Force 1994; HM Government 1995; Welsh Office 1998). *Tackling Drugs Together* (HM Government 1995: para. 1.3) committed the government 'to take effective action by vigorous law enforcement, accessible treatment and a new emphasis in education and prevention'. There were no details of the treatment programmes in these strategies but promises were made that these would be provided in a later task force report. The emphasis in

Tackling Drugs Together was on reorganising local services, including replacing them with Drug Action Teams.

The later *Task Force Report* (Department of Health 1996) assessed the range of treatment services and commissioned some research; its terms of reference included 'a comprehensive survey of clinical, operational and cost effectiveness of existing services for drug misusers'. In 1998 a second drug strategy was introduced by the newly appointed Anti-drugs Co-ordinator, entitled *Tackling Drugs Together to Build a Better Britain: The Government's Ten Year Strategy for Tackling Drug Misuse* (HM Government 1998). This largely reiterated the themes of the 1995 document whilst adding performance targets for drug reduction for the next decade. Finally, in 1999, guidelines on the clinical management of drug users gave advice to the medical profession about how best to implement the drug strategy.

The National Treatment Outcome Research Study (NTORS) – the biggest study of drug treatment ever conducted in Britain – showed that there were considerable benefits in bringing drug users into treatment. However, the rates of improvement were less than in the USA (Gossop *et al*. 1997, 1998). NTORS followed the progress of 1,100 drug misusers through treatment and concluded that there were no 'magic bullets' to cure drug problems. In a review of treatment using NTORS data, the conclusion was that drug abuse was a chronic relapsing condition which required treatment to fit the client's needs. Drug treatment, which embraces social care and support as well as clinical intervention, can be effective in reducing drug-related harm, but most substance misusers require several attempts at treatment before noticeable success occurs (Gossop *et al*. 1997).

In June 2001 the post of Anti-drugs Co-ordinator was abolished, and the Drugs Czar was initially given a part-time job as an international adviser, but that ended soon after. The centre of the government's strategy moved from the Cabinet Office to the Home Office, presumably on the grounds that policy had traditionally come from the Home Office and that two centres of policy-making produced unnecessary duplication.

In April 2001 the National Treatment Agency (NTA) – a Special Health Authority within the National Health Service – was launched (see Bean and Nemitz 2004: chap. 7). The NTA covers England; other arrangements are in place for Scotland, Wales and Northern Ireland. The aim of the NTA is 'to co-ordinate the drive for better and more consistent treatment for people with drug problems'. This includes 'the commissioning and delivery of high quality effective treatment for drug misusers (which) is fundamental to the success

of the Government`s drug strategy' (NTA undated). This statement of purpose is in line with the government`s strategy 'To increase participation of problem drug misusers including prisoners in drug treatment programmes which have a positive impact on health and crime by 66% by 2005 and by 100% by 2008' (*ibid*.). In February 2002, the NTA produced *Models of Care for Substance Misuse Treatment* aimed at providing a framework 'intended to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in the UK' (p. 2).

All these government initiatives emphasised the need for treatment. Treatment was to operate alongside law enforcement, prevention and control – the latter mainly through the criminal justice system. Treatment was endorsed as a desirable platform in the government's strategy, which inevitably concentrated on Class A drugs controlled by the Misuse of Drugs Act 1971 (i.e. mostly heroin and cocaine). In its strategy the government called on substantial evidence from America (now transformed into British thinking), which shows that 'Treatment Works' – a slogan particularly favourable to Britain which, nationally, has well developed, widespread treatment services.

Legislation has been introduced that requires some drug offenders to submit themselves to treatment – these in addition to facilities already in existence. The DTTO provided for under ss. 61–64 of the Crime and Disorder Act 1998 (and drug testing in prison carried out under s. 16A of the Prison Act 1952) links the treatment services with the criminal justice system in ways that require them to work according to criminal justice requirements. The Criminal Justice and Court Services Bill, which was then before the House of Lords, illustrated government thinking: 'Identifying drug misusing offenders at every stage in the criminal justice system is now a prime objective of the crime reduction strategy and will make an important contribution to the overall drug strategy' (House of Commons, Explanatory Notes 2000: para. 28). Additional powers require offenders and alleged offenders to be drug tested at various points in their contact with the criminal justice system. These are at a national implementation cost of £45.5 million, of which £20 million will be police costs (*ibid*.: paras 133 and 134). Clearly this is where the government is putting the funding. There are also drug abstinence orders which require the offender to refrain from misusing Class A drugs and to undertake a drug test on instruction, as well as pre-sentence drug testing.

Why are these additional facilities required? There have long been facilities to treat offenders under a probation order, perhaps with a condition of treatment as an inpatient or outpatient. There have been

also opportunities to require some offenders to be inpatients as a condition of their probation order. However, these appear not to have been taken up, for reasons which have not always been understood. Briefly, the Criminal Justice Act 1991 tried to boost the use of treatment under a probation order and gave the courts powers to impose treatment as part of a sentence of probation – as it was then called. It was rarely used. The Home Office Probation Inspectorate said this was because:

- The Home Office and Probation Services adopted a neutral stance, declining to issue guidance.
- Probation officers did not believe coerced treatment would work so were reluctant to recommend it in their pre-sentence reports.
- Sentencers lacked information on the treatments available.
- Within the criminal justice system treatment providers were un-enthusiastic about operating coercive systems.

The result is new legislation where the overall effect is to shift towards more forms of treatment (some of which are coercive) and away from the earlier approach, which is still beloved by many of the treatment services – that treatment should at all times be voluntary. This is not the place to discuss the philosophy of treatment (see Bean and Nemitz 2004 for a discussion on treatment generally), but the government has clearly been influenced by the American research which proclaims in unequivocal terms that treatment is successful (Anglin and Hser 1990).

Yet behind the slogan 'Treatment Works' lies a range of difficult questions. First there is a group of empirical questions, such as with whom does treatment work? Can successful treatments be given over a single period, or do they require subsequent treatments even after the success of the first? Is a single type of treatment appropriate to all patients? Then there are questions about the principles of treatment. What are the aims of treatment? What should be the remit and to whom should treatment be given (it clearly cannot be given to everyone who takes drugs)? Finally, there is a group of questions specifically surrounding treatment within the criminal justice system, such as: what are the aims of treatment in criminal justice? Do they or should they differ in a qualitative sense from that provided outside the criminal justice system – that is, can treatment be effective if the offender is coerced, or does it always need to be voluntarily? The questions to be dealt with here centre on the links with the criminal

justice system and the corresponding matter of coercion. Others of a more general nature are considered in another volume more directly concerned with treatment generally (see Bean and Nemitz 2004).

The aims and nature of treatment

The treatment of substance abuse, whether in or out of criminal justice, uses a mixture of traditional medical interventions, including treatment talk, which is likely to dominate treatment programmes. In the early stages when the offender enters the programme, the focus tends to be narrow, perhaps centring on detoxification or other forms of withdrawal. As treatment progresses it becomes more inclusive (i.e. more therapeutic), taking in wider aspects of the drug takers' lives. The Royal College of Psychiatrists (2000: 155) sets out the aims of treatment: to prevent and reduce the harm resulting from the use of drugs. The Royal College says this definition includes social, psychological or physical harm, and may involve medical, social or educational interventions. It also includes prevention and harm reduction – prevention presumably means for everyone, but harm reduction is for those who are chronic substance misusers (*ibid*.).

The straightforward definition provided by the Royal College differs in content hardly at all from that found in most standard texts on the rehabilitation of offenders, although it differs in form in that rarely are definitions as succinct as this. This is to its advantage as it spells out the treatment aims in a clear, unequivocal manner – a quality rarely found in textbooks on treatment. More likely there will be a discussion, or rather a description, of the nature of drugs and addiction; there will then be a discussion of assessment, followed by an examination of measures of intervention – usually including a discussion on the range of treatments and the special types of problems encountered – with a final section on follow-up and outcome. The central questions will be neatly bypassed, such as what should treatments aim to achieve, and for what reason?

Within the drugs field the language of treatment is predominant medical. There is little to suggest, however, that treatment is aimed at curing an 'illness', although the patient's condition during the withdrawal period may be akin to this, requiring expert medical intervention. The model of addiction most favoured in Britain, including that by the Royal College of Psychiatrists, is a socio-behavoural one; an alternative, the disease model, has little support outside the rather narrow confines of AA/NA (Alcoholics Anonymous/Narcotics

Anonymous), who provide programmes such as the '12 Steps' and other self-help groups.

Treatment has, and will continue to be, thrust into prominence for two main reasons. First, there has developed a wider understanding of the links between drug taking and crime, initially promoted during the late 1980s when drug cases began to escalate dramatically alongside an ever-increasing crime rate, particularly property crime. Within this research, studies confirmed what many had suspected – that large numbers of offenders on arrest were testing positive for a range of drugs and were claiming they committed crimes while under the influence of drugs (Bennett 1998). Overwhelmed by this increase in drug use and the apparent criminality it produced ('apparent' because, as shown in Chapter 1, the links with crime are more tenuous than at first appears), the government's response has been to increase the range and numbers of treatment programmes. This, it expects, will provide relief from the so-called revolving door of crime, where drug users endlessly move between the courts, the criminal justice system and the world of criminality. The NTORS is a clear example of government interest (Gossop *et al*. 1997). Of course not all drug users are part of the revolving-door syndrome, but those who are create the biggest problems.

Secondly, treatment has been revitalised by the growing belief that it works. The veracity of this is more alive in America than in Britain as Britain does not have the complement of research data to verify it, but it has been picked up in Britain, none the less, and the NTORS study goes some way to redress the balance. Research has not always made clear how treatment works with whom it works, or whether some treatment modalities work better than others, but there has arisen the popular belief that it does work. Perhaps this slogan has been accepted because it provides the only way of dealing with a problem that is almost out of control – treatment provides a life-raft and gives hope against an otherwise relentless increase in drug use. Whether this is the case or not, treatment (and the expected success it will bring) is imbedded in the popular image, and governments are prepared to invest heavily in treatment programmes.

However, does treatment work only when the offender seeks it, or does it work when the offender is coerced? This is one of the key questions, not simply because of the empirical questions about outcomes and success rates but because treatment within the criminal justice system must operate according to different parameters than those involved in the traditional freedom of the doctor–patient relationship. Criminal justice is about control; the classical model of

treatment, however, involves freedom on behalf of the doctor and patient to break the relationship. Small wonder that those treatment agencies wedded to the traditional model find it difficult to work within a criminal justice framework. Too often they insist that treatment must be voluntary but find themselves involved with a system that does not permit their patient – the offender – to make his or her own decisions; this is essentially a coercive system. The problem is compounded by the demands made for treatment by the criminal justice agencies. The group most in need of treatment almost certainly comes from the criminal justice system and, indeed, about 60% of all those seeking treatment come from this source. What, then, of coercion?

Coercive or enforced treatment of substance abuse

It seems axiomatic that any increase in the treatment services will be directed towards the criminal justice system, for this is where the government sees the problem at its worst and, consequently, is most likely to spend its money. Governments no longer live in that world where they hope the drug problem will magically go away; they recognise its enormity and the cost it brings, socially and otherwise. This would suggest (whether the treatment services like it or not) that there must be a closer working relationship between the treatment services and the criminal justice system. This has already happened in the USA. In the 1980s there occurred a so-called 'paradigm shift' where the treatment services and the criminal justice system agreed on a development programme and a strategy about how best to implement it. This included decisions about who should and who should not be treated, about the best way to move forward and about how to remove existing barriers to co-operation. It meant sharing beliefs and accepting a new set of aims and objectives. In practice, the changes were almost all one way: the criminal justice system shifted its position hardly at all. That 'paradigm shift' has not yet occurred in Britain but it cannot be long before it does.

A likely implication of a closer working partnership is that the treatment services will lose some of their independence and, with it, their more theoretical approach to treatment. A possible outcome is that treatment agencies will be subcontracted to the criminal justice system, providing treatment to offenders on court orders, whether at the pre- or post-sentence stage. This is already happening under the DTTO, but the change is likely to be accelerated in the short and long term as governments seek new ways to control drug offenders. Treatment

agencies will also have to face demands to evaluate their work (most of which have been able to avoid this type of scrutiny hitherto). The effect will be to bring about an erosion of some cherished beliefs and a corresponding change in some of the assumptions underpinning the agencies' work.

One established cherished belief likely to come under threat is that which asserts that treatment ought only be provided if the patient seeks it voluntarily. (This was one of the first casualties of the 'paradigm shift' in the USA.) This view, which, like so many others, has been promoted and sustained with little or no research evidence to support it, has become one of the shibboleths of the treatment world. It is based on a set of assumptions that suggests the patient must give of him or herself fully and freely to a treatment programme or it will not be successful. A coerced patient will be a failed patient.

Much confusion centres on the term 'coercion', as if there was something sinister about the fact that offenders are coerced. Yet coercion or enforcement is a *sine qua non* of the criminal justice system. Treatment agencies working within the criminal justice system must expect to work within a coercive apparatus; that some appear to try to operate otherwise shows they misunderstand the nature of their task. It is not therefore whether coercion is acceptable for, by definition, coercion is part of criminal justice. The questions are, or should be: what is an acceptable level of coercion and what should be the powers of those able to coerce? What should the boundaries be of a coercive regime?

As far as coercive treatment is concerned, two major legal forms of coercion can be identified, each with its own subtypes:

1 Those involving *civil* commitment. The agencies undertaking civil commitment usually include the courts sitting as a civil court, created government agencies (including the police) and a medical agency.

2 Those involving *judicial* commitment. This occurs where commitment is a condition of a sentence, as in a probation order or compulsory after care. Imprisonment for the Index offence is not included in this category.

First comes civil commitment. There are no provisions in Britain for the civil commitment of substance misusers. The Mental Health Act 1983 expressly forbids including drug addiction as a category of mental disorder, although a mental disorder resulting from drug abuse could warrant compulsion. The first Brain Committee report (Department of Health 1960) considered introducing civil commitment

provisions for substance abusers but rejected it, and the Review of the Mental Health Act 1959 (which led to the Mental Health Act 1983) noted that government advisory bodies said it was incompatible with current thinking to regard drug dependence and drinking problems as a form of mental disorder:

> These conditions are increasingly seen as social and behavioural problems manifested in varying degrees of habit and dependency. However, it is recognised that alcohol and drug dependency can be associated with certain forms of mental disorder. (Department of Health 1978: para. 1.29)

However, the distinctions have increasingly become blurred. Substance abuse is frequently found in mentally disordered patients and mentally disordered patients are frequently found to be substance abusers – the so-called dual diagnosis patients. Moreover, substance abuse can mask or mimic disorders, making diagnosis difficult and treatment equally so. None the less, as a general proposition, the Brain Committee were correct to make and establish the distinction, and the recent review of mental health legislation was also correct to leave things as they are.

Civil commitment has been used extensively elsewhere; in a United Nations' survey of 43 countries, 27 had civil commitment provisions for substance abuse (Porter *et al*. 1986). In America, civil commitment was introduced early in the twentieth century when users were referred to so-called narcotic farms and, later, to hospitals (as in Lexington, Kentucky). It was used again in the 1960s in California and New York, again through the civil law, based on assumptions that, whilst some drug abusers are motivated to treatment, others are not. Accordingly, a mechanism had to be established to deal with the less motivated users (what was called 'rational authority') but which Inciardi *et al*. (1996: 28) say was a euphemism for appearing not to be punitive, yet able to exercise mandatory control. The California programme permitted commitment for up to seven years – without, of course, having convicted the drug user of any offence. In New York it was similar.

Few civil commitment programmes have been properly evaluated, including those in America. Inciardi (1988) says of the New York programme (that is, where such evaluation as there was existed) that it was an abject failure. This, he says, was not because the idea was wrong but because it was poorly funded, had poor treatment facilities, appointed untrained staff, had a poorly developed aftercare programme and lost public support, leading to a wave of bad publicity. Anglin

and Hser (1991) evaluated the California programme and concluded that civil commitment was an effective way of reducing narcotic addiction, yet added that this conclusion should not necessarily lead to immediate implementation. It was useful for bringing users into treatment, but it could not take the place of treatment (Leukefeld and Tims 1988; Anglin and Hser 1991). Anglin and Hser (1991) believe that drug abusers should be given greater encouragement to enter treatment voluntarily and, unless funding is provided to create new programmes or extend existing ones, the coercion of an individual into drug treatment may make the situation worse.

There are, of course, civil rights questions to be asked about civil commitment. People in Britain rightly object to the notion that a person can be detained without having been convicted of a criminal offence because he or she abuses substances. (In Britain there are, incidentally, fewer qualms about compulsory detention of the mentally ill without due process of trial.) It may be true that the extent of abuse makes a user a danger to him or herself as death rates are high. So, too, are they amongst motorcyclists or young car drivers – are these to be detained also? The justification for civil commitment in the USA is also based on health/economics (that is, detention is justified because of the expected cost to the public health services if left untreated). Of course the same could be said for anyone engaged in dangerous pursuits, from skiing to working as a steeple-jack. The more serious point, however, can be made with those who directly care for children, including pregnant women, where substance abuse can damage the physical and mental health of those in their care.

The second type of commitment (judicial commitment) is, however, used extensively in Britain, as shown by the data in Chapter 3. This involves committal to treatment by a court order and, whilst the offender is given a choice about accepting the order (as in the DTTO), in practice this choice is illusory – resembling more of a Hobson's choice than a real choice. Judicial commitment has existed for some time through the probation order and it has been extended through the DTTO (through parole and for offenders in prison).

Critics of judicial commitment, many of whom are from the treatment services, see judicial commitment as coercive and, by implication, wrong. They see it as standing in stark contrast to voluntary treatment which, they say, by definition, is their approved form of treatment. This assertion is at best misleading and at worst simply wrong. It produces a *coercion* v. *voluntary* dichotomy which fails to take account of the possible shades of meaning within each of the terms. For example, judicial commitment does not mean the

drug abusers always feel coerced into treatment; some may enter willingly and be glad of the opportunity to be offered the options. Nor does it mean that coercion from the courts is the only source of coercion; greater coercive pressure might have come from elsewhere, family, friends, employers, etc., which may be more powerful and influential.

It makes more sense to talk of different levels of coercion operating at different points on a continuum, and coming from different sources. Take the court and the legal system as an example. De Leon (1998) suggests that the court offers different levels of coercion, able to invoke a range of options based on different degrees of severity (Farabee *et al*. 1998). First, de Leon (1998) says there is *legal referral* which operates according to an explicit procedure where the offender is referred to treatment according to a sentence of the court or by some other formal practice as in probation or parole. Secondly, there is *legal status* where the offender is referred according to an administrative device, as with bail or arrest referral schemes. Finally, there is *legal pressure,* which refers to the extent to which the offender experiences discomfort over the potential consequences of non-compliance, such as where the court makes clear that failure in treatment is likely to lead to a long prison sentence. *Legal pressure* is the form most likely to be regarded as coercive, but even then coercion might not be excessive – for example, some offenders might regard a prison sentence as a less fearful option than a spell in a treatment programme. Moreover, levels of coercion may vary within programmes: some probation orders with a condition of treatment may appear coercive but, in practice, the treatment agencies rarely report shortcomings and failures, including the failure to attend for treatment and that, to all intents and purposes, means the offender does what he or she likes.

Or consider social and family coercion. Family coercion could be seen as qualitatively different from the coercion of friends and employees, as it is more likely to be sustained and to have longer-term consequences. It might also be more effective in driving offenders into treatment. It is more useful, then, to see coercion as existing where the offenders enter at a certain point and stay or leave at the same or different points. The source of referral does not determine the level of coercion, although it might (O'Hare 1996).

To concentrate for a moment on *legal pressure* as this is likely to be the mainstay of the opposition to court-based programmes, the assumption has been that the level of coercion will always be high. Assume, however, that it is. Does this warrant opposition to providing treatment under those circumstances? Not in terms of ethical or

jurisprudential matters. Courts have traditionally been permitted to require treatment as part of punishment (for various conditions including mental disorder or alcoholism) and have been allowed to impose conditions attached to sentences. What are the research results? The case for coercion would be weakened if it were shown coercion does not work. In fact the research evidence, albeit American, shows that the circumstances under which an individual is exposed to treatment, voluntarily or under coercion, are irrelevant. The important point is that the drug user should be brought into an environment where intervention occurs; the more routes into this environment the better, even if they include coercive routes. Treatment outcomes are not based on the reasons for entering treatment but the length of time remaining in treatment. That is to say, the longer the period in treatment the better the outcome. This makes sense: the longer a person spends in treatment, the greater the number of options and the greater the possibility that the choice will be abstinence (Anglin and Hser 1991).

The initial motivation to enter treatment may not be high for many of those brought before the courts, but motivation to enter the programme is not that important. Motivation is less important than retention: 'Considerable research demonstrates a direct relationship between retention and post treatment outcomes' (Lipton 1995: 46). 'How an individual is exposed to treatment seems irrelevant. What is important is that the narcotics addict must be brought into an environment where intervention can occur over time' (Anglin 1988). Or, this time, from Sally Satel: 'It is the length of exposure to treatment that powerfully predicts patients' success', which, she says, occurs 'no matter what the treatment setting' (2000). In a review of a number of studies, Satel says two major findings emerge: first the length of time in treatment is the most reliable indicator of post-treatment performance so that, beyond a 90-day threshold, treatment outcomes improved in direct relationship to the length of time spent in treatment. Secondly, coerced patients stayed longer and therefore were the most successful. Weaknesses occur where the offenders do not experience consistency or uniformity about the treatment demands; outcomes are higher when they know the rules, when the rules are enforced fairly and consistently, and when there is appropriate pressure to meet treatment demands. Coercion then might turn out to be irrelevant, except in a moral sense; success seems to be more about how the regime is operated and the length of stay.

In practice the enforced (coerced) treatment of drug users appears to sit uneasily on the shoulders of many treatment agencies. They

seemingly prefer to treat only those patients who are apparently sufficiently motivated to enter the treatment programme voluntarily. Given the otherwise consistent research findings, might it not be time to rethink that ideology, doing so in a way which permits a more receptive approach to new ideas and allows a more flexible approach to the problem? To remain within the existing boundaries might produce a measure of certainty, albeit misplaced, but it does not provide much of an opportunity to move forward. As things stand at present, the courts and the treatment services talk past each other, yet the point made by Anglin and Hser (1991) is a sound one: 'that members of both systems need to move away from adversarial stances and towards collaboration to produce the desired behaviour change in drug users'. The suspicion is that, if the treatment services do not make the appropriate move, they might well be the ones who are coerced, this time to accept the enforced patient. Already their hand is being forced; the DTTO is on the statute books and, were the American-style drug courts to be introduced into Britain, they would eclipse existing provisions.

Mandatory drug testing

Jay Carver (2004) is scathing about the way criminal justice systems fail to make use of drug-testing facilities. He says that some offenders with drug-taking histories are not tested at all. He reminds us that some supervision programmes test only infrequently, and then on regular, scheduled reporting days, and that some drug-testing programmes have so few internal controls that offenders find it easy to avoid detection through any number of techniques:

> Even if a probationer tests positive, the most likely response will be nothing but a warning from the probation officer at the next reporting date, which could be a month after the test was taken. If the violation does come before the judge, the hearing is likely to be months after the fact. (*ibid*.)

He gives an example from data taken from the District of Columbia, collected as of November 1997 and concerning probation violations. This example shows that only 29% of the infractions reported to the court were handled within 60 days, whilst 71% either were never reviewed by the sentencing judge or were handled more than 60 days after the violation. He says:

> Judges are likely to do one of two things. They may revoke probation and impose the remainder of the sentence in prison. Or they may admonish the person not to use drugs again. In summary, we have a system where there is a low rate of detection for drugs. There is a low rate of enforcement for violations. There may be high punishment severity *if punishment is actually applied* (*ibid*.) Emphasis original.

His conclusion is salutary: if one sets out to design a system to produce failure, it is hard to imagine a better one.

Mandatory drug testing is not confined to the criminal justice system; certain occupational groups are routinely tested (for example, airline pilots and athletes), whilst some employers insist on testing their employees. It becomes a moot point about which occupational groups should be tested: train drivers perhaps, or bus drivers even? Or anyone working in a highly skilled occupation, or anyone where public safety is concerned? In fact, Corkery (2003) reports there has been a surge of interest in drug use in the workplace, with some firms operating a drug-testing policy.

The data are interesting. For example, in 1998 the Institute of Personnel and Development (IPD) surveyed 1,899 firms, of which 18% reported illegal drug taking by staff – an increase of 3% on the corresponding figure two years previously. Although 81% of firms encouraged individuals to seek counselling and help, time off for treatment was only allowed by 38% of companies. Dismissals were used by firms in 31% of cases. It was noted that the level of work performance deteriorated as a result of drug taking, at least according to 64% of respondents. There was seen to be a worsening in working relationships with co-workers as a result of drug abuse by 57% of companies, and in 27% relationships with clients deteriorated. Yet surprisingly only about half (53%) of companies surveyed had a drugs policy, and only 15% had an illegal drugs awareness policy. The two main ways in which personnel or management departments became aware of drug misuse were deterioration in work performance (75%) and notification by other members of staff (72%). Accidents in the workplace accounted for 14% of notifications, but random drug testing only 4% (Corkery 2003).

That apart, the theory behind mandatory drug testing is based on the proposition that, with the development of cost-effective technology, we can now intervene more appropriately in drug users' lives (Wish and Gropper 1990: 322). Without mandatory drug testing it is suggested there is no possibility the courts (which, in Britain,

also means probation officers) will be able to know the extent of the problem. Self-report studies are valuable as they provide useful information and give some data on the extent of drug use, but they are not always valid in that they do not give the whole picture. There is evidence that, when drug users are questioned about their drug use, especially at the time of arrest, they understate it, although they will often correctly admit the extent of lifetime use or use in the distant past (*ibid*.: 325). Drug testing is used to detect and provide that information which would be otherwise absent. Carver (pers. comm. 1999) goes further and says that, without this information, the justice system is unable to obtain quick, accurate information on the offender's drug use so that the court environment is one in which the offender can remain in denial with no immediate consequence for continued use: 'In a very real sense the criminal justice system becomes an enabler for the addict. The judge is in the dark, the defendant knows the judge is in the dark, and the con game continues' (*ibid*.: 1). He goes on (*ibid*.) to ask: 'Is it any wonder then that the justice system is viewed as ineffective in dealing with the underlying addiction that fuels the problem? Is it surprising that there is widespread scepticism on efficacy of treatment and rehabilitation?'

Drug testing can also be used as a deterrent to future use or, equally, to verify compliance with conditions of release – which will in turn deter future use. Deterrence in drug testing operates as in all other forms of deterrence; it deters the individual and it deters others, although the evidence suggests it works best when it is tied into a treatment programme. The aim, as far as drug treatment is concerned, is to monitor treatment and provide accurate up-to-date information on the extent of use.

A short note on drugs and driving

The Road Traffic Acts prohibit driving under the influence of drugs and alcohol. Whilst there has been considerable research on driving under the influence of alcohol, there has been much less for drugs. Testing for driving under the influence of drugs is a much more difficult matter than for alcohol. A self-report study involving 1,008 drivers aged 17–39 shows that 9% said they had driven under the influence of any drugs, and 5% had done so in the previous year (Ingram *et al*. 2001). These figures represent 26% and 36%, respectively, of those who had used drugs ever or in the last 12 months. Not surprisingly, males were 2.6 times more likely than females to have ever driven under the influence of drugs, and 2.7 times more likely in the last year.

Research by the Transport Research Laboratory covering the period

October 1996 to June 2000 shows that there has been a significant increase in the number of road traffic accident fatalities involving the consumption of drugs (Tunbridge *et al*. 2001). In 1985, 7.4% of a sample population in a similar study were found to have used medicinal or illicit drugs, and 35% alcohol (Everest *et al*. 1989). A decade later, the proportion taking drugs had risen to 24.1% but that for alcohol had fallen slightly to 31.5%. In a study involving a total of 1,184 fatalities 17.7% tested positive for a single drug and 6.3% for multiple drugs (i.e. in a quarter of cases where drugs were detected multiple drugs were implicated). This contrasts with only 5.3% in the earlier study. Where two or more drugs were found cannabis (11.9%), opiates (5.6%), benzodiazepines (4.8%) and amphetamines (4.5%) were the drugs most commonly detected. Most of all illicit drug consumption (75.3%) was in those aged under 40, whilst the majority (78.3%) of medicinal use was in those aged 40 and over.

The number of studies concerning driving whilst under the influence of drugs remains small. It goes without saying that this is an important area of research which must include those who use licit drugs (i.e. prescribed drugs and not necessarily those covered by the Misuse of Drugs Act). One wonders how many drivers in the morning rush hour are driving under the influence of medication (sleeping pills, etc.) taken the night before, or whether reclassifying cannabis to a Class C drug will increase the extent of drug driving. More research is to be welcomed on all these matters.

An overview of the types of tests available

Basically there are six types of drug tests: sweat, saliva, blood, hair, eye and urine. Urine tests remain the most widely used and, for all their limitations, are still regarded as the most suitable. Others are used to complement urine tests or to act as a screener, or are used when a urine test is inappropriate.

The sweat patch

This testing system identifies drugs through perspiration. It involves a small patch being placed on the offender's arm for between 10 and 14 days. It measures the presence of selected drugs but not the amounts. It is not intrusive, although, sometimes, the arm has to be shaved before the patch can be applied. It is easy to apply and has the advantage of being what is called 'tamper evident' – although claims have been made that the patch can be successfully adulterated

through the use of certain types of bleach. The disadvantages of the sweat patch are, first, that there are large variations in the amount of sweat produced from one offender to the next, and this has, it has been claimed, produces distortions in the results, although whether this is true or not is far from clear. There is, secondly, the risk of accidental removal, especially in areas of high humidity. More importantly, however, the offender is given a 'licence' to continue drug use if the baseline proves positive. This means that, if the offender tests positive for certain drugs at the time the patch was put on, he or she might as well continue to use those drugs for the duration of the patch. The cost is about £3 per patch, with a further cost of between £8 and £10 for analysis. The general conclusion is that the patch has its uses (e.g. when other tests could not be given over a specific period of time) but it is not as successful as urine analysis, in that the patch system only gives results when the patch is taken off and sent for analysis.

The saliva test

The saliva test, which tests for oral fluids, has been available for alcohol since the 1950s and is now used for a variety of drugs, including the amphetamines, cocaine and the opiates. Typically, two swabs are taken, the first for screening and the second for confirmation. Test results tend to support the use of saliva tests in that there is a good correlation between drug and saliva concentrations. The saliva test is therefore seen as a useful additional test, having a number of advantages over the urine test in that it is neither demeaning nor invasive (it avoids the so-called 'ugh' factor which is present when handling urine specimens). It has, however, a number of disadvantages. First, there is no agreement as to the cut-off points, and the courts in the USA have produced no precedents about these. Accordingly, the FDA has not approved the saliva test. Secondly, there is strong cross-reactivity to certain over-the-counter medicines, especially amphetamines and ecstasy, where, typically, adulterants are placed under the tongue at the time the test is taken. Moreover, the so-called 'window of opportunity' is limited. This is the period between the ingestion of the substance and the time during which it can be measured. This varies between drugs; for cocaine it is about 12 hours, for cannabis it is 3–5 hours and for methadone it is 12–16 hours (incidentally, there is little agreement about these times; they vary depending on whom one talks to. The strongest supporters of saliva tests give the longest times). The unit costs are about £4 per test, before analysis (i.e. quite low) but without the FDA's or the Supreme Court's approval, its use is limited in the USA.

The blood test

Blood tests are rarely used, being more appropriate for tests for infectious diseases. There are a number of problems with blood tests. First, they are invasive. Secondly, blood tests have to be taken in a hospital so as to remove all possibilities of contamination at on-site testing facilities – and they have to be done by a trained paramedic such as a nurse, thereby excluding most (if not all) court staff. They are also expensive at about £30 per test. Moreover, clinicians must turn up at court to present the findings – this is, incidentally, true for other off-site hospital tests, including hair analysis. Finally there is the problem of the disposal of the sample but, again, a problem not exclusive to blood tests. Largely for these reasons blood tests are not regarded as a viable option. They have an advantage in that agreement exists about the cut-off point at which the test is accepted as positive unlike, say, that for saliva. There is little future for blood tests despite the obvious validity and reliability of the results. What courts are looking for is a form of testing that is quick, reliable, valid, not intrusive and that does not require a laboratory to produce the results. There is no test yet devised that fits all the criteria, but blood tests are thought to fail most.

Hair tests

The history of hair testing goes back to the 1970s. However, the reasons why there are drug samples in hair are still not fully understood, but all types of body hair can be tested (the tests need not be confined to head hair). Many of the problems of blood testing apply to hair testing – that is, there can be no on-site testing facilities, tests have to be undertaken at the laboratory and the unit costs are high – about £75 per test. The main advantage of hair testing is that it can provide details of the history of substance abuse going back about six months and, for that reason, it is used more frequently at the workplace or in post-mortems than in the courts. It takes about one week for a substance to show up in a hair analysis test so it is of little value if results are required about recent drug-taking incidents, as they invariably are. An advantage is that, like blood tests, hair analysis is tamper resistant. The advantage of blood and hair tests is that they can give information on the amounts used. This, however, is not regarded as important; it is more important to know if the offender has taken (say) cocaine than if he or she is a heavy user.

Eye testing

Eye testing operates on the basis that certain substances will produce

significant changes in the eye's reaction to light. Eye tests measure dilation, the saccadic velocity of the eye (i.e. the speed the eye moves from side to side), the constructive latency (i.e. the speed the eye constricts down) and the constructive aptitude (i.e. the way the eye returns to normal). Drugs affect the eye in different ways so that eye tests can pick out specific drug use in the same way as other tests. However, each person must have their own baseline established before assessments can be made and interpreted, and this baseline must be established at a time when the offender is drug free. The technology is still in its early stages, although eye testing is not new. It is currently being marketed as a screening test able to bring to the attention of the court possible drug misuse. Its value is that it is not invasive, it is easy to administer, accurate (or reasonably so), gives immediate results and detects most abused substances. It has a low unit cost; the equipment can be hired at about £3,000 per month and, as some courts test about 1,000 offenders per week, this is a relatively cheap screening test. The general consensus of opinion is that eye testing will, if the technology is improved, be the flagship of the future. It has many advantages.

Urine testing

Little needs to be added to what is already known about urine testing. In spite of certain disadvantages it remains the most favoured test. The technology is effective (it has been available for over 30 years), it has been given High Court approval, has been cleared by the FDA and has an agreed and accepted cut off-point. Recent developments have been directed less at justifying the use of urine tests and more towards reducing unit costs (it costs about £4 per test). Urine testing remains pre-eminent, with the only likely rival being the eye test or the patch, but the latter only when other forms cannot be used. There are two likely developments to urine testing. First, attempts are being made to measure the amounts of drugs taken – but this then raises again the question: to what end? Secondly the aim is to facilitate presentation which, for these purposes, means being able to download the data directly from the testing device to the printout in a way that removes any human contact, including the interpretation of results. The aim is to restrict further human error, as well as further reducing unit costs.

The procedures are fairly standard. Usually, the offender is given a screening test and, if positive, then he or she is given a confirmatory test. Screening tests provide rapid results, are inexpensive and have an accuracy level of about 97% or 98%; confirmatory tests are more

expensive but give a greater level of accuracy. The most common screening test is urine testing and the most common confirmatory test also uses urinalysis (Visher and MacFadden 1991). Operating these tests requires considerable skill, and there are numerous pitfalls to avoid, both legal and technical. The procedures must be sufficiently foolproof to minimise arbitrary or erroneous decisions, at least to the extent that it is feasible to do so. Insuring a completely error-free process is the aim, albeit a distant one, but a positive drug test can lead to deleterious results, including incarceration or other restrictions on liberty. Accordingly, drug-testing procedures must be as reliable and valid as possible. Moreover since drug testing (urine testing, that is) is relatively new, the possibilities of legal challenges are considerable. Ideally tests should be undertaken in laboratory conditions, and never by poorly trained assistants.

Likely errors and ways of tampering with the tests

Two types of errors are likely. The first creates false positives. These occur when a test result proves positive for a given drug when that drug is actually absent in a urine sample or present in concentrations below the designated cut-off level. The second creates false negatives. These occur when the test result indicates a negative result for a given drug yet that drug is present in the sample. What constitutes a false positive or false negative can be largely determined by the cut-off level for the test. This is defined as the concentration of a specific drug in the urine, usually in nanograms per millilitre (ng/ml), and this is used to determine whether a specimen is positive (at or above the cut-off level) or negative (below the cut-off level). The point at which the cut-off level is set is critical to the results; a cut-off level set too low will produce false positives – one set too high will produce false negatives. Tampering by users (where the aim is to neutralise the results) can lead to false negatives.

Some errors can be produced by defects in the equipment, others by a failure to use the correct procedures and yet others by tampering. Equipment errors occur when, for example, licit drugs cross-react with the urine sample to produce a set of positive results which are wrong. For example, codeine, pholcodine (found in some cough syrups) and even poppy-seeded bagels will produce positive results on some tests. This is especially so for saliva tests. Ephedrine (found in some cold medications) can cross-react with amphetamine, and urine samples containing enzymes can mimic certain drugs to produce false positives (Meyers 1991: 298).

Other errors are more concerned with the way the system is used. One commentator (Wish 1988: 151) says, from his experience of using urine tests in offender populations, that the problem of false negatives is much larger than for false positives – laboratories simply fail to pick up the drugs. He says his studies show that, even when a person admits to taking a drug one or two days before the test, it is discovered in only 70%–80% of cases. Moreover, most tests fail to identify the quantity of the drug taken, its purity and the time since ingestion.

Then there are administrative errors. These can produce false positives and false negatives. These are much more common and much more difficult to control – at least those described above are well known and expected. Robert Blanke puts it this way: 'The most difficult errors to control are administrative ones. Labelling errors, spelling errors, transposition of numbers, all can lead to a correct test result being assigned to the wrong subject. In fact most laboratories have learned that these occur more frequently than errors in testing procedures' (cited in Meyers 1991). Contaminated systems and temperature variations cause other administrative errors which can also produce false positives. Meyers (1991) says the very ease of performing these tests belies the care with which they must be undertaken, and the consequent reliance on people not trained to laboratory standards may lead to an underappreciation of the dangers of cross-reactivity and of the importance of other potential threats to their accuracy. He cites the case of *US* v. *Roy* (1986) where the defence introduced log sheets that reflected sloppy and careless operations in the Superior Court's system. Claims of an accuracy of 97% can only be achieved in ideal laboratory conditions, and these are rarely met outside. Errors in prisons produce false positives ranging from 46% to 13% (*ibid*.).

The use of a confirmatory test is one way of reducing errors. Generally speaking, confirmatory tests are used after the initial screening test is recorded as positive, although some confirmatory tests have been used when the results are negative. Not all courts are able to obtain confirmatory tests, especially when the testee is in the criminal justice system and will be tested regularly, perhaps weekly, in which case a second screening test is likely to be used alongside a diagnostic interview (Wish 1988: 151). When tests are intended to trigger further investigation or to determine whether a person is involved in drugs, a confirmatory test is not usually seen as necessary; they will be deemed more necessary if the offender is in a treatment programme (*ibid*.). Things are different outside the criminal justice system as a confirmatory test is more likely and the

consequences more immediate. For example, in one reported case in the USA a private sector employee was fired because he tested positive (i.e. as a false positive) and he consequently received $4.1 million damages against the laboratory (Meyers 1991: 288). Offenders in the criminal justice system have a better chance to set the record straight than employees, but, nevertheless, errors in whatever form and for whatever reason are damaging.

Then there are problems surrounding the officials who supervise and man the tests. These officials will quickly find that clean urine is a valuable commodity: it is worth a great deal of money to those able to market and sell it. Within the drug-testing world there is a trade in clean urine. As early as 1986 a case was reported of an American defendant who allegedly bribed an employee to have his urine result reported as negative when it was actually positive (*Washington Post* 12 July 1988). This is but one of a number of examples where officials have been open to bribery. In Britain, the Prison Service insists that two prison officers are present when urine samples are taken in prison (this, incidentally, would be regarded as wholly unsatisfactory in some circles for there still remains the possibility of bribery at a later stage, such as at pre- and post-analysis). What is needed is a system that virtually eliminates human interventions so that the opportunities for bribery are eradicated; that is, a system that is fully automated, that excludes transcription errors and is not open to falsification by corrupt officials. The American system works under the slogan: 'If the system is not foolproof, don't bother testing.'

Drug testing in general (and urine testing in particular) has to meet and cope with constant attempts to undermine the validity of the tests. It has been reported that, in the USA, the number of attempts at tampering have increased, alongside a proliferation of tampering products. The public perception is that the safeguards are weak and ineffective. Hence the view that tampering is the 'number one issue'. Moreover, a clearly expressed view is that if you are not directly involved in the test (i.e. you cannot observe it directly), 'don't bother doing it'. Or again: 'There are some very clever drug users out there.' Specimen validity tests (SVTs) are a group of procedures which determine whether the urine has been tampered with in some way or the test compromised after the specimen has been given.

One way of beating the test is to dilute the sample. A diluted sample is defined as being less than 20 mg/dl, which is not consistent with normal urine. Dilution can occur as a result of drinking large quantities of water prior to being tested – 4–8 pints of water will sufficiently dilute the sample to make the test invalid. Creatinine, a

nitrogenous-based compound, measures the strength of the sample to determine its concentration.

Another way of determining the concentration is through its specific gravity. This is a measurement of dissolved solids in a liquid. It can also be used to measure the strength or concentration of a urine sample. So, if the levels are between 1.003 and 1.001, the sample is said to have been diluted and is therefore invalid. In some American states a diluted sample is regarded as a positive drug test; in others the test would have to be retaken. Dilution can occur at the pre-test stage (taking salt to affect the specific gravity is one way to dilute the sample) or it can occur at the post-collection stage when drug-free liquids are added to the sample.

A pH measurement determines the acidity or alkalinity of a specimen. The purpose of a pH test is to detect the presence of certain adulterants (acids, etc.) which have been added to distort the test results. These adulterants can cause the pH level to change in ways which disrupt the chemistry of the drug-testing procedures, thereby distorting the results. (A favoured, but ineffective, way of altering the pH level is to drink vinegar before the test.) The generally accepted rule is that if the pH is equal to or less than 3 or greater than 11 (i.e. it is very acidic or very alkaline), adulterants have been added.

Finally there are the nitrates. There are tests to measure the concentration of nitrates in urine which are intended to act as adulterants. The most common adulterants are sodium or potassium-based compounds which come in the form of proprietary brands of some soda drinks. If the results show a level greater than 500 mg/ml the urine is considered to be adulterated. As with other compounds, the aim of nitrates is to distort the test results.

The main impact of SVTs is to restore confidence in the procedures. They provide safeguards against tampering, especially as there is a proliferation of tampering products and devices. The aim must always be to be one step ahead of the field or, if not, then never too far behind so as to allow too many tests results to be successfully distorted. SVTs also help reduce the costs of tests by ridding the system of those which are invalid, and they help to reassure the public that tests are carried out according to appropriate guidelines. In America, the formation of a national Drug Testing Advisory Board has assisted in this. This comprises a selected group of toxicologists who meet quarterly to set standards, advise on testing policies, draft guidelines, determine cut-off points and examine and approve certain laboratories to establish whether their testing procedures are adequate. Tampering is taken very seriously.

The debate in America is not whether drug offenders should be tested – this has long been accepted. The debate is about how to improve procedures, whether at the unit-cost level, through the development of new technology (as with eye tests), or in reducing tampering. The appointment of a national advisory board shows how seriously the USA takes the latter. Unfortunately Britain has not taken the matter on board or treated it with the same sense of urgency. That is a serious failing.

Some legal and social issues concerning testing

A central jurisprudential question is the extent to which governments might order random drug testing in the absence of reasons to suspect a person of using drugs. As a general rule, courts have held that mandatory drug testing is permissible when it serves a special need of government. So, for example, in America in *Skinner v Railway Labor Executives Association* (489 US 609 (1989)), government testing was justified because there was a special need to maintain the safety of the railway system. In another case, this time involving customs officers (*National Treasury Employers Union* v. *von Raab* 816 F2nd 170 5th Circuit 1970), the court held the government has a special need to maintain the integrity of its border to ensure public safety. In both cases the demands of the government were said to outweigh individual privacy. The argument was that certain employees in the public sector have a reduced expectation of privacy because they are required to produce high levels of public safety, and their health and fitness are important aspects of their jobs (Skousen 1991). Similarly, such officials as customs officers should reasonably expect scrutiny into their probity and fitness. Similar arguments have been used in Britain where it has been suggested there should be mandatory testing of airline pilots, police officers and members of the armed forces (*The Times* 14 June 1997, *Sunday Times* 15 June 1997).

As in the world of sport, those who test positive will always seek to discredit the system, and offender populations are no exception, and rightly so if they believe an injustice has been done. Clearly, training programmes are required and should be set at a high level if the system is to be free of bias and error. The fear is that too little training is provided and, where it is, then not always at the appropriate level (i.e. not undertaken up to that required for laboratory conditions).

A special problem for offender populations is that, once in the criminal justice system, they may lose many of their rights. British

customs officers have unrivalled powers to search someone on the basis of reasonable suspicion of an offence being committed. Police surgeons under the 1984 Police and Criminal Evidence Act (PACE) can use 'reasonable force if necessary to take non-intimate samples' – which include urine (PACE 1984, Code of Practice, para. 5.5, as amended by s. 58 of the Criminal Justice and Public Order Act 1994). The balance is already tipped towards those doing the testing, so the least the offender should expect is that tests will be as free from error as possible. I am not always certain this is so.

An offender in prison (alongside those on probation or parole) can be subject to searches, and some of an intimate nature. Those who test positive therefore run the risk of additional sanctions. Exceptionally, these could involve incarceration but, more likely, a restraint on liberty, such as requiring the offender to report more frequently or to provide additional samples. An unintended consequence of a vigorous testing system is that it may lead to an increase in the prison population as more offenders test 'dirty' and violate their probation or release conditions. An increase in the prison population under these circumstances may be neither cost effective nor part of the overall strategy. However, it is a possibility, at least initially, or until treatment services are properly organised and offenders dealt with under treatment programmes, a point to be developed in the last chapter.

There is still the tricky problem of interpreting the results. Put simply, what does a positive test mean? Assume an offender on a treatment programme is required to be tested weekly. In the first week he tests positive for heroin, cocaine, cannabis, amphetamines and ecstasy. He does so again in the second week but says that he has reduced the amount. In the third week he no longer tests positive for heroin and cocaine, but does so for cannabis, amphetamines and ecstasy. This pattern is maintained for three more weeks, except that he no longer tests positive for amphetamines. What then? Presumably the best that can be hoped for in the next few weeks is that things do not get worse. But is the offender to be reported to the court, taken off the programme or what?

The fashionable answers would be that progress has been made and we should be satisfied with that, or that the drugs being currently taken are not dangerous and, anyway, should be legalised. The unfashionable answer is that officials making these decisions ought not to be required to decide what is and what is not lawful. Parliament, in its wisdom, has decreed that certain substances are illegal, and the job of officials is to enforce that. It is the Benthamite distinction that insists 'is' should be distinguished from 'ought'; it is not about the

law as it ought to be but what the law is that is the deciding matter. Moreover, failure to deal with substance abuse, whatever the form or type, is as presented in these tests a de facto way of legalising the drug, and thereby undermining Parliament's wishes.

Part of the muddle we get ourselves into is that we are unclear about what we are trying to achieve. Are we trying to achieve abstinence or harm reduction? If the latter, then it is difficult to see how this can be achieved within the criminal justice system. Harm reduction might be an appropriate response for non-offender populations, or may be used as a strategy to progress towards abstinence at a later date – drug users are rarely able to become abstinent overnight – but it cannot be an end for offender populations. Harm reduction allows the use of less harmful drugs in preference to those that are more harmful, which means that the criminal justice system is required to turn a blind eye to continued use and use which is unlawful. The alternative (abstinence) is more logical and straightforward; abstinence means the offender stops all drug taking and so, by definition, stops breaking the law. That after all is what a court order should involve. Abstinence, however, is not a fashionable proposition nowadays, but it has the obvious virtue of making treatment goals compatible with the goals of criminal justice, and it avoids the confusions involved in clinging to a harm reduction philosophy. It might be an advance that an offender stops injecting heroin but smokes cannabis. Yet that cannot be the aim of a drug treatment system working within a criminal justice setting. That must be compliance with the law.

Questions about who should see the test results are no less easy to resolve. A positive test can produce the stigmatising effect of being labelled a drug user on the court record. Clearly, sets of regulations are required to determine who should or should not have access to test results if only because most people would equate a positive drug test with being a drug user – perhaps even a persistent one, although the proportion of offenders who are found positive and are seriously involved in drugs is unknown (Wish 1988: 152). Protecting the rights of the offender in this respect is never going to be easy. The history of pre-sentence reports (PSRs) in Britain is testimony to that. PSRs find themselves in all sorts of establishments with all sorts of people having access to them, even though they were prepared for the court. It raises the point about the dangers of making test results available to employers or potential employers and, even more difficult, whether there should be a duty to do so if employment involves matters of public safety, such as being in the transport industry – a train driver perhaps.

Finally there are questions about what lawyers refer to as 'search and seizure'. In 1989 the US Supreme Court held that urine tests that were compelled by the government constitute a search under the Fourth Amendment. Traditionally only those tests which necessitated an actual physical intrusion (such as a blood test) were afforded Fourth Amendment protection. In a famous case *Skinner* v. *Railway Labor Executives Association* (489 US 609 (1989)), Justice Kennedy said:

> There are few activities in our society more personal or private than the passing of urine. Most people describe it by euphemisms if they talk about it at all. It is a function traditionally performed without public observation: indeed its performance in public is generally prohibited by law as well as social custom (in Skousen 1991).

The court held that urinalysis is a search because it implicates expectations of privacy. It does so in the act of urination and in the subsequent analysis of the urine specimen. Urine analysis could reveal highly personal information about the testee (e.g. such as pregnancy, epilepsy or diabetes). As far as the English legal position is concerned, urine analysis also constitutes search and seizure and for similar reasons to the USA. That is, urine is 'of possessory interest', and its analysis can reveal features about a person's life. An aggravating factor is that it is necessary to ask additional personal medical information before the sample is given, otherwise the test results could be interpreted wrongly (e.g. such as whether or not the testee is taking other medication). And because these personal questions need to be asked, urinalysis becomes increasingly intrusive. What appears, then, on the face of it to be a relatively straightforward exercise – that is, testing for illegal substances – turns out to be highly complex with issues far beyond that of the tests themselves.

Conclusion

I have tried to untangle some of the knots we have tied for ourselves, especially in the fields of coercion and drug testing. There are many examples of sloppy thinking surrounding these topics which have led to numerous problems and, hopefully, in this chapter some have been eased. In the next chapter an examination is made of some instances where coercive treatments and drug testing have been introduced. The questions asked here are: what effect are these new provisions likely to have on the solution to the drugs problem? Where are these proposals likely to lead us in the future?

Chapter 5

The Drug Treatment and Testing Order and drug courts

It was noted in Chapter 2 that relatively little use had been made of the arrangements under Schedule 1A (6) of the Powers of Criminal Courts Act 1973 (as inserted by the Criminal Justice Act 1991) to impose treatment as part of a sentence. The findings of the Home Office Probation Inspectorate as to why there had been a failure to make use of these services have been given earlier, but two of those findings need emphasis:

1 Reluctance on the part of probation officers to make such proposals in their pre-sentence reports, based on the view that coerced treatment is unlikely to be effective.

2 A perception of a lack of enthusiasm on the part of treatment providers to operate mandatory programmes.

The implied criticisms by the Home Office were that the Probation Service retained an outdated view that coercive treatment was unacceptable in moral terms, or not likely to be effective, illustrating again the alliance of probation with traditional social work values – an alliance not to the government's liking. One result of this was an order, the Drug Treatment and Testing Order (DTTO), introduced in the Crime and Disorder Act 1998 (see ss. 61–64). It remained the government's flagship until the 2003 Criminal Justice Act and, according to the official government publication, would solve many of the earlier problems by strengthening the courts' powers. Its aim was to toughen up the probation response to drug abuse and required the offender to undergo treatment, either as part of or in association with an existing

community sentence. It was to be targeted at serious drug misusers and aimed at reducing or removing the amount of crime committed to fund their drug habit (Home Office 1998a). The government identified two crucial differences between this and earlier provisions: the DTTO would review the offender's progress through a court review hearing, and drug testing would be mandatory. It added somewhat darkly and prophetically that 'The success of any new legislation will depend on the availability of treatment and the resolution of cultural differences between the criminal justice system and treatment providers, underpinned by strong interagency arrangements' (*ibid*.: para. 4). What the government calls 'cultural differences' I have called 'ideological differences ' – it is the same point with different terminology.

Briefly, the legal provisions were that, under s. 61 of the Crime and Disorder Act 1998, the court by or before which the offender is convicted may make a drug DTTO. This will require offenders to undergo treatment for their drug problems, either alone or in tandem with another community order. The DTTO lasts for not less than six months and not more than three years.

The order was for offenders over the age of 16 years (*ibid*.). They were supervised by the Probation Service, and supervision included provisions for the order to be reviewed at intervals of not less than one month. Under s. 63 the offender was required to attend a review hearing although, if progress was maintained, the order could be amended so that the offender need not attend. Where treatment was not satisfactory, or the offender committed another offence, the court may consider the order within the meaning of s. 6 of the Criminal Justice Act 1991, that is, it may sentence the offender again for the offence for which he or she was made subject to the original order.

Section 62 required a DTTO to include a treatment requirement stating whether the treatment will be residential or non-residential. It must identify the treatment provider and include a testing requirement with a specified frequency of drug testing. Treatment providers were required to give each offender the minimum number of tests required by the court and to submit the results to the supervising probation officer who will report them to the court. The offender must report to a probation officer as required, and notify the probation officer of any change of address – this is in line with probation orders generally.

There have been numerous criticisms of the DTTO, and recognition of its limitations in that under the 2003 Criminal Justice Act DTTOs were phased out, if not in practice, then in name. They were replaced by a Drug Rehabilitation Requirement (DRR) which was aimed at

providing a more flexible sentencing structure as well as toughening up the existing format. As with DTTOs the DRR can last between 6 months and 3 years, and allow the courts to order a number of different treatment requirements which can be bolted onto an order. These may include curfew requirements, activities to improve social skills, education etc., as well as various types of treatment. Under the DRR courts are able to make up a bespoke community order, relevant to the offender and the offences committed.

The DRR clearly gives the courts greater flexibility, described by one judge as 'a much better vehicle' because they are tougher and allow him to 'do all sorts of mixing and matching' (Nolan 2008). However, it is the manner in which they are implemented which are as important if not more so and the way in which the DTTOs were implemented is not encouraging. It is most unlikely that much has changed under the DRR; the personnel are the same, and so, it is suspected, are many of the practices.

The model for the DTTO was that of the American drug court although nowhere is there any public recognition that this is so. The DTTO uses the three central platforms of the drug court: first, treatment is provided by outside agencies (called treatment providers in the legislation, itself an American term); secondly, treatment is backed by drug testing; and, finally, treatment is reinforced by supervision, which in this case includes that of the Probation Service mixed with frequent court appearances where progress is reviewed. However, differences between this and the drug court are immense, not the least because in the DRR these features are poorly integrated. In practice, the DTTO, and DRR turn out to be a weak carbon copy of drug courts, lacking certain essential features necessary to make the system work.

Take two examples: drug testing and the review hearing. In the first there are questions to be asked about the link between drug testing and the treatment programmes. Some American commentators say that positive urine tests should always be backed by other information (progress in the treatment programmes, etc.). Experiments in Texas, where drug-testing programmes were introduced without the necessary treatment backup, showed how it failed. The conclusion was that drug testing was a poor deterrent on its own; it works best as part of a wider strategy where it is incorporated into a programme.

It is doubtful if that measure of integration exists. This is due to a number of reasons, one of which is a lack of clarity in the guidelines (Home Office 1998a) on the drugs to be tested. For example, the *Guidance for Practitioners Involved in Drug Treatment and Testing Order Pilots* (Home Office 2000) says that, 'The index drug or drugs (i.e.

the drug most closely implicated in the offender's criminal behaviour) should *always* be tested for. Treatment providers and supervising probation officers should consider in addition if it would also be valuable to test for the presence of other illicit drugs.' If the supervisor does not know which drugs are being taken, it is difficult to see how treatment can be properly assessed. The lack of clarity or, rather, a lack of urgency pervades the system.

Another is the manner in which results are obtained. The *Guidance for Practitioners* (*ibid*.: para. 5) says that 'Test results should be returned to the treatment provider within 5 working days of dispatch'. Most judges in the American drug courts have the results sent to them immediately or within 20 minutes. They say delays allow the offender to manipulate the system, whilst decisions based on past events are of little significance to current treatment requirements. The aim in American courts is to integrate test results into the programme immediately; the judge and the supervisor need up-to-date information if supervision is to be meaningful. Delays up to five days would be regarded as unacceptable.

Then there is the rather vague manner in which the review is to be conducted. Under review hearings (s. 63 (1) of the Crime and Disorder Act 1998), we are told in the *Guidelines* (Home Office 1998a: para. 8) that the aim is to examine progress under the treatment programme. Here it is said these are not breach proceedings but a unique opportunity to assess the effectiveness of the sentence (*ibid*.: para. 7). The order can be amended at the hearings, depending on progress or lack of it, and the court will have reports from the probation office. One obvious problem is that there is no guarantee that the offender will appear before the same bench of magistrates; indeed, it is highly likely that he or she will not and, again, continuity is lost. The *Guidelines* (*ibid*.: para. 8) say that where this occurs 'it is vital that magistrates are made aware of the history of the order, particularly what was expected in the time immediately prior to the present review'. Damage limitation, perhaps, but hardly satisfactory given the nature of the exercise.

A second problem concerns the style of the review hearings. On the one hand, whilst in very broad principle they follow the style of drug courts, they lack the sense of firmness of purpose that drug courts possess. Drug courts may have an informal style but this is deceptive if informality is seen as being lax or lacking strength. In Britain, for example, the bench is encouraged to acknowledge success and to be firm in seeking explanations for missed appointments. It is also encouraged to permit active participation by all concerned,

and there is to be no format for the hearing (*ibid*.: para. 9) – presumably individual benches may vary in their approach. But there the matter ends. In contrast, the drug court has all the informality, allows encouragement and blame to be accorded, and there are enormous variations in practice. The difference is that they act quickly and forcefully against any shortcomings and, they *require* all involved to be present. For the DTTO, the *Guidelines* (*ibid*.: para. 6) say: 'It is also expected that in the vast majority of cases either the probation officer or a drugs worker would attend the hearings to assist the court.' In the drug court, sanctions are imposed immediately; DTTOs have breach proceedings at some later date.

In addition there are the ethical and jurisprudential questions of testing, which seem to be ignored. As said earlier, erroneous results place the offender in jeopardy, as indeed do all positive tests. Everyone who tests positive for drugs within the criminal justice system runs the risk of incarceration or some other punitive decision. In the USA, drug-testing laboratories that report erroneous positive test results to the court are civilly liable to defendants injured by the erroneous information. One wonders what would happen if the same threat existed in Britain under the DRR.

As discussed in detail in Chapter 4, errors also occur when the samples are contaminated:

> False positive results are also caused by contamination of samples or equipment, improper calibration, inadequate maintenance of the equipment, temperature variations, or failures in the chain of custody system. The very ease of performing these tests belies the care with which they must be done, and the consequent reliance on persons who are not trained to laboratory standards may lead to an under-estimation of the danger of cross reactivity and the importance of other potential threats to the accuracy of the tests. (Meyers 1991: 299–300)

As for testing 'up to laboratory standards' there is little hope that this will be achieved in Britain. The *Guidelines* say that:

> The sample should be divided into two containers in front of the offender, who should be asked to sign two labels for the sample containers. These should be affixed to the two containers in his/her presence. One portion of the sample should be offered to the offender … [who] … should be advised to refrigerate the sample immediately if they wish to undertake independent

> testing. The remaining portion should be split again and one portion refrigerated to be dispatched for confirmatory testing. The remainder should be frozen and retained for one year in case of judicial review or challenge. (Home Office 1998a: para. 10)

The American system aims to produce a drug-testing system free of all possible errors, and that means reducing the possibility of any human contact, whether with the offender or the drug-testing equipment. In Britain, as reported in the evaluation of the DTTOs, there was a certain laxness when it came to supervising urine tests. Sometimes offenders were handed the container and allowed to give a sample in the privacy of a lavatory; in one probation area there were no facilities for supervised testing (Turnbull *et al*. 2000: 36). The possibilities of error, of providing false samples, of corrupt officials (as said earlier, there is a trade in clean urine) are endless. It is difficult not to conclude that, in Britain, the rules and regulations fail to provide the necessary protection, whether for the offender or the person doing the testing. They could well produce trouble for all concerned, whether from the Court of Appeal or elsewhere.

The pilot studies

Before they were introduced nationally, the DTTOs were piloted in three areas, Gloucestershire, Croydon and Liverpool. Inexplicably, the government decided to introduce DTTOs before the evaluation was completed, suggesting that a political decision had been reached rather than a criminological one. Had they waited they might have been able to iron out some of the problems thrown up by the evaluation. The results of the pilot were not wholly convincing. It is difficult to summarise them all, but the main ones were as follows: the use of drugs of the offender population, urine testing, interagency working and supervision of the offenders whilst on the order.

First comes drug abuse. This appeared to be the most successful feature, at least on the face of it. Offenders substantially reduced their drug abuse, at least at the beginning of the order, and the six-months' follow-up confirmed this. Of those who completed or nearly completed the order, a similar pattern emerged: a number said they were drug free and crime free, except for cannabis use. However, without a comparison group, it is difficult to state to what extent the DTTO was responsible for the change and, with the small numbers interviewed, it is difficult to draw firm conclusions. None the less, on

the basis of these results (and many were based on self-report data which are not the best from which to draw conclusions) the DTTO made some impact on the use of some drugs.

Secondly is urine testing. The frequency of urine testing varied markedly between the pilot areas. The evaluators thought that testing needed to be integrated fully with treatment programmes, with testing regimes tailored to the objectives set for individual offenders. They suggested a minimum standard – twice per week for the first three months of the order with discretion to reduce this to a minimum of once per week after that period (Turnbull *et al*. 2000: 85–6). Croydon administered the test three times a week throughout the order; Gloucestershire averaged two tests a week; and Liverpool about one a week.

There seemed little to suggest a standardised approach was being operated for the testing procedure, and observation was not always undertaken with care. The evaluation reported as follows:

> Before administering the test DTTO staff asked drug using offenders if they had used drugs. It was not uncommon for drug using offenders to admit to drug use, in which case staff recorded a positive result without testing, in order to save money. Croydon was the only site where urine sample giving was observed routinely. Observation was frequently undertaken in Gloucestershire although there was emphasis on an offender being observed if falsification of a sample was suspected. Of the comparison sites only the STEP programme routinely observed the provision of urine samples. The Hastings programme had no facilities for supervised testing: PASCO and Fast Track occasionally observed the provision of urine samples. (*ibid*.: 36)

Thirdly, there is interagency working. All three teams struggled to develop an effective model of interagency working, in spite of training for team members at all pilot sites. The evaluation said that: 'although inter-agency relationships improved at all three pilot sites only the Croydon team resolved conflicts and disputes sufficiently thoroughly to be operating as an effective team whose whole was greater than the sum of its parts' (*ibid*.: 53). One wonders how it was possible to run an effective programme in these circumstances. Interagency co-operation, always difficult in any circumstances, is likely to be additionally important in a project such as this where responsibilities for tasks need to be made clear, and where processes are outlined to review supervision goals.

Finally comes supervision. Supervision, which is another critical component, suffered in similar ways to that of interagency working. The guidelines, such as there were, appeared not to be clear or, if they were, they were not appropriately implemented. The evaluation says the teams had different expectations: 'The three sites had widely differing approaches to warnings, breaches and revocations. In all three sites offenders quite often failed to meet the conditions of the order. The main form of non-compliance was failure to attend but . . . many continued to use illicit drugs especially near the start of their order' (*ibid*.: 80). Again it is difficult to see how such a situation arose. From the offender's point of view, these variations violated basic principles of natural justice in that one team, the Gloucestershire team, applied much stricter requirements about drug abuse and attendance and produced the highest revocation rate at 60%. This compared with Croydon at 40% and Liverpool at 28%. For the probation officer, it highlighted levels of uncertainty about the object of the exercise as, apparently, teams found it quite difficult to give precise definitions of breach criteria (*ibid*.: 42).

The general conclusion, as reported in the evaluation, is not one which leads to a measure of confidence in DTTOs. At best, the failings can be explained by reference to the uniqueness of the programme, the expected teething troubles which were bound to arise and the lack of preparation – which was clearly not adequate. The alternative explanation is less charitable and points to a failure in training, preparation and planning, which should have been resolved earlier, and where the obvious question is: if this was the outcome for the pilot stages, what are we to expect now that DTTOs are made nationwide?

Given these failings, how are we to interpret the results? Considerable time has been given to an examination of the DTTO if only to show how, without training and built-in safeguards, failure is inevitable and immediate. The testing procedures were not adequate to produce valid results, and the data on drug use were based largely on self-report information, especially at the end of the order. It is difficult to see how credence can be given to these results given the shortcomings of the data and the processes involved in their production. At best it seems that the data should be treated with caution. Can we assume, then, that the failings in the procedures will be ironed out in the national implementation? Probably not, as many are not failings or shortcomings due to a lack of preparation but structural failings created by the isolation of organisations from one another, and from their reluctance to change traditional ways of working.

The *Guardian* (22 May 2002) described the way the DTTO was introduced: 'the early pilot results were so bad that Home Office ministers, anxious that they might lose the money promised by the Treasury, simply rolled them out nationally before the final results came through and lied about the pilots.' These are severe criticisms of a key measure of criminal justice policy. The journalist in question, Nick Davies, quoted a Whitehall source saying 'Breach is the norm with DTTOs' (*ibid*.), adding that 'last year [2001] only 6,186 orders were made but there were 5,419 proceedings against users for breaching them'. Apparently offenders do not accept the treatment available and are willing to take their chances if the court decides to punish them. Davies (*ibid*.) says: 'The Government has come up with a remedy; regardless of the failure. Downing Street last year asked the Treasury to fund yet more DTTOs; the Treasury agreed to put up an extra £20m. but only if the Probation Service agreed to increase their targets by 50%.' Davies reports that the Probation Service had no chance of hitting these targets, but the Home Office accepted and rewrote the rules to produce a new DTTO which imposes only minimal requirements on offenders. This, according to Davies, is dubbed the 'DTTO-lite' by drug workers.

The manner in which DTTOs were introduced highlights the methods used by the government to deal with the drug problem: seek quick solutions and then throw some money at them. Above all, do not disturb existing structures or operate on the basis of a research-led programme.

Drug courts

In 1987, Chief Judge Wetherington, alarmed at the ever-growing numbers of convicted drug users appearing at the Miami courts, sent Judge Klein on a sabbatical year to come up with a solution. The result in 1989 was the first American drug court or, rather, the first drug court to use the approach known as the 'Miami drug court model'. Other drug courts existed, but their aim was to process drug users more speedily through the system – these are called fast-track administrative courts. The Miami model is different; it is a slow-track treatment court where the aim is to provide court-based treatment programmes to treat the offender's addiction. From a relatively modest beginning in 1989 there has in the space of a decade been a burgeoning growth to well over 400 Miami drug courts in the USA (or simply drug courts henceforth) in every state, as well as in Australia, Canada, Ireland, Scotland and Puerto Rica.

Drug courts arose for three main reasons. First, the existing system was not working. Early efforts to speed up the process for the large numbers of drug offenders appearing before the courts (the so-called 'expedited case management courts' merely produced a faster, more efficient system by reducing the waiting time between arrest and conviction. Paradoxically, this had the reverse effect: these courts hastened the offender's progress through the revolving door from court to prison and back to court. Other attempts to deal with the problem fared no better. The so-called 'build out' approach, which meant building more prisons to deal with more and more offenders, produced no relief. All that happened was the prison population grew exponentially with an alarming increase in costs. As one Miami drug court judge said: 'Before the Miami drug court began the strongest prisoners slept on mattresses, the weaker on the floor and the weakest standing up' (pers. comm.).

A second reason was the link between drug taking and crime. As in Britain, the research evidence shows that large numbers of American offenders tested positive for drugs at the time of arrest, and many claimed that their criminality was a direct response to their habit. In the circumstances it was reasonable to infer a direct link – with more certainty where the users were street addicts. The crack/cocaine epidemic of the late 1980s and beyond produced large numbers of offenders charged with possession offences, especially from the inner-city areas. Efforts to reduce crack/cocaine use became a high priority.

Thirdly, there are the courts themselves, especially the judges, who were critical of legislation which redefined the criminal codes and escalated penalties for drug possession and sales. The 'three strikes' policy restricted judicial action, as did other sentencing guidelines, so that judges increasingly saw themselves tied into a sentencing straitjacket. They believed these guidelines produced no tangible results, except perhaps longer sentences and, where they did not, offenders were moved through the system in ways which did nothing to reduce their drug taking on discharge. The 'three strikes' policy invariably produced sentences of 30 years plus, sometimes for a relatively small amount of cocaine, and many judges saw this as neither sensible nor productive. The drug court became a judge-led movement where judges wanted a more humane, effective programme which dealt directly with the problem of drug abuse.

These features alone did not account for the popularity of the drug court, the shape of its programmes and the ethos surrounding it. For that there needs to be an assessment of drug courts as a

social movement, which is beyond the scope of this book. There are, however, a number of aspects worth highlighting. First, drug courts operate according to an abstinence model which sits easily within the compass of the earlier prohibition movement. Also, there is within the drug court system a strong evangelical approach that is part of an American cultural worldview which is not used elsewhere. Thirdly, drug courts operate under a free-market model where the offender is expected to pay towards the treatment, and where the aim is to return the offender to being 'a productive member of society' – terminology rarely used outside the USA. The European perspective is suspicious of abstinence, preferring harm reduction, is suspicious of evangelism and is unused to talking in terms of a 'market model of treatment'.

Yet for all these criticisms drug courts have produced the largest number of clean addicts to be found anywhere; the drug court movement is burgeoning and, at present, unstoppable; and it has already attracted international interest and acclaim. Evaluations of drug courts are promising but not as hopeful as were earlier thought. As less tractable offenders enter the programmes, rates of compliance and graduation will decline and recidivism rise; this is an inevitable feature, especially as the earliest drug courts dealt with less serious offender groups. None the less, drug courts still achieve their aim of reducing levels of addiction and are more successful than any other programme.

Drug courts have also been introduced into the juvenile justice system, and there are similar courts for drunken drivers, domestic violence offences, mentally disordered offenders and for 'dead beat dads'. More recently, drug courts have moved into the prison system where pre-parole prisoners are placed on a drug court programme and, if successful, are granted parole. It has been said that we should expect only one good idea in criminal justice per decade; that being so, the drug court makes up for two.

Drug courts are not a homogeneous group and, within the Miami model, there are differences. Some place offenders on a diversionary or quasi-diversionary programme, others are post-adjudicatory – that is, the offender is sentenced to a drug court programme after conviction. Some drug courts deal only with minor offenders; others will not take offenders with convictions for violence; and yet others will take only those charged with a possession offence. As the movement develops, so the population of offenders has become more varied, but one of the main criticisms is that, too often, they have concentrated on low-level offenders (Gebelein 2000). It is interesting that the Australian approach has been to target the persistent drug user and high-level offender.

The National Association of Drug Court Professionals (NADCP) lists the following as ten key components of drug courts. These are taken from its document, *Defining Drug Courts: The Key Components* (NADCP 1997), where each component is explained, followed by performance benchmarks (some of which will be given here). These key components provide the most useful means of examining and explaining drug courts.

1. *Drug courts integrate alcohol and other drug treatment services with justice system processing*. This is one of the most important of the components as it sets out the mission of drug courts, which is to stop the abuse of alcohol and other drugs and related criminal activity through a co-ordinated team approach that includes all the court personnel and the police, alongside community organisations such as education services, housing, etc. Drug courts operate on the basis that the criminal justice system has the unique ability to influence a person shortly after a significant triggering event, such as an arrest, and thus persuade or compel that person to enter and remain in treatment. This mission statement repeats the point made in Chapter 4, which is that research indicates that a person coerced to enter treatment by the criminal justice system is likely to do as well, if not better, than one who volunteers.

One of the many innovative features of the drug court is that the court supervises the offender. Elsewhere, the offender is handed over to another criminal justice agency (such as the Probation Service), who decides on the nature of control and treatment. Often that agency will itself subcontract some or all of that control and treatment to another agency – perhaps psychiatry, where the subcontractor is required to report to the Probation Service on the offender's progress. That they rarely do is another criticism of the traditional approach to treatment, irrespective of the type of treatment or the type of offender. In the drug court, the court retains supervision and control, and directly employs the treatment providers. This means hiring and firing according to the demands of the programme. The treatment providers work for the court, as do those involved in drug testing, and probation officers. In the drug court, judicial control is pervasive, with the judge at the centre of the programme – this being a way of using the status and power of the judge to impose the programme on the offenders.

2. *Using a non-adversarial approach, prosecution and defence counsel promote public safety whilst protecting participants and due process rights*. Drug courts make much of the importance of the team approach

where, it is claimed, in order to facilitate an offender's progress in treatment, the prosecutor and defence counsel must shed their traditional adversarial courtroom relationship and work together. This, of course, is easier said than done or, rather, when it is done it may work to the detriment of the offender's rights. The drug court has provoked intense criticisms in some quarters by shedding the non-adversarial methods and opting for a team approach (Boldt 1998; Bean 2001b). As it turns out, the prosecuting attorneys seem to experience fewer problems than the defence, for the former has a duty to protect public safety by ensuring that each candidate is appropriate for the programme. That is relatively straightforward. The defence counsel, on the other hand, is required to seek a not-guilty verdict or, if not, then the most lenient sentence, as well as to protect the offender's due process rights. According to the NADCP, the defence counsel does this by advising the offender on the nature of the drug court (one of the benchmarks for this component), whilst encouraging the offender's full participation in the programme. But what happens if the defence believes that a successful rebuttal of the charges can be achieved, or that it would be possible to receive a more lenient sentence than in the drug court? Should he or she go for that and forgo the possibility of his or her client receiving treatment for his or her addiction? The drug court movement has never answered these questions satisfactorily – nor can they be, for they centre on a subsidiary question about priority. That is, should priority be given to the offender's rights or to his or her welfare?

3. *Eligible participants are identified early and promptly placed in the drug court programme*. The period after arrest is seen as a critical time for an offender, who conveniently gives the drug court a window of opportunity for intervening and introducing the value of treatment. Judicial action, taken promptly after arrest, capitalises on the nature of the arrest. Entering the drug court typically takes place as soon as possible after being convicted, and the programme itself will usually begin within 24 hours of coming before the drug court judge – this is one of the benchmarks to be achieved. The offender enters the drug court after being found guilty of one of the accepted offences: 'accepted' in the sense that it must be one of the types of offences and offender the drug court will take. Instructions will be given immediately about reporting to the court (usually three or four times a week at this stage), followed by the first of many regular drug tests when the offender will be promptly allocated to a treatment programme.

Generally speaking the programme will last for two years, and if the offender successfully completes it, he or she will have the original charge dropped and, possibly, have it taken off the file. This is important especially for those subject to the 'three strikes' policy. In exceptional cases, as in the Superior Court at Washington DC, successful completion will lead to a two-year probation order.

4. *Drug courts provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services*. The drug court claims that the treatment experience begins in the courtroom and continues throughout, making it a comprehensive therapeutic experience. On entering the drug court, there will be an initial screening and evaluation period, lasting about 24 hours, after which the offender enters the programme. Successful completion, however, requires more than abstinence. The Delaware drug court, for example, not only requires four months of abstinence but also requires that the offender meets the other demands of full employment, etc., in order to graduate. Different criteria operate throughout, but abstinence plus full employment are likely to be the most common. However, treatment also includes dealing with co-occurring problems (such as mental illness, primary medical problems, HIV and sexually transmitted diseases, homelessness and domestic troubles), some of which may include domestic violence. It will certainly expect to be long term for, unless these other factors are addressed, success in treatment will be impaired.

5. *Abstinence and use of alcohol and other drugs are monitored by frequent drug testing*. Drug testing is an essential feature of the programme as accurate testing is seen as the most objective and efficient way to establish a framework of accountability to determine the offender's progress. Those who do well – that is, do not test positive – and advance in treatment and, if they fulfil other requirements such as hold down a job and become a productive tax-paying citizen (the drug court is more than about being drug free; it is about being fully rehabilitated), they will be allowed to report less frequently. Drug testing is almost always through urinalysis and the results are made available immediately. One of the benchmarks is that failure to comply (i.e. testing positive) and missing treatment appointments and court appearances will produce immediate sanctions. In some courts the local police give a high priority to those who fail to attend and are in breach of the programme. Another benchmark is that drug

testing must be certain – the samples must not be contaminated. Alcohol is invariably included as one of the drugs to be tested, as the NADCP argues that alcohol use frequently contributes to relapse among individuals whose primary drug of choice is not alcohol. Contracted laboratories are held accountable to established standards (Carver *et al*. 1995).

6. *A co-ordinated strategy governs drug court responses to participant compliance*. An assumption behind the drug court is that addiction is a chronic relapsing condition, so that becoming drug free is a learning experience in which failures, especially in the early stages, are to be expected. None the less, sanctions are imposed for continued drug use, and responses increase in severity for failure to abstain. In contrast, if the offenders complete the programme successfully they are rewarded. This may be praise from the judge, encouragement from the treatment staff or ceremonies in which accomplishments are recognised and applauded; or they may be an award of a diploma or some other means of official recognition at the graduation.

Drug courts have what is called a co-ordinated strategy to deal with non-compliance, which will often involve short periods in prison. State legislation permits these multiple sanctions, which are almost unique in common law jurisdictions. Normally, there will be no more than one sanction imposed for each offence and, when that punishment is served, the offence is expiated. The exception is on a probation order where it is possible for the offender to be dealt with on more than one occasion for breaking the conditions of the order, but it would be very rare for that to occur more than once.

7. *Ongoing judicial interaction with each drug court participant is essential*. The judge heads the team, which includes the prosecuting and defence counsel, the police and all other officers of the court. This team approach is another of the innovations of the drug court, which was traditionally absent in the adversarial system where collaboration and co-operation are at a minimum. Competition is more common. In the drug court, all work together for the common good – stopping the offender from taking drugs. The origins of the team approach can be found in the TASC programme (Treatment Alternatives to Street Crime), which itself emerged from research showing that treatment was more effective in settings in which legal sanctions and close supervision provide incentives for offenders to conform with treatment protocols and objectives (Lipton 1995). To operate successfully, there had to be

a team offering co-operation rather than a number of agencies pulling in different directions. However, TASC (unlike drug courts) did not seek to fuse the criminal justice system with the treatment services but to provide a bridge by supplementing traditional adjudication with treatment services, usually through diversion. (The TASC programme is discussed in more detail later in this chapter.)

8. *Monitoring and evaluation measure the achievement of programme goals and gauge effectiveness*. From the outset, drug courts have been evaluated. Evaluation is often a condition of funding, where process and outcome evaluations are built into the programme. Process evaluations are concerned with the way the system operates; outcome evaluations are about the success, achievements or failures of the programme. In spite of this, only a small number of evaluations have been sufficiently rigorous to meet acceptable standards; most have varied in quality, comprehensiveness, types of measures used and the appropriateness of comparison groups (Balenko 1999: 7). Initially, the drug court movement claimed results which have not been validated, and some of the earlier claims have had to be scaled down. More realistically, later evaluation results are consistent with some, but not all, of the earlier findings – that is, drug courts continue to engage drug offenders in long-term treatment, providing more regular and closer supervision than that received by those in other forms of criminal justice supervision in the community. Drug-use rates and criminal activity, as measured by urine test results and recidivism, are reduced whilst participants are on the programme. In the evaluations of outcomes that use a control group, post-programme rearrest rates and drug use, the rates are lower than for those who drop out or who are terminated from the programme (*ibid*.: 4). The overall conclusion is that drug courts are more successful than any other drug- involved prevention activity, and cost evaluations suggest that for every US$1 spent on drug courts there is a saving of US$7 in the criminal justice system.

9. *Effective drug court operations require continuing interdisciplinary education*. Those working in drug courts, at whatever level, are expected to participate fully in the training programmes. One reason is to bridge that gap (noted in Chapter 4) which exists between criminal justice and treatment personnel. Criminal justice personnel need to be familiar with treatment goals and the many barriers to successful treatment, whereas treatment personnel need to be familiar with criminal justice

accountability and courtroom operations. All need to understand and comply with drug-testing procedures. Drug courts operate best when a spirit of commitment and collaboration is promoted, and this can be achieved through education and training programmes – which should always take place before the drug court is up and running and where, as a benchmark, attendance is regarded as essential, whether at the outset or later.

10. *Forging partnerships among drug courts, public agencies and community-based organisations enhances drug court effectiveness and generates support*. Most communities are proud of their drug courts, believing that they offer a serious attempt at dealing with an otherwise intractable problem. One of the lessons learnt by the earlier drug courts was to seek and obtain support from the media, especially in the formation stage, as opposition from the media was a severe disadvantage to their success. Accordingly, drug courts have learnt to promote themselves and present themselves favourably to the local community. Federal funding has rarely been sufficient so that drug court judges have had to raise monies themselves – selling lottery tickets was not unheard of, alongside other popular activities. Promoting and producing public support have been an important way of securing funding and help restore faith locally in the criminal justice system.

Some additional comments

The ten points listed above cover much of what constitutes a drug court. They do not, however, convey the flavour of the court, the dramatic intensity which is often present and the interactions between judge and offender (for a full description of the drug court and its personnel, see Nolan 1998). Drug court, in Nolan's terms, produces personalised justice and, with it, a set of attendant dangers. There is little doubt that it has raised again the spectre of rehabilitation which was widely discredited in the late 1970s but which has appeared again under a new guise and a different banner. The emphasis on treatment, the belief that treatment breaks the link with crime and the transformation of the judge into a type of judicial social worker have helped push rehabilitation into the forefront (for a critique of this, see Bean 2001b). But anyone who has experienced a drug court in full swing will know how easy it is to be pulled along on that tide of enthusiasm. Drug court workers believe in their crusade, for a crusade it certainly is.

It would not be impossible to introduce drug courts into Britain on a larger scale than at present (see the discussion of the Scottish drug courts below), but it would need a political commitment and require the courts and their appropriate government departments to be persuaded of the need to be innovative. Opposition would be expected from the Probation Service, who would find itself marginalised with a less dominant part to play than under the DTTO. In the drug court, the judge is doing what the Probation Service does, and much more. As one drug court judge said: 'There is nothing the Probation Service can do that I cannot do, and I can do a lot more than the Probation Service' (pers. comm.). The voluntary sector might also find it difficult to work in the drug court, although initial reservations in the USA diminished when voluntary agencies saw that the work was worth while and profitable. There is little doubt that drug courts would produce stresses and strains on the existing system, but there will always be such stresses with radical change, and the drug court is nothing if not radical. Its supporters talk of reinventing justice and, to some extent, this is so.

The judge is an integral part of the court structure – it is the unique power of the court and the status of the judge that drive the system along. Attempts to weaken the system by handing over responsibility for treatment to, say, psychiatrists or probation officers emasculate it to the point where it ceases to be a drug court. There is no one else able to command the same respect as the judge or to have powers to enforce the order in that way. Judges promote a type of regime which mixes sympathy with control; no excuses are accepted for not reporting or for returning to drugs, whether it be a family bereavement, doing overtime or the car breaking down. (One drug court judge urges new offenders on the programme to call all their families together as, from the judge's experience, most will die during the treatment programme – some more than once!) It is not unusual for a drug court judge to have a caseload of over 80 each day. Burnout rates are high and, when a drug court judge steps down, it is not always possible to find another sufficiently motivated to continue and, without a highly motivated judge the drug court does not work well (Gebelein 2000).

Drug courts and the DTTO and DRR: a comparison

Too often claims are made that a drug court has been introduced in Britain where the 'drug court' in question turns out to be nothing of the sort. Or demands are made to introduce 'drug courts' where

Table 5.1 Drug courts and the Drug Testing and Treatment Order (DTTO): a comparison

Drug court	DTTO
Aim is abstinence. That may include alcohol	Aim is harm reduction, especially heroin or cocaine
Treatment providers are employed by the court	Treatment providers work for the Probation Service
Judge conducts the supervision	Probation Service conducts the supervision
Adversarial system replaced by team approach	Adversarial system remains intact
Judge can impose multiple sanctions	Court restricted to breach proceedings defined in legislation
Drug test results sent to the judge immediately	Drug test results take up to 5 days before arriving at court
Courtroom procedure is less formal	Formal procedures remain
Offender may be required to pay for treatment	Treatment is part of NHS provisions
Drug court judge concentrates on drug offenders	Judges retain full range of offenders
Probation Service has only a minor part to play	Probation Service is central to the workings of the DTTO

there seems little understanding of what this means. Sometimes the so-called 'drug court' places the offender on probation, and the offender returns occasionally to the court to report on progress. Or the 'drug court' involves a few probation officers who have found a group of treatment agencies willing to take an interest in treating drug offenders. These are not drug courts in the sense in which the terms are used here: they are traditional courts using probation orders with bells and whistles attached.

However, in 2006 two new courts were introduced, one in West London, the other in Leeds which more closely resembled drug courts than hitherto, but they still differ markedly from the Miami model. Their sentencing powers are limited, and the probation service retains its dominance. Nonetheless, they represent a move in the drug court direction being incidentally, part of a wider movement of so-called 'Problem Solving Courts' (Nolan 2008).

In what follows I have preferred to discuss the DTTO rather than the DRR, the latter being a refinement of the former in both principle and practice.

Table 5.1 compares selected features of the two systems, although it needs to be emphasised that, within the Miami model, there are differences between drug courts, and sometimes between states as well as with a state. Differences are usually about the type of offenders, the length of the programme and the manner in which the original conviction is retained on file. They do not differ in their basic methodology.

The table compares the two systems and, incidentally, shows the types of changes necessary were drug courts to be introduced more generally into Britain or, for that matter, into any common law jurisdiction. It is not simply about bolting drug courts on to the existing system but of making structural changes to the way the courts operate.

The differences between the DTTO and drug courts are considerable and show, first, in the ideologies and aims of treatment. In drug court it is abstinence; in the DTTO it is harm reduction.

The second major difference is that the court employs the treatment providers. This is a radical departure from existing practice and has profound implications, whether at the criminological, jurisprudential or political level. Treatment providers in Britain have traditionally been employed by voluntary agencies or the major national agencies, such as the NHS. Working for the court, as opposed to working with the court, would be a new experience, where some professionals, including those in medical and allied practices, might find it difficult being an employee of a judge or panel of magistrates. Some psychiatrists, for example, have said they could not accept such forms of employment; on the other hand, some directors of voluntary agencies say they would welcome the opportunity, seeing the introduction of drug courts more generally in Britain as a new, challenging, profitable experience.

The third major difference is that the judge conducts the supervision. Judges in drug court have invariably made themselves knowledgeable about addiction and its associated effects, and have become experts in their way. They may not be entirely suited for the social work role they are required to undertake, but there is little doubt most conduct themselves with confidence. They have been prepared to break the mould and engage in activities not always to the liking of some of their colleagues. Their position is not without justifiable criticism and, were drug courts to be transferred on a larger scale to Britain, the British counterparts may not be expected to engage in the more

extreme activities, nor may they want to. On the other hand, a few changes by the magistrates might be welcome.

The fourth difference produces the most controversy, for this changes the complexion of a common law adversarial system of justice that is deeply ingrained in the ways things are done. To a large extent claims by drug court to 'reinventing justice' are hyperbolic, although there is no doubt that they have made things different. Operating as a team changes judicial roles and produces a loss of procedural rights, as well as the protection those rights provide. The question for the offender is how much is he or she prepared to trade off or forgo rights when there is the prospect of being drug free. For the judicial system, the key question is: how far is it prepared to go in the direction of that 'team' approach? Legal restrictions can be imposed on drug courts and the powers of the judge could be limited, or it could be allowed an unbridled development. The latter would not seem a sensible option.

Fifthly, there is the question of multiple sanctions. Were drug courts to be developed more widely in Britain, legislation would be required should they operate on the Miami model. Multiple sanctions, the key to drug court success, are not permitted under current legislation, yet without them the drug court becomes not much more than an extended type of probation order.

Tests results are given to drug court judges immediately. Under the DTTO, delays of up to five days are to be expected. The difference is critical if decisions are to be made about the offender's current position and, if they are not, one wonders how they can ever be effective.

The courtroom procedure in drug court is less formal than is likely in the hearing for the DTTO. Offenders in the drug court believe that the informal contact with the judge is an important ingredient for their success. Some drug courts operate more like a legal circus; others are more muted in their response. There is no evidence to suggest one is more successful than the other, but offenders are clear that personalised justice, in some form, is important to them.

Some drug courts require the offender to pay for his or her own treatment, on the basis that he or she produced his or her problem and should pay for it to be removed. Their view is that it is not the business of the state to pay through the taxes of its citizens for a self-inflicted disease. The European perspective is more corporate and unused to this rampant individualism. Given the manner in which many American ideas have arrived in Britain, usually first being considered outrageous and unacceptable, how long, one wonders, will it be before this one is accepted? Drug court is what it says – a

separate court with a specially appointed judge who hears drug court cases only when drug court is sitting. There is no court set aside for offenders on a DTTO.

Finally, in the drug court the Probation Service has a minor part to play; under the DTTO, the Probation Service is central. Opposition to drug courts is likely to continue to come from the Probation Service, who would be a major loser. On the other hand, treatment services would be the major victor, albeit employed by the court, for they would have increased funding and would assume a dominant position in the new drug court structure.

Clearly, the DTTO is the government's flagship to deal with the problem of drug abuse and crime. It has within it certain flaws and, as such, it will, in my judgement, be a failure. I say this more from sorrow than anger, yet the omens were not good at the start: the pilot results were hardly satisfactory, but the government pressed ahead none the less. Everything that one hears about the way it operates confirms that pessimistic view. It will be another example of doing too little too late and, in part, of not grasping the nettle about coercive treatment. It is also another example of a fudge and of having an eye on the professionals so as not to make too many changes, not to spend money and to tinker with existing institutions rather than reform them.

There are, of course, other models of treatment, but the drug court remains a persuasive one which other countries are using, but Britain, with the exception of Scotland, is left with a system already outdated and creaking at the seams. It is not only that the DTTO will not work. It is that time and energy have been given to it which should have been directed elsewhere. The DTTO leaves too many pertinent questions unanswered, including: what types of actions are likely to produce the best results when tests are found to be positive? Will testing work more effectively on certain types of offenders than others? Can strategies be developed for estimating a person's risks on the basis of drug-test results? These are what we should be asking, but they must remain for the future, at least until we have sorted out the current predicament. No one suggests that drug courts are free of blemish, but they have produced a more coherent and considered approach than the DTTO, and should have at least been considered.

Drug courts in Scotland and Ireland

Scotland is ahead of the rest of the UK in that the first pilot drug court began in Glasgow in the autumn of 2001, and another opened in Fife a year later. Their history is interesting. A working group entitled

'Piloting a Drug Court in Glasgow' was established in February 2001 on the initiative of the Scottish Justice Department. The remit was 'to make proposals to the Scottish Deputy Minister for Justice and report by Easter on a model within existing legislation of a Drug Court and on the arrangements for its operation in Glasgow Sheriff Court by the Autumn of 2001'. The timetable was commendably tight, allowing two to three months to prepare a report and a further six months to complete preparations.

The working group proposed that the objectives for the Glasgow drug court should be to:

1 reduce the level of offending behaviour;
2 reduce or eliminate offenders' dependence on or propensity to misuse drugs; and
3 examine the viability and usefulness of a drug court in Scotland using existing legislation and to demonstrate where legislative and practical improvements might be appropriate.

Point 3 is interesting because the aim in Scotland was to produce a drug court within the existing legislative framework and then see which new features were needed. The working party concluded that, in comparison with other courts generally, drug courts are successful in engaging and retaining offenders in treatment services; that drug courts provide closer and more intensive supervision; criminal behaviour was lower; and drug courts save money.

The court operates in the same way and with the same authority as other courts. Initially, there was the same range of powers and sentences available, but as will be shown later, sentencing options have been expanded. In the early stages the sentencing options were a probation order with a condition of treatment, a DTTO, a concurrent DTTO and a conditional probation order, and a deferred sentence. What the drug court did was to impose on these sentences the principles and practices of the Miami model and, in so doing, adapt the Miami drug court model to the Scottish system. In addition to the usual conditions of probation, etc., the Scottish drug court requires the offender to:

1 submit to treatment with a view to the reduction or elimination of dependency on or propensity to misuse drugs;
2 conform to the directions of the treatment provider;
3 agree to be tested for drugs;
4 attend review hearings; and
5 abide by any such additional conditions as may be inserted.

It could be argued that the court could act in this way already under the DTTO, so that the drug court is doing little more than operate as a DTTO with another name. But that is wrong; it is doing much more. It is taking the Miami system and recasting it to fit the Scottish experience and, in so doing, maintaining many distinguishing features:

1 It has a specialist bench consisting of a Sheriff who develops a considerable measure of expertise.
2 A multi-agency team who oversee the operation of the drug court.
3 Regular and random testing of all orders, including offenders on probation.
4 Regular review of the offender's progress.
5 A multi-disciplinary screening group and interagency working.
6 Fast-track court procedures to get the offender into treatment quickly.
7 Initiation of breach proceedings by the bench.
8 Use of summary sanctions at reviews.

Point 1 is new; point 2 is also new but does not go so far as giving the team the powers and responsibility of the American system. Point 3 constitutes a departure from existing practices, as does point 4, and point 5 moves close to the American team approach. Point 6 is not new except that the existing system is slow, but point 7 certainly is new. Point 8 is interesting: the aim here was to seek legislative change to allow multiple sanctions to be introduced so that the offender can be dealt with on breach of the order and the order be allowed to continue.

These have now been introduced under the Criminal Justice (Scotland) Act 2003. This Act, *inter alia*, designates a court or class of court as a drug court: 'that is to say, as a court especially appropriate to deal with cases involving persons dependent on, or with a propensity to misuse, drugs.' The 2003 Act gives the drug court additional power to impose a limited period or periods of imprisonment or a community service order for failing to comply with the requirements of a DTTO or probation order, without affecting the continuation of the order. Community-based supervision and treatment options include DTTOs, probation with a condition of drug treatment, combined DTTO and probation, and deferred sentence.

The court in Glasgow (as in Dublin) is closely aligned to an American model of designated drug courts. As such, both courts are characterised by:

- dedicated judges (Sheriff and District Court judge);
- dedicated supervision and treatment teams; and
- powers to impose multiple sanctions, including periods of custody before final disposition.

Currently, a Sheriff with the same range of sentencing powers available to a Sheriff court as under summary proceedings constitutes the Glasgow court. The Sheriff operates a 'fast track' procedure so that breaches of an order are dealt with by the next scheduled review. Depending on the circumstances, if a breach is proved, the court may allow the order to continue and impose a fine, or community service order in the case of a probation order. Alternatively, the order could be terminated and the offender sentenced for the original offence. Irrespective of the new power to impose interim custodial sanctions, the court would have the opportunity (in dealing with multiple sentences for a number of offences) to impose a custodial sentence for one offence whilst allowing other orders to continue.

By agreement with the legal profession, lawyers do not appear after the first review hearing (if they do, legal aid fees are limited). The 2003 Act does, however, require that written details of alleged breaches of the DTTO or probation order are given to the defendant, who must be informed that there is an entitlement to be legally represented and that he or she need not answer the allegation before an opportunity has been given to take legal advice.

Referrals to the drug court are considered at a steering group convened by an assigned procurator fiscal with a range of professionals in attendance. The supervision and treatment team consists of social work (probation) staff and staff from the Glasgow Drug Problem Service (health and addiction workers). A multi-agency drug court group representing the Sheriffs, Sheriff's clerk, drug court procurator fiscal and project leader of the supervision and treatment team oversees their work. The status and authority of the drug court procurator fiscal contribute in no small measure to the efficiency and effectiveness of the overall operation of the scheme.

The Glasgow drug court takes some of the so-called 'hard to treat' users. It is thought about 8,000 drug users in Glasgow could benefit from the drug court but it will be able only to take about 150 per annum. The criteria for entry to the drug court are as follows:

1. The age group is over 21, but those over 16 will be considered in exceptional circumstances – there is a steep upward failure rate in American drug courts for those under 28 years of age.
2. Male or female.

3 Prosecuted summarily at the Sheriff court.
4 Known pattern of substance misuse susceptible to treatment.
5 Known record of drug-related crime.
6 No dual diagnosis of drug misuse and mental illness.
7 Past record of community supervision does not preclude referral.
8 Must reside in a defined geographical area.
9 Must plead or be found guilty.
10 No outstanding petition matters.

Drug testing is central to the programme, although treatment could include substitute prescribing (including methadone maintenance) (Glasgow Drug Court undated). The results are encouraging. For the first 18 months of the Glasgow drug court (up to the end of April 2003), the court received 144 referrals and placed 86 people on drug court orders. The majority were DTTOs (60 out of the 86). The majority of these orders were for 18 months. The offending history shows that there were no serious traffickers in the drug court, the majority of offenders having convictions (past and present) for dishonesty and minor drug offences. Most offences were acquisitive. In the 18-month period, there were seven completions and ten breaches of the order. This suggests a fairly low failure rate and, whilst there are grounds for optimism, not too much should be read into these figures as the numbers are too small to make a more confident interpretation (Price pers. comm.). And, of course, the success rate should be high; after all, a condition for entry into the drug court is that the offender has been assessed as 'motivated to change'. A second Scottish drug court in Fife began in September 2002.

Ireland has a drug court which began in January 2001 in Dublin and, in the first four months from January to May 2001, there were 22 referrals. The Dublin drug court team consists of two probation officers, a liaison nurse, two community workers and an educational assessor. Cases are referred from other courts and then assessed. If the offender is suitable – and the Irish court takes those who have failed under voluntary programmes as well as serious offenders – he or she is sent to the drug court. The programme lasts for two years.

The Dublin court is a bail bond court (it operates with the offender on bail). Being on bail, the offender can opt out at any time. He or she has not been sentenced but, whilst on bail, must abide by the conditions of bail. The Irish Bail Act says it is a breach of conditions of bail if the offender is no longer of good behaviour, and this is

Table 5.2 Irish drug court: allocations and numbers (March 2003)

Allocation	Number
Graduated	4
Ineligible	38
Terminated	16
Assessment	8
Phase 1	11
Phase 2	12
Phase 3	10
Total	99

Source: Haughton G. (2003 pers. comm.).

what gives the court its powers. This is another example of the way in which drug courts can be adapted to local conditions yet retain the spirit of the drug court (Haughton 2003 pers. comm.).

The district judge in the Irish drug court exercises no sentencing powers as such. By agreement with the legal profession, once referred to the drug court, the legal representative will not appear. The court enforces conditions of bail, which include drug treatment and testing (Haughton 2001).

A feature of the bail bond entered into by an offender is that the terms and condition of bail may be varied from time to time by the judge, and that bail may be suspended for a period of not more than eight days for failure to comply with the conditions of bail or any drug treatment programme. The drug court judge has suggested that an offender's record of convictions could be expunged on completion of the treatment programme, though we know of no authority for this. Suspension of bail for a period (or periods) is clearly less satisfactory than primary legislation for interim sanctions with the safeguard of legal advice and representation. However, the court functions without challenge.

To be eligible, an offender must:

1 be 17 years or over;
2 have lived within the catchment area for a minimum of one year, but the area covered is to be expanded;
3 have pleaded or been found guilty of a current non-violent criminal offence related to dependency and/or abuse of drugs;

Table 5.3 Outcomes of the Irish drug court treatment programme

Period	No. of participants	% arrested in programme	% with new charges	% with bail revoked
First quarter	9	86	86	56
Second quarter	15	47	33	47
Third quarter	28	36	36	21
Fourth quarter	35	31	28	19

Source: Haughton, G. (2003 pers. comm.).

Table 5.4 Responses to drug testing, Irish drug court

Period	No. of participants	No. of tests	No. of clean tests
First quarter	9	100	42 = 42%
Second quarter	15	144	81 = 56%
Third quarter	28	324	203 = 63%
Fourth quarter	35	509	417 = 82%

Source: Houghton, G. (2003 pers. comm.).

4 be likely to be sentenced to custody;
5 be abusing or dependent on drugs;
6 understand the implications of participation in the drug court; or
7 be willing to co-operate with supervision.

Table 5.2 sets out the position of the Irish drug court as of March 2003 in terms of allocation and the numbers of offenders.

The treatment programme is tightly structured and has the benefit of an education programme too. In many respects the treatment programme in Ireland is more extensive and demanding than that in Scotland. There are three phases of treatment. Phase 1, the stabilisation and orientation phase lasts about three months. In this phase the offender is expected to reduce illicit drug use and demonstrate an ability to remain free for a significant period, to cease criminal activity and begin treatment. In phase 2 (expected to last between six and eight months), the offender has to demonstrate the ability to remain permanently free of illicit drugs, to address life issues through counselling and to commence study, vocational training or employment. Phase 3 requires the offender to remain consistently free of illicit drugs and crime and to be well established in study, a

vocation or employment. Phase 3 is expected to last about 12 months. The supervision and treatment team is much the same as that in Scotland, though accountability is directly to the workers' respective agencies. This is a disadvantage as it could divide loyalties.

The intention in Ireland (as in Scotland) has been to take the hard-to-treat and serious offenders. This is based on the assumption that, if drug courts have anything to offer, they should be able to deal with those offenders who cannot easily be dealt with elsewhere. In this respect the first 35 participants had a total of 872 prior convictions (with a range of 1–85 prior convictions), 60% of which had over 11 convictions. All had been to prison and all had been on probation (Haughton 2003 pers. comm.). The effect of the drug court has been measured in terms of recidivism and response to drug testing. However, there is no control group with which to make comparisons. First comes recidivism. Table 5.3 shows that the number and percentage of arrests decreased as the offenders went through the programme, as did the frequency of bail revocation. In terms of responses to drug testing, the data are presented in Table 5.4.

Clearly, the frequency of clean tests improved throughout the programme: in the fourth quarter they were up to 82%. Notice the difference between the results here and those surrounding the DTTOs.

An overview and summary

What is most apparent and common to both the Scottish and Irish systems is the justifiable enthusiasm of the participants, including, surprisingly enough, those on the receiving end of the criminal justice system. The speed with which recognisable and distinct drug courts were able to be established without primary legislation is also a tribute to those who planned and operate them. Recognition also has to be given to the co-operation of all the agencies and professionals involved and to the ability of the systems to deal with offenders with long-established drug use and a considerable history of offending.

The systems offer a 'carrot and stick' approach by providing an opportunity to expunge convictions on completion of treatment but by imposing penalties for backsliding. What is also impressive is the manner in which the dignity and authority of the courts have been maintained and, indeed, for many offenders even enhanced, by the drug court judge, notwithstanding the more informal processes of periodic review.

Both the Glasgow and Dublin courts show what can be achieved under existing legislation to create a more focused and knowledgeable approach to drug misuse. The designated judges play a major role, commanding respect and retaining authority. The example of Scotland perhaps offers a more securely based model, even without the more recent powers provided by the 2003 Act. Multidisciplinary teams can present problems however structured. The attitude of the legal profession appears not to be an issue, nor has the cost of the programme.

As the English courts have the same sentencing options (with the exception of powers under the 2003 Act), given the will and the co-operation of the professions, including the police, there are no legal procedural restrictions on what could be achieved in England with district court judges or stipendiary magistrates. The time is ripe to benefit from the experience gained in Glasgow, Fife and Dublin.

Improving treatment services

The clear and obvious aim of the DTTO is to provide treatment under a court order. The assumption that 'Treatment Works' is there for all to see; what is missing is a deeper understanding of what is required to implement such a programme. The DTTO was simply added on to an existing framework, plus a few modifications, as if that is all that matters. It is not (nor can ever be) as simple as that. Taxman (2000) sets out what are called 'threats which impede the implementation of treatment services':

1. Lack of clear crime control goals for treatment services.
2. Lack of clear assessment and eligibility requirements.
3. Insufficient treatment duration to effect behavioural change.
4. Lack of supervision and sanctions/rewards to reinforce treatment goals.
5. Lack of objective drug testing to monitor treatment services.
6. Insufficient case management services.

Taxman (*ibid.*) argues for a system in which 'correctional and treatment agencies build a delivery system that cuts across and integrates the systems, reduces duplication in efforts to create and recreate processes for unique programmes and emphasises empirically driven programmatic components'. The DTTO does little of that; in fact the six 'threats' identified above all apply to the DTTO. It is almost

the perfect example of all that Taxman says should be avoided. For example, there was a 'lack of clear crime control goals for treatment services' as in threat 1, and an equally 'lack of clear assessment and eligibility requirements'. So, too, for the others. However, I want to examine more closely the sixth threat – what Taxman refers to as the 'insufficient case management services'. I regard this a key 'threat': it needs to be implemented before the others.

By 'case management services' I mean the manner in which offenders are identified as being suitable for treatment, as being transferred into treatment and being supervised therein. A tried-and-tested model is that developed by TASC in the USA – originally standing for Treatment Alternatives to Street Crime but now changed to Treatment Accountability for Safer Communities. It aims to span the boundaries of the treatment and justice system by identifying appropriate treatment referrals through clinical screening processes, assessing the treatment and other needs of clients from the justice system, referring clients to treatment and other services, and providing client-centred case management. TASC case management can be distinguished from more traditional types of case management by its level of assertiveness; its ongoing nature; its focus on long-term positive outcomes resulting from multiple interventions; and its continual interagency and inter-system communication (Goodman 2004).

TASC began operations in Wilmington, Delaware, in 1972. There are now over 150 TASC programmes in 40 states. It has continued under state and local auspices, and has been described by many commentators as the largest and most widely respected organisation of its kind. Its purpose was (and still is) to serve as a link between the traditional functions of criminal justice and the treatment community. The objective is to provide an effective bridge between two groups with differing philosophies: the justice system and community treatment providers. Whereas the justice system sanctions reflect community concerns for public safety and punishment, the treatment community recommends therapeutic intervention to change behaviour and reduce the suffering associated with substance abuse and related problems. The basic goal of TASC is to identify offenders in need of drug treatment from within the criminal justice system and, under close supervision, provide community-based treatment as an alternative or supplement to more traditional criminal justice sanctions. TASC is in part a diversion programme yet also a supervisory programme, for it not only refers drug users from the courts to the appropriate treatment programmes but it also undertakes the supervision, monitors progress whilst in treatment and links the programmes to the courts. Some TASC programmes

undertake the treatment themselves, but that is not a critical element of the standard TASC model. TASC takes offenders sentenced to deferred prosecutions, community sentences, probation and pre-trial services as well as taking those on parole.

TASC programmes make the links, place the offenders, undertake the supervision and monitor progress, whilst acting as a bridge between the courts and treatment. The bridge is required because of the philosophical differences between the two systems. Presumably in Britain the Probation Service already acts as a sort of TASC, able to operate in the same manner; but could it, or would it, behave like TASC if required? Probably not. TASC operates under what it calls 'vigorous or aggressive supervision'. This is what it means by case management. It is doubtful if the Probation Service in Britain would work in that way.

TASC began as a federal initiative to foster and improve the delivery of treatment and other services to drug offenders and others in the justice system who disrupt the community, endanger their families and threaten public safety because of their substance abuse. It has developed approaches which, it claims, are applicable to those involved in criminal and civil matters, and in all stages of the justice continuum. A number of states now have 're-entry courts' for prisoners on parole or licence, and TASC also provides services to these courts. The TASC model is now used with mental health, family and juvenile court cases.

TASC aims to reach people wherever they are in the justice system and place them in the appropriate treatment programme. The methodology and practice are designed to deal with the multiple co-occurring problems of substance abuse, mental and physical health, social disorder, etc. – so often a feature of those going through the criminal justice system. TASC provides links between treatment agencies, the support services and the criminal justice system to ensure the systems work together. The programmes are designed to secure the delivery and monitoring of services and effective operational standards. Protocols and service agreements are designed to illustrate its approach to case management. (For a full discussion on TASC and how it operates, see Goodman 2004.)

One of TASC's strengths is that it assists in providing treatment services by negotiating with the treatment system and providing advocacy for those in the criminal justice system who might otherwise fall through the cracks. TASC programmes also provide information and training to treatment and justice on effective strategies for managing substance abuse. It serves as a central point for managing

policy and information, as well as managing those referred for treatment and other services. The direct services provided include screening, assessment, continuous case management, alcohol and drug testing, and treatment network development. Formal communication protocols have been established to assist the integration of justice and other systems (Swartz 1993).

The benefits claimed from TASC programming include the following:

- Providing the organisational structure to manage substance abusers referred from the justice system in a logical, organised and cost-effective fashion.
- Developing and improving treatment delivery networks.
- Using resources efficiently by screening, assessing and placing in appropriate levels of care.
- Negotiating to ensure justice 'clients' access court-ordered treatment.
- Co-ordinating treatment requirements with justice processes.
- Imposing sanctions or incentives to prevent unnecessary or avoidable discharge from treatment or to improve treatment outcomes.
- Improving inter-system communication.
- Encouraging treatment to hold justice system referrals accountable.
- Encouraging justice responses that support effectiveness and retention of treatment.
- Providing support through transitions from prison to the community and from residential to outpatient care (*ibid*.).

Not everything is plain sailing. For example, where TASC acts as a treatment provider in addition to carrying out case management functions, there is potential for a conflict of interests. That said, the TASC programme has been established and developed over some 30 years, and federal agencies are enthusiastically supportive. The TASC programme is well researched, scientifically based and well documented. It is a comprehensive programme and it covers the whole of the justice continuum, including re-entry to the community from prison. The model has also been adopted for juvenile and civil courts. The programme is not dependent on the drug court model being employed.

Chapter 6

Trafficking and laundering

For our purposes here trafficking is defined widely. It includes the distribution of illicit drugs by large-scale operations, which can and often do cross national boundaries, as well as the small-scale syndicates which distribute drugs at a local level. All operations at whatever level pose questions for law enforcement, for governments and for local communities. Each distribution system has its own methods and practices that pose distinct problems requiring different strategies.

This chapter will not examine the nature of production, although the circumstances in which drugs are produced can have an effect on distribution. The aim here will be to examine some of the central features of trafficking. There is a large amount of information available on trafficking for South America, but not as much for South East Asia or elsewhere. Much less is known about the production and distribution of those precursor chemicals necessary for the manufacture of drugs such as heroin and cocaine. A great deal of the research is American, and concerned with American matters, especially those relating to cocaine trafficking which has dominated American drug policy for two decades.

Trafficking – an overview

The geographical areas of production are worth listing, for they show where trafficking occurs and the different types of organisations used to distribute a variety of drugs. Briefly, coca leaf is produced

extensively in Bolivia, Peru, Venezuela and Brazil, although for our purposes Brazil is the least important. Invariably the coca leaves are sent to Colombia in the form of coca paste which is refined into cocaine hydrochloride. 'Crack' (the base form of the salt, cocaine hydrochloride) is almost always produced in the areas of consumption. Unlike other illicit drugs, which grow in a wide range of geographical regions, world coca production is limited to the Andes, with Peru (60%) and Bolivia (20%) being the major producers.

Afghanistan currently accounts for almost 75% of the world's illicit opium supply (MacDonald and Mansfield 2001). Much of the remainder is from the traditional growing region of the Golden Triangle (Burma, Laos and Thailand). Significant amounts, however, are grown elsewhere, such as in Iran and Turkey. There was firm evidence that heroin production was also occurring in the Andean region with the Colombian cartels moving away from cocaine (Drugs Intelligence Agency 1992). There the 1970s were characterised by an increase in cannabis trafficking; in the 1980s it was cocaine; in the 1990s to the present day heroin is the major concern. In 1991 and in the first quarter of 1992 Colombian authorities destroyed a total of 3500 hectares of poppy fields and three heroin laboratories (*ibid*.). With the maximum market share of cocaine, the move now is to increase heroin production and already high levels of purity are being achieved. Whether this means a major shift in the world markets is difficult to say, but it is interesting to note that the price of heroin in Puerto Rico continues to fall (there are about 80,000 heroin addicts in Puerto Rico), giving further evidence that heroin is available in that region (DEA 1994, cited in Bean 1996).

Cannabis is produced worldwide. Estimates of cannabis production suggest that world production is increasing in spite of intensive crop eradication programmes. Unfortunately in countries such as Belize or Jamaica, where crop eradication has occurred, the dealers have shown a readiness to transfer to cocaine (*ibid*.). Cannabis is now grown extensively in Britain. Manufactured drugs are also produced worldwide: Ecstasy was, until recently, mainly produced in Amsterdam (Bean 1994), but local British factories are now operating. LSD is manufactured throughout the industrialised countries, with production moving as factories are closed down.

Trafficking and traffickers differ according to the drugs being smuggled, the source of production and the local distribution (Dziedzic 1989). One early and important text (Cooper 1990), which concentrates on the economic forces which drive the drug trade, shows that drug dealing was then worth an estimated $500 billion

per year. Moreover, Cooper showed that the traffickers are flexible and effective, especially when set against some rather ineffective and outdated forms of interdiction, especially in the Caribbean region and some parts of Europe, and that this is in spite of the occasional successes by law enforcement. Given the size of the drug market it would not be an exaggeration to say the drug trade is the largest and most successful form of criminal activity ever developed (*ibid*.) and European research confirms this (Ruggiero and South 1995).

Once drugs have crossed the local customs area and reach their final destination, such as Europe or the USA, their value increases dramatically. Table 6.1 below gives the figures for cocaine. It is thought they have not changed greatly over the last decade as far as the street price is concerned, but even if they had the point remains that the price in Colombia bears no relation to the price on the streets.

The figures for opium are no less impressive. The total value of opium production in Afghanistan at so-called 'farm gate' prices at harvest time was estimated at US$183m, or about US$35 per kg. By the time it had passed through customs in the UK it was estimated to be worth US$25,000 per kg (MacDonald and Mansfield 2001: 3). The massive increase in the price at each stage of the operation shows how the end price bears no relation to the cost of production: distribution costs are the heaviest. Peter Reuter (2001) adds to this by calculating that a pilot who demands $50,000 for flying a plane with 250 kg of cocaine is generating costs of about $2,000 per kg, less than 2% of the retail price of each kg.

Moving against the drug cartels, especially in South America, involves serious economic and political costs for governments as well, as the drug industry has accumulated significant political influence (Lee 1989). The resulting concentration of wealth and coercive potential in the hands of drug cartels, especially in Colombia, has led to a severe threat to that and some other country's national and regional security. While it is clear that the drug producers (the farmers, growers, and so on) receive only a small percentage of the

Table 6.1 The value of cocaine whilst en route to users (in US$ per kg)

Leaving from Guajala (Colombia) in an air drop	$300 per kilo
Arriving at the US border	$3,000 per kilo
Into the USA	$12,000 per kilo
Distributed to users	$20,000 per kilo

Source: DEA 1994, cited in Bean 1996.

vast profits, to what extent these cartels threaten Western security is not yet known, but already there are disturbing signs of their influence on smaller economies within the Caribbean. The massive inflow of drug money into economies such as that of the Bahamas in the late 1990s is immensely destructive. The Bahamian government in the early 1990s had considerable difficulty meeting immense pressure from the traffickers on the one hand, and the American government on the other who wanted rid of the traffickers.

Damage is not restricted to the economic environment alone: it extends to political institutions, where the proliferation of sophisticated weaponry amongst traffickers, and the ease with which they undermine democratic institutions, are commonplace. This is so, whether in South America, South East Asia, or elsewhere, but it is in Latin America that all these factors are most often combined (Dziedzic 1989).

In Colombia the situation is almost beyond repair (MacDonald 1989) but Venezuela and Ecuador increasingly attract trafficking, and cocaine production is extensive which makes them additionally vulnerable. One of the many difficulties for national governments is that traffickers have appeared to assist local industries, although of course their assistance quickly turns out to be catastrophic. In one of the most carefully documented studies in Peru, Morales (1989) shows that coca production and the processing of its derivative alkaloids have become major Peruvian growth industries, the ramifications of which reach into the heart of Peru's political life, its law enforcement and its judicial systems. Morales (1989) says 'the effect of this new commerce has been corrosive of traditional society and of modern institutions, has placed the country in even more onerous conditions of international dependency and has solidified new trends of social class exploitation'. In the long term, Morales believes the net effect will create conditions that will produce greater levels of social and political impoverishment than hitherto seen. Peter Reuter (2001) is, however, more optimistic. He claims that the land under coca cultivation fell in Bolivia and Peru from 150,000 acres in 1992 to 60,000 acres in 1999 (p. 21). Of course all these figures must be viewed as estimates, but Reuter believes crop eradication programmes have had some measure of success in parts of South America.

A study of the long-term effects of the narco industry in all societies, including Western European countries, would need to include selected political and social institutions, especially those centring around finance. It would also need to determine the extent of the traffickers' current influence, and then show the likely impact in the short and long term. The US experience suggests that Western

European institutions are strong enough to be impervious, although to what extent they can remain so must be difficult to calculate. The amount of drug money available must always constitute a threat to institutions, however large.

Again, in Morales's study of Peru (1990) he notes the extent of dependency on the lives of peasants and workers whose livelihoods are closely linked to the production of cocaine. It was they who have resisted attempts by governments to introduce alternative cash crops in the region. Peasants and workers have traditionally supported the drug producers, seeing them as providing an income higher than that expected in crop substitution programmes. Healey (1989) found similar results in Bolivia, where support for coca leaf production came from well-organised peasant unions closely tied to the national labour movement. So too in Pakistan where resistance to crop eradication programmes of opium is legendary. These studies tell us a great deal about the impact of drug production on local industries, and for that reason, incidentally, they could easily provide a model for a study on the impact of the drugs trade on local areas in Britain and elsewhere (i.e. showing the dependency of local landlords, traders, and the like on local drug markets). There are differences to be sure, but sufficiently isomorphic in their structure to suggest one could usefully act as a model for the other.

Generally speaking, more is known about South American traffickers than those from South East Asia or elsewhere. However, MacDonald and Mansfield report (2001) that in Afghanistan although the agricultural conditions for growing opium are conducive, it is not grown nation-wide. They say that the labour requirements are heavy, so that the producing areas depend greatly on a type of sharecropping where women and young children are actively involved in the weeding and harvesting. Farmers growing opium are given preferential access to credit, thereby ensuring harvesting and continuity in terms of production. While the authorities in Afghanistan, including the Taliban, have passed an edict banning the use, production and sale of opium (and cannabis), implementation of this edict has been problematic (*ibid*. p. 5).

Colombian trafficking operates largely in cartels which are best characterised as a federation of multiple independent groups that, when necessary, forge multiple alliances. They are not centrally organised, although some cartel members are more powerful than others and offer leadership when required. The cartels function much like legitimate businesses, with sections concerned with distribution, sales, financing, product promotion, security, and so on. They tend to

compartmentalise their organisations into production, transportation, distribution and money laundering. However, unlike legitimate businesses the cartels cannot resort to the courts or other legitimate enterprises to sort out disputes over product quality, to collect debts, or to resolve other matters. Instead, they rely on bribery, extortion and violence to achieve effective and efficient production and distribution, to avoid arrest and to gain a huge profit (Florez and Boyce 1990). South East Asian heroin traffickers seem to be slightly less sophisticated in their business methods, preferring to remain more individualist, but no less reluctant to resort to extreme levels of personal violence when required (Lo and Bean 1991). In Britain, Turkish traffickers control much of the importation of heroin with the drugs coming into Britain from Afghanistan via Turkey.

There were once four major cartels in Colombia – the Medellin, the Cali, the Bogota and the Northern Coast cartel (although some see the North Coast and Bogata as one and the same). The position has changed in the last decade, with cartels in Mexico assuming greater importance. Traditionally the Medellin cartel had the most publicity, but the Cali cartel was larger, more efficient and certainly more business-like, although recently unconfirmed claims have been made that the Cali cartel has been broken up. Almost all the cartel members in Colombia are known to the DEA and the FBI, as are their movements and their major business associates. By all accounts the traffickers were, or are, small-time gangsters, unsophisticated and with an easy recourse to violence. Their lifestyles are ordinary and their tastes crude. They have a shrewd organisational sense which allows them to know whom to employ, how to obtain the best financial advice, and how to enforce discipline. The DEA and FBI have developed an extensive portfolio of cartel members, and consistently and persistently apply to the Colombian government for their extradition. Rarely do they succeed (DEA personal communication).

Generally speaking we can distinguish between cartel members, traffickers and dealers, although sometimes they are one and the same. As a rule, cartel members own the drugs while the traffickers transport them, acting as middlemen between the cartels and the more local dealers. Sometimes cartel members hand the drugs over to the traffickers, sometimes not. These high-level traffickers usually work directly with the cartels, but mostly outside national boundaries, and are responsible for transporting the drugs having purchased them from the cartels, and some may be cartel members in their own right.

Alongside the cartel members are the financial advisors, mostly from Europe having emigrated to Colombia before or after the Second World War. Typically these are sophisticated professionals with a detailed knowledge of financial markets and financial institutions. Culturally and socially they have little in common with the traffickers and regard themselves as superior. Yet they are as central to the operation as the traffickers are, for money and drugs are but two sides of the same equation. Without the financial advisors there would be no trafficking, and without the trafficking there would be no financial advisors. Both create the profits, for without profits there would be no drugs (*ibid*.).

Cocaine is typically transported from the Guajala peninsula in Colombia, or from Venezuela, using at least four major methods. They are:

1 In containers where the drugs are sent direct to selected ports.
2 By air drops to selected Caribbean locations.
3 By sea to selected Caribbean locations.
4 By small time couriers.

Most of the earlier trafficking was done in containers and this seems to be the most successful form, at least from the perspective of the traffickers. The Port of Miami randomly selects one in 100 of all containers passing through and subjects them to detailed examination. This is in addition to those selected as a result of information from undercover activities, informers and the like. It takes a small team about two weeks to examine each container. Corrupt employees within the port, working for the traffickers, will often know in advance which containers have drugs and so will remove them before they are searched. This is another example of how traffickers find ways of undermining attempts to seize illicit drugs. The drugs may have travelled in a number of different containers, perhaps leaving Colombia and going round Cape Horn, and Ecuador, before passing through the Panama Canal *en route* to Miami. The aim is the same as with money laundering – to leave no trail that can be followed.

Large amounts of drugs are sent by air to be dropped into the sea somewhere off a favoured island in the Caribbean, where they are picked up (traffickers are able to use the most sophisticated equipment, usually purchased indirectly from the US military) and stored until they can be moved to the USA, Europe or beyond. Peter Reuter (2001) states most air drops are of 250 kg or more. Using a global positioning device the claim is that drugs can be dropped

within six feet of a target area. Corrupt local police will be paid to look the other way as will others, including senior politicians, who will all be paid in cocaine and the drugs will thus find their way into the network as required. Air drops are probably less successful than containers, as US radar is very effective in the Caribbean region.

Local fisherman using small craft are able to ship quite large quantities of drugs from Colombia to the Caribbean islands. The shortest route takes about five days. These boats are difficult to detect by traditional radar, are low-slung and fast, and the local peons see drug transportation as more profitable than fishing. The aim is to avoid patrols by the Royal Navy and others (especially from the USA), but by all accounts there is no shortage of volunteers willing to transport drugs, in what remains a hazardous exercise given the size of the boats and the distances travelled. Some go as far as Jamaica.

The fourth method of transportation is by local courier who will transport small quantities, but given the numbers operating these will (when added together) produce a large total aggregate. The major aim may have less to do with the amounts transported and more to do with testing out new routes for later evaluation by the traffickers. Tourists too can be effective couriers, helping to promote new routes and new markets, or seeking to sustain existing ones. Too little attention has been given to this group. Additionally, European nationals and former nationals returning to see relatives or coming home to Europe for other reasons (including seeking medical treatment) can help establish new networks (e.g. Surinam to Holland, and so on). Again, this is an under-researched area that needs closer attention. Couriers (or 'mules', as they are often called) from Nigeria or Jamaica are small-scale traffickers bringing small amounts of heroin into Britain, one of the major effects being to increase the female prison population in Britain (see Chapter 9).

Traffickers tend to sell to their own ethnic or cultural groups, believing these to be the only ones to be trusted. They will sell drugs to Jamaica but will also insist on transporting them. Accordingly, and as expected, Spain is the major destination for trafficking from South America to Europe (Gillard 1993), but increasingly West Africa has assumed importance. Jamaica remains a main staging post for drugs on their way to Britain, as are some other Caribbean islands such as St Martin for transferring into France and Holland. St Martin is an island in the Caribbean owned jointly by France and Holland. There are no customs posts between the two parts of the island and no customs posts between the island and their European counterparts. Accordingly, traffickers getting their drugs into St Martin find no

difficulty in then getting them into France or Holland, and once there, to send them off around Europe. This is another example where political systems favour the traffickers.

There are numerous methods used to conceal drugs and ship them to their destinations. Two famous cases involved drugs packaged as fruit. In May 1999, Interpol Madrid reported the seizure of 550 kg of cannabis concealed in tins of tomatoes. This seizure was similar to that in Essex where 2,061 kg of the drug were seized, again in tins of tomatoes (NCIS Annual Report 1999–2000). Traffickers invariably deal in specific drugs, but some high-level dealers are more generic. For example, a Belgian national was intercepted while driving a lorry and importing drugs through Dover. In the lorry were 20 kg of Ecstasy, 200 kg of base amphetamine, 2 kg of cocaine, 9 kg of herbal cannabis, and 1 kg of cannabis resin (*ibid*. p. 32). Or again, an operation in Nottingham resulted in the seizure of cannabis, amphetamine and Ecstasy with a street value of £1.6 million (National Crime Squad Annual Report 1999–2000: 16). Traffickers and dealers will easily switch commodities depending on the profits. In Britain large numbers of drug dealers are moving into cigarette and tobacco smuggling. The profits are as good, the operational arrangements less difficult and the likely sentence if caught much less severe – an expected sentence of three years for a multi million pound tobacco trafficking operation is not uncommon, whereas for a Class A or Class B drug producing similar returns they could expect at least ten years.

It is difficult to evaluate interdiction practices. Most of the research evidence is American (Reuter 1988) and there are few comparable British studies. The American studies show that many traffickers are simply not sighted, and their couriers are not detected. Based on data relating to seizures, these studies invariably conclude that 'we do not have the data to support conclusions about how successful we are now, what impacts our efforts have, or what the situation might otherwise be' (Home Office 1986). It seems that the systems perform well once a trafficker had been detected but again, the data supporting this are not all that strong and many improvements are required (Reuter 1988). Peter Reuter (2001) notes that US policies are heavily supply-side orientated: the primary aim is to restrict the availability of illegal drugs. He notes (*ibid.* p. 16) that the federal government and other departments together spent US$35 billion annually on drug control in the year 2000, up from $10 billion annually in the mid-1980s.

The general conclusion reached is that seizing drugs before they enter a country has little impact on the extent of drug use within

that country, except of course on the price, unless a seizure is a monopoly seizure. This was the case with Operation Julie, which was not an overseas operation but is none the less instructive in this respect. Operation Julie closed down a large LSD manufacturing site in Britain, and, as this was a monopoly supply site, it effectively stifled LSD consumption in Britain and elsewhere for many months. A likely impact of some successful interdictions is that this will affect domestic consumption, and sometimes local drug production (Reuter 1991). For example production may be shifted to other sites, some local, some not. Those drugs having a direct substitute effect are likely to lead to shifts in production, so that the successful interdiction of heroin, for example, can lead to a growth in methadone production. It is unlikely however that one successful interdiction, no matter how large or impressive, will greatly affect consumption or price. Drug production is cheap and losses can easily be restored (Bean 1995a). Indeed, Peter Reuter (1991: p. 22) notes that where it would cost US$10,000 to ship a kilogram of cocaine from Bogota to Miami, a legitimate private company would charge only US$100 to ship the equivalent legal amount. 'It is hard not to attribute the differential to law enforcement'. This is, of course, one measure of the success of supply-side interdiction, as, in a legal regime, cocaine would sell for US$5 per gram (*ibid*.).

Clearly interdiction is not a complete failure and efforts should not necessarily be directed elsewhere. The best that can be expected is to disrupt and seriously interfere with trafficking so as to inconvenience the traffickers. Interdiction puts up the price and sends out an important political message that governments are not prepared to give way to trafficking and they will devote extensive resources to that end. In fact Dorn *et al.* (2005: 38) are even more optimistic, pointing out that it would be wrong to say that evidence is lacking showing the success of law enforcement on upper level markets. What they call 'near source pinch point action' can, if extensively applied, considerably reduce drug flows. A measure of displacement is however inevitable, followed by dispersed patterns of trafficking. None the less, near source intervention is most likely to have a sustained effect if embedded in a wider political strategy involving *inter alia* erosion of local political support for traffickers.

The expansionist model of consumption asserts that the American market is almost full and Britain (along with other Western European countries) provides the means by which this existing market can be expanded. Moreover, the amount of land area given over to cultivating the coca leaf in South America has increased to such an extent that

there is a need to look for new markets to take up the growth in supply (i.e. an increase in drug use, as cocaine is supply led) (Stutman 1989). For other drugs such as heroin or Ecstasy a different theory applies, which is perhaps more demand led. The expansionist model implies that trafficking to Britain will increase over the short term, which means that interdiction policies will continue to be required.

International cooperation

The methods of transportation and the means by which drugs enter national boundaries and are transported to other counties differ widely. One means by which interdiction can be improved is through international cooperation. There is evidence to suggest that some forms of international cooperation do exist and are increasing, but existing formal and informal mechanisms of cooperation need to be strengthened and developed if the investigation and prosecution of international trafficking is to be improved (House of Commons 1990; Birch 1991; Bruno 1991; Anderson and De Boer 1992). The prospect of a Europe without internal frontiers, plus the need for information sharing between countries, are the driving forces for greater cooperation. Increasingly, high-level traffickers live in one country and direct operations in another, with the drugs imported and sold in a third country.

As far as Britain is concerned there are three main areas in which formal cooperation against trafficking takes place. This does not include the extensive cooperation between Britain and America which takes place in the Caribbean, and in other places such as Turkey and the Far East. Here, the concern is mainly with formal European cooperation.

There have been a number of developments in international cooperation. First, there is the Schengen Group. Initially this included all the EC countries other than Britain, Ireland and Denmark, with Greece having observer status. In 2002 the government decided to apply for 'partial but significant' membership of the Schengen group. Second, in a development described by the NCIS as 'significant', was the agreement within the European Convention allowing Europol to store criminal intelligence (NCIS 1999–2000: 37). Europol has no executive or operational powers and no capabilities to gather evidence: it is an intelligence-based organisation able to offer services to operational teams in the EU (*ibid*. p. 39). The UK has a designated National Unit for Europol, with four officers seconded as

liaison officers. Third, there have been international activities, such as the International Intelligence Branch (IIB) which consists of the Drugs Liason Officers (DLOs) network based at The Hague. All are seen as contributing to the increasing international nature of drug trafficking and the annual reports of both the NCIS and the NCS are full of examples where cooperation was successful. Nicholas Dorn talks of the way 'co-operation is increasingly linked through information systems, is rapidly converging in their methodologies and is becoming more slowly harmonised in terms of their general rules' (Dorn 1993).

Yet how much cooperation actually occurs is not known. Clearly some takes place, but it is uncertain how much or what its level of effectiveness really is. One possibility is to produce larger and larger centrally-directed organisations leading to 'some super Europol' (Birch 1992). Another is for a more pragmatic approach which improves arrangements for cooperation between existing agencies without taking away their independence or unique role (*ibid.*). Sadly, the history of cooperation at a national and international level has not always been good. There have been some spectacular rivalries between agencies – the early years of the DEA and its rivalry with the FBI being the most dramatic – with gross inefficiencies in and between the international community. Policing at an international level has often been a hit-and-miss affair, dominated by national interests which seem rarely to be transcended to allow full cooperation to occur (see particularly the US Home Government Operations Committee for a description of such rivalries). There is, it seems, rather more cooperation in Europe than elsewhere, with some evidence to suggest things are going quite well, but this still remains below what should be required, with some European countries reluctant to provide more than token assistance.

Drug dealing within Britain

An early model of drug use which saw Britain as an overflow from America promoted a view of drug dealing within Britain as a static triangle or pyramid, with a big Mafia-type organisation sitting at the top controlling the market. Dorn *et al*. (1992) concluded otherwise: 'There is no person, no Mafia, no cartel organising the market overall. Rather a large number of small organisations operate fairly autonomously of each other in a manner that may be described as disorganised crime' (p. 203).

Such a view has support from Peter Reuter's seminal American study: 'The old images of highly centralised and controlled drug distribution systems have largely disappeared in face of growing evidence of competitive violence and the failure of individual organisations to endure a dominant position' (Reuter *et al.* 1990 p. 23).

In a later study (2001), Reuter modifies this somewhat and says 'There are probably just a few hundred people with significant roles as importers. Roughly 400 tons of cocaine enter the US each year and since some criminal organisations handle 10 tons or more annually not a lot of importers are needed' (p. 18). Johnson *et al.* (1990) suggested that larger and more hierarchical organisations will emerge in the retail crack trade as it matures. Reuter (the same year) disagreed:

> Two factors make this outcome unlikely. First without the ability to buy large scale corruption from law enforcement agencies, the leader of a large organisation is at risk from his employers, any of who can turn informant. Second the erratic behaviour of so many heavy drug users is the crack trade makes for a particularly difficult management problem: successful long term entrepreneurs are likely to be those able to select a small number of reliable subordinates. (p. 24)

In Britain, at least up until 2002, the notion of the large-scale trafficker operating within national frontiers has largely been promoted and sustained by the police. Organised trafficking, says Dorn *et al.* (1992: 203), had helped create a near consensus within the ACPO (Association of Chief Police Officers) that some degree of centralisation of policing was needed. Moreover, 'the function of the Natural Drugs Intelligence Unit, its role in piloting the broader National Criminal Intelligence Service (NCIS) and the elevation of the intelligence centre over local operational teams effectively bequeathed Britain a national detective agency along the lines of America's FBI' (p. 203). They therefore would ask, what more is needed to further promote the myth of the big trafficker? If there is no central control organising the market, what is there? The general conclusion seems to be that there are a large number of small independent organisations:

> This analysis of the returns to participation in the drug trade is not much complicated by the existence of monopolistic organisations. In most cities entry into the drug selling business seems relatively easy, requiring little capital or skill beyond which is acquirable through familiarity with the trade and

> its members. Low level dealers are not apparently subject to systematic extortion by broad-based criminal syndicates. (Reuter *et al*. 1990: 24)

This is so for America as well as for Britain. Drug markets, it seems, are fluid and made up of many diverse trafficking enterprises that change their *modus operandi* over time. Of course, all of these are organised if only to pursue strategies designed to make a profit, collect debts, sell drugs and keep as far away from the enforcement agencies as possible. But that does not mean being organised in the sense of there being one overarching structure which controls trafficking in Britain.

I have said in an earlier paper that there were about 4,000 people in Britain able to move quite large quantities of drugs, not all at the same time, and about 100 gangs in London operating within the drug world as reasonably high-level dealers (Bean 1995b). These figures are now out of date and a later estimate puts the figures higher: about 300 major drug importers in Britain, with 3,000 drug wholesalers and 70,000 street dealers, amassing a turnover of £7–£8 billion per year. In one northern town, 50 crime gangs were smuggling drugs for a population of less than 100,000 (Lander, *The Times*, 17 Feb 2007). This in contrast to the USA, which six years earlier had about 200,000 people involved in cocaine retailing, some on a part-time basis (Reuter 2001: 18).

There have been numerous attempts to produce a typology of trafficking in Britain. An earlier version by Dorn *et al.* (1992) pointed to the difficulties of being able to represent the fluid nature of the British drug markets, but they believed it looked something like this:

1 Trading Charities, which are enterprises involving an ideological commitment to drugs with profit as a secondary motive.
2 Mutual Societies, involving friendship networks of user dealers who support each other and sell or exchange drugs amongst themselves.
3 Sideliners, which represent the licit business enterprises that begin to trade in drugs as a sideline.
4 Criminal Diversifiers, which are existing criminal enterprises that diversify into drugs.
5 Opportunistic Irregulars, which are those who get involved in a variety of activities in the irregular economy, including drugs.

6 Retail Specialists, which are those enterprises with a manager employing others to distribute drugs to users.
7 State-sponsored Traders, which are are those enterprises that operate as informers and continue to trade (see Chapter 8).

Dorn *et al.* looked closely at these various organisations and, *inter alia*, concluded that there are many mixed cases which are difficult to classify and that generally speaking the amateur trading charities were likely to be replaced by more overtly criminal elements (1990, p. xii–xiv). None the less, this was at the time an interesting and valuable typology which allowed a greater understanding of the way dealing operates.

A later typology has been developed by Dorn, Levi and King (2005). This takes a much wider, international, perspective consisting of three main groups of major traffickers. First there are those they call the 'insurgent group' and/or paramilitaries, who impose 'taxes' on producers and/or traffickers. They involve themselves in trafficking to enhance their military and political ambitions. They are typically hierarchical in structure and may only last as long as their movement exists. Examples include the Shining Path in Peru and the FARC in Columbia.

Then there are the 'business criminals' who are driven by personal financial considerations and do not seek political change, although they may influence events but only for their own purposes. They typically adopt a 'core group' structure, making them resistant to infiltration and law enforcement. Examples include the leaders of the Calli or Medellin cartels, plus a varied group of enterprises operating in South America and beyond. These 'business criminals' (as described by Dorn, Levi and King) closely resemble a group of traffickers and dealers from South East Asia, who are mostly men approaching middle age or older, who have excellent organisational skills, and established connections, often with organised crime syndicates or are prepared to work closely with organised crime, and have capital to invest. They also have a willingness to take large business risks. Their activities exist within a highly competitive market populated by individual entrepreneurs. These traffickers change as enforcement strategies change, or as they tire of the corrupt practices endemic to the illegal trade (Chaiken and Johnson 1988). Some may be intermittent traffickers – they are often in South East Asia – and are active perhaps once every two or three years. Some may not be involved for a period of time but seem to be drawn back into it. There is, it seems, some compulsive and highly attractive element

about high level-trafficking, generating levels of excitement not found elsewhere (Lo and Bean 1991).

Third are the 'adventurers', often small-time opportunists usually operating on a precarious basis. For them high-level risk taking is the norm, either because they have little choice in doing otherwise, or because of the pleasure they have in beating the authorities. Examples are Afghan villagers trying their luck as traffickers, migrant workers and others who try to beat the system hoping for extensive rewards were they to do so. They are more vulnerable than the 'business criminals', having no protection from being in an organised group, and their bravado can lead them into direct conflict with others. If they do get caught, especially in those countries retaining the death penalty for trafficking, then long-term prison sentences may be the best they can expect.

Dorn, Levi and King also suggest that international markets may be changing, thus making earlier divisions and typologies less relevant. They believe new structures and new organisations are developing, together with established linguistic and cultural barriers breaking down. This is leading to different forms of cooperation including the formation of new multicultural, multinational teams and is in contrast to the earlier view where organised crime syndicates, such as the Mafia, triads and the like, tended to dominate. Highly structured and highly organised groups are being replaced by more unstructured and disorganised groups, although Dorn, Levi and King believe that business criminals and certain core groups will still remain important (2005: 37).

This later view replaces more established versions from the Council of Europe and the European Community, who have been saying within the framework of TREVI (Terrorism, Radicalism, Extremism and International Violence) that there is an urgent need for more action to deal with organised crime. They retain a strong belief that the interdependence of national economics has helped spawn the growth of multinational crime systems that are becoming difficult to identify and control (Martin and Romano (1992). Moreover, as Europe has a barrier free-style, single market the spectre of criminal organisations without frontiers looms large, and the Mafia, amongst others, is thought to have seen a golden opportunity to extend their influence – even beyond the EC to the East European countries (Reuters News Agency 1993). How much influence is retained by Mafia style organizations is difficult to say. They have a long history and will not easily give way to those new organisations defined by Dorn, Levi and King.

There is another literature, even older, which links organised crime and terrorist organisations such as the IRA (Boyce 1987) where drug trafficking provides the money to finance these operations and the drug traffickers use the terrorists to ensure the source of their supply. The end product is social disruption (Sen 1989). One view is that as the financial rewards of drug trafficking increase, so too will drug-related terrorist activities (Langer 1986). Another is that terrorist links are constantly being redefined and new terrorist organisations are in turn being developed. Interpol, for example (ICPO – Interpol 1989), draws attention to developments in Africa where heroin from the Indian subcontinent, intended for Europe and North America, is being funnelled through Africa by Nigerian organisations – some of whom are composed of African terrorists. And of course Dorn Levi and King, in their typology, describe these terrorist groups: they call them 'insurgent groups' and/or paramilitaries who impose 'taxes' on producers and/or traffickers and they involve themselves in trafficking to enhance their military and political ambitions, e.g. the Shining Path in Peru and the FARC in Columbia.

What still remains unclear is how the traffickers and terrorists/organised crime syndicates interact. At what point do they work together and at what point do they part company? Boyce, for example (1987) says there does not appear to be any links between traffickers and terrorist groups within the USA – although there may be a measure of cooperation before drugs enter the country and, as mentioned earlier, Dorn *et al.* say of Britain that there is little direct organised crime linked to trafficking. In contrast, Wardlow (1988) says 'eliminating terrorist links will have little impact on the flow of drugs. Drug connections are established for practical academic reasons rather than ideological ones'. There remains a shortage of data on those links. If, as Dorn *et al.* suggest, drug markets are fluid, then how such organised crime syndicates work with terrorist groups (both of whom may also work with local distributors) is an important area for future research.

The extent of anecdotal evidence linking trafficking with organised crime is more than adequate to suggest links exist, are sustained and operate at all levels. What is less clear are the terrorist links. Terrorists avoid publicity. Their world is one which thrives on secrecy, ill-informed opinion and as few contacts with law enforcement as possible. Traffickers have no great political conscience about changing the world, their aim is to change their financial position within it. Working with publicity-seeking political ideologues seems not to their liking. And yet, anecdotally, we are told that trafficking and

dealing support terrorist organisations. If so, and there is no reason to believe otherwise given the claims made by journalists and the like, it is important to know the basis and means by which they interact and the manner in which such deals are secured. Is there a go-between, and if so who would that be? Are contacts made directly with traffickers or are these through national dealers? These are some of the types of questions needing an answer.

Money laundering

The recognition that drugs and money are but two sides of the same coin marked an important change in the way in which traffickers were seen and dealt with. In Britain, the 1986 Drug Trafficking Officers Act (amended by the 1994 Act) introduced detailed provisions for dealing with trafficking, including the introduction of confiscation orders i.e. based on the older process of forfeiture to deprive traffickers of the proceeds of their crimes. The 2002 Proceeds of Crime Act and the creation in 2006 of the Serious and Organised Crime Agency (SOCA) are further examples of the present government's apparent determination to do something about the proceeds from drugs – 'apparent' because too often the rhetoric outpaces the activity. One example of such rhetoric was Mrs Thatcher addressing her remarks to traffickers on the 21 January 1986 when she said

> We are after you. The pursuit will be relentless. The effort will be greater and greater until we have beaten you. The penalty will be by prosecutions. The penalty will be confiscation of everything you have ever gotten from drug smuggling. (Parl. Debates 21.1.86 col. 273)

It is doubtful if the pursuit was relentless, and as previously shown the later confiscation of assets rarely reached a level which troubled the dealers.

'Laundering' is defined as the concealment of illicit income and its conversion to other assets in order to disguise its source or use. Laundering for the traffickers is the process used to solve the problem of large amounts of detectable cash arising from sales, which cannot at that stage be declared to the authorities. There is an extensive literature on money laundering but much less on confiscation orders.

The legislation on money laundering is complex and full of difficult moral, jurisprudential and sociological questions. Briefly, the main legislation is the Criminal Justice Act 1993 which has amended the Drug Trafficking Offences Act 1986, by inserting into that Act Sections 26B and C which define the obligation to report money laundering, as well as creating a new offence of 'tipping off' money launderers who are being investigated. These sections create new and drastic offences. 'Tipping off' is disclosing to any other person information or any other matter which is likely to prejudice that information (Fortson 1996). This aspect was introduced when police officers found local bank clerks were notifying their investigations to money launderers. As the police came in by the front door, the teller went out the back and made the phone call. Hence it is now an offence to 'tip off'.

Section 26B places an obligation to report money laundering. It says a person is guilty of an offence if

- they know or suspect that another person is engaged in drug money laundering
- the information or other matters on which the knowledge or suspicion is based came to their attention in the course of their trade, business, profession or employment
- they do not disclose this information or other matters to a constable as soon as is reasonably practical after it comes to their attention.

American legislation imposes a duty on persons to report – in effect to the police – transactions and other information on the basis of suspicion held relevant to a possible contravention of the drug trafficking legislation. For England and Wales that imposes a duty to report suspicious circumstances related to money laundering, but this applies to all persons and not just those people working in financial institutions. The amount of such transactions which those in America must report about varies, but in some states this is $10,000 or above.

International cooperation in relation to money laundering is becoming extensive – the 1988 UN Convention against illicit traffic in Narcotic Drugs and Psychotropic Substances; the 1990 Council of Europe Convention on Laundering, Search Seizure or Confiscation of the Proceeds of Crime; the 1991 Council of Europe Directive on Prevention of Use of the Financial System for the Purpose of Money Laundering (Gilmore 1991). Collaboration is seen as essential, given

the movement of funds and the complex processes involved in money laundering.

Assistance by way of formal treaty obligations is a major weapon in fighting the traffickers. The Financial Action Task Force is a big step forward in this respect (FATF 1990). Article 3 of the UN Convention against Illicit Drugs (1988) requires parties to establish as criminal offences *inter alia* the international conversions or transfer of property knowingly derived from production or trafficking for the purpose of concealing or disguising the illicit origin of the property, or assisting any person involved in production to evade the legal consequences of his/her actions. Parties to the Convention are required to make laundering drug money a criminal offence. However, there are some European countries who have signed but still not ratified the Convention and many Caribbean countries amongst others, who have neither signed nor ratified. Nor has the EC Directive on money laundering been enacted in the domestic laws of all community states – the Directive requires member states to introduce a mandatory, supervision-based reporting regime that is applicable to all credit and financial institutions (see Gallagher 1990).

Problems about cooperation in the money laundering field are not dissimilar to those relating to policing – one view is that cooperation is largely cosmetic, another is that it is in its early stages and developing slowly (FATF 1990). As far as providing information is concerned, one of the most important innovations in EC cooperation is the development of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This body has comprehensive documents relating to laundering involving the powers of the Council, the Commission, the European Parliament and the Courts of Justice, which include official discretions, decisions and even the written questions that were asked (EC 1993). One of the major problems relating to cooperation at an international level is that money laundering is itself international in scope. As the EC noted: 'Internationalism of economies and financial services are opportunities which are seized by money launderers to carry out their criminal activities, since the origin of these funds can be better disguised in an international context' (EC Chapter IV (ii) document E Explanatory Memorandum I (i) p. 243). The EC, through the Financial Action Task Force goes on to say in respect of the problems of cooperation that:

> Many of the current difficulties in international co-operation in drug money laundering cases are directly or indirectly linked

> with a strict application of bank secrecy rules with the fact that in many countries money laundering is today not an offence and with insufficiencies in multilateral co-operation and legal assistance. (*ibid*. CH.1. DOCB. p. 14)

This second quote sums up the major difficulties, but even so substantial progress has been achieved in a relatively short period of time.

Others would remain less optimistic, pointing to the reluctance of some countries to comply (*ibid*. p. xix). By way of illustration, Levi and Osofsky (1995) speaking of the British police say that their relationship with HM Customs is far from smooth, for among other things they each have different priorities. Customs are concerned with seizures, the police with developing informants (pp. 40–1). Herein lies the seat of the difficulty, for if cooperation cannot easily take place within national borders it is even less likely to take place across national borders. This relationship has, however, improved from about 2004 onwards with the introduction of middle market policing, requiring both organisations to work together if things are going to work at all.

There are a number of bibliographies which include the major national and international declarations – one of the best is provided by Gilmore (1992). Similarly, there are a number of collections describing the methods and nature of money laundering and the practical ways in which money launderers can be defeated (Gallagher 1990). Apart from international and national cooperation the methods that seem to be recommended, are:

- more staff training to make staff aware of the nature and importance of money laundering
- emphasising the importance of staff knowing their customers and their customers' backgrounds.

There are also some useful handbooks (see Parlour 1994).

There also exist extensive bibliographies on money laundering. The UN in Vienna has one of the best, and a study in 2005 by van Duane and Levi provides accounts of money laundering within a European context, i.e. apart from that in the USA (2005).

A great deal of the literature is descriptive, setting out the ways in which money launderers operate and the environments in which they flourish e.g. those with poor quality exchange controls, bank

secrecy laws, unregulated casinos and money changing bureaux, and offshore financial services – which, when combined with minimal disclosure requirements, provide a highly facilitating environment. There are also the beginnings of another literature on the role of the civil courts and what they could do to trace and recover laundered money, especially where banks are involved in involuntary laundering and that money needs to be traced (Birks 1995).

Any money launderer is faced with a central question – how can they return money to the owners of drugs in a currency which they can use? Or if not, then how can they invest it in countries and in forms which will produce a safe (i.e. will not be confiscated) and legitimate return? Drug trafficking is cash intensive, and increasingly governments aim to confiscate that cash. How best to launder? That is the aim of all launderers. Typically, money laundering goes through three processes. These are called 'placement' (which also involves smurfing), 'layering' and 'integration', although in practice there is an overlap and the processes are far from discrete.

(a) Placement

Placement is the initial stage in the process, which involves putting cash into the major financial institutions of the selected economy. There may be and often is, an even earlier stage, where money is taken out of one country to be placed in another, but this does not affect the main point here that the money launderer will be seeking to place large quantities of cash into the retail economy. The placement stage for a launderer is the weakest link in the money laundering chain, as it is that point where detection is most likely. Where, as in the USA, there are limits to the amount of monies allowed to be deposited in a bank in a single hit, 'smurfers' will deliver the maximum amounts, less $1 to qualify as a deposit, i.e. $4,999 where the maximum is $5,000. A 'smurfer' is someone who conducts financial transactions in sums below the threshold amounts. In one interesting case, a smurfer was caught with a number of caches of monies to be deposited. He told the police, correctly, that the monies did not belong to him. When the police compounded the monies the smurfer wisely asked for a receipt. He would have to convince his immediate superiors that he had not kept the monies himself.

There are numerous ways in which placements can occur, some more sophisticated than others. The most obvious involves using a form of bank structure which produces bank deposits in such a way as to evade the threshold currency reporting laws. This may involve making numerous deposits in many different banks before bringing

them all together in one central bank account. The easiest as far as the money launderer is concerned is to place all the deposits in one bank, with the complicity of a corrupt employee who will accept the deposit without question, or better still they must find a bank whose ethos is corrupt. Alternatively, the money launderer could buy into the securities and commodities markets, again with the help of insider traders. Or he might purchase large, expensive items for cash, such as precious metals, precious stones, works of art, boats, property, or play the casinos in the expectation of winning legitimate money. All these activities represent the early stages of a paper trail aimed at disguising the true source of ownership.

(b) Layering

Layering involves separating the illegal proceeds from their source by creating complex layers of financial transactions designed to disguise the audit trail. Once layered into the financial system, detection becomes increasingly difficult. The favoured method is to convert cash into monetary instruments such as money orders bonds and stocks and then move them elsewhere. This allows the use of electronic funds transfers – probably the most important facet of the layering process, as they offer the advantage of speed, distance and increasing anonymity – to move them anywhere throughout the world. Alternatively, deposits of cash may be converted into material assets which can then be sold or exported with the proceeds then held in another form.

(c) Integration

Integration is the final stage in the process of creating a paper trail that is increasingly impossible to follow. The methods used will involve the most sophisticated forms of financial transactions, usually through 'shell' companies which do indeed trade but which have been specifically set up for the purpose of acting as front companies, where the launderer may even pay tax by using bank cheques drawn on a company account. Shell companies may be used, say, to buy and sell property which will lead eventually to a sale that appears to legitimise that company's funds. False import and export invoices will be used in other transactions where the documents will over value these transactions. Most of all, were the launderer able to get the help of a bank with secrecy laws that could protect them, then this bank would be the focal point of all such transactions.

These are but a small number of examples of what has become a highly specialised form of criminality, yet they demonstrate the range

of laundering activities undertaken. The destructive nature of money laundering shows itself whenever a small company is taken over by money launderers and is converted to their aims. So, imagine a small company is trading as a boatyard, making, selling and repairing boats. This is bought up by the launderers and listed as one of their companies. It then has a slow but increasing amount of laundered cash passed through its books and on the face of it appears to be a wealthy company growing at an exponential rate. But in fact the lifeblood of the company has been drained away and it becomes nothing more than a convenient route for vast sums of laundered money produced elsewhere. Here is where the impact of money laundering is important – it might not be economically destructive in the whole scheme of things, it is just one company after all, but multiply this a number of times, especially in the Third World, and it becomes a different matter. The means by which laundering distorts economic activity are beginning to be well understood. The difficulty lies in getting key organisations, such as banks and professional organisations, to cooperate.

The developed countries have, according to van Duane and Levi (2005), been able to cope rather better. They believe a small number of dealers have obtained more than a few villas – some have acquired apartment blocks and shopping malls – but these assets have not been sufficient to obtain a dominant market position (p. 180). Yet there are always worrying exceptions and taking the profit out of crime must remain a central aim if only for reasons of justice. It is not only the *grande* dealers who are the problem but also the thousands of others including the small fry, even those on the street or in the prisons (see *The Times*, 9 September 2006, for a report on corrupt prison officers), who launder monies and seemingly get away with it. They too pose a problem.

The current government sees things rather differently. At present (2007) it wants to introduce Super ASBO control orders, aimed at restricting the movements and activities of so-called 'untouchable criminals'. These orders would be issued by the High Court against suspects, which is expected to lead to about 30 orders per year, without the need for a criminal trial. Judges could ban a suspect from owning a mobile phone or attending clubs where the police believe criminal activity may take place. Those who breach the Order could face up to five years in prison. The Serious Organised Crime Agency has apparently identified 130 'untouchable' criminals in Britain who will be prime targets. Seven years ago police and customs identified 39 top criminals who had amassed up to £220m in illicitly obtained

wealth. Not all, of course, are involved in money laundering, but it is thought nearly all 'untouchables' are heavily involved in drugs in some form or another. They have however remained largely out of the reach of the law, or have escaped conviction by witness intimidation or corruption. These are now to be targeted by the Super ASBOs (*The Times*, 18 January 2007).

While the methods involved in laundering are interesting in themselves there are implications for our major institutions which require consideration. Mike Levi (1991) has analysed the development of police–bank relationships, principally in the UK but also elsewhere, within the context of money laundering. He found that we have moved from a situation of national control over bank secrecy to new and emerging international order in which most, though not all, countries are pressurised into taking greater measures to reduce bank secrecy where money laundering is suspected. In Europe, banks are being turned into an arm of the state by being required to keep detailed records and to inform the police where they suspect, or even where they ought to suspect, that monies banked are the proceeds of crime (European Community 1992). Alternatively, consider the proposed ASBOs mentioned above. There will be no requirement for a trial in the formal sense of that term – a further erosion of rights and liberties, albeit said to be in a good cause, but an erosion nonetheless.

It is difficult here not to conclude that there is a surfeit of material on how to deal with money laundering and a shortage of such material (except from Levi) on the implications. In our eagerness to defeat the traffickers we may sometimes forget that changes are being introduced the implications of which seem not to be fully realised. It is, or ought not to be, a one way street. Trafficking and laundering must be reduced, but not at the expense of damage elsewhere.

Confiscation orders

The literature on confiscation orders is slim by comparison, yet claiming and recovering the proceeds of drug dealing is as important a task as developing strategies for dealing with money laundering. Surprisingly, confiscation orders have received little attention from philosophers of punishment (Levi and Osofsky 1995). Generally speaking the justification for confiscation is often cited as a way of compensating society for behaviour which is socially unacceptable (Mitchell *et al.* 1992; Bin-Salama 1996). This, however, cannot be the sole reason.

If conversations with high-level drug dealers are anything to go by, the confiscation order is what they fear the most. They will say they can do the 'time', even if it amounts to a long sentence of eight years or more, but what they dislike most is where their family have to leave their leafy-wooded five bedroomed, suburban house, their children are removed from private school and sent to the local comprehensive, and their family are forced into local authority accommodation. If that is so, and it is said too often to suggest otherwise, we need to pay more attention to the powers and impact of confiscation orders and use them more vigorously.

However, there are important issues raised by the legislation on confiscation orders, some of which are jurisprudential, others more directly related to social science. Critics of confiscation orders point to the dangers of allowing courts to seize property, without what is referred to as the 'due process of law', for in this case the courts have considerable discretionary powers in the making of an order (Levi and Osofsky 1995). The social science questions involved are more about the impact of this legislation on drug dealers, but they are also about the way in which property is collected. For example, there is a wide discrepancy between the assets restrained by courts and the amounts collected. Under the Criminal Justice Act 1988 the total assets restrained as of 31 December 1994 were £9,258,742 but the assets confiscated amounted only to £527,419. Again, under the Drug Trafficking Act of 1994 the total assets restrained as of 31 December 1995 were £3,815,707, but the assets confiscated were only £795,451.74 (Confiscation Statistics 1995). The figures for the year 2000 in England and Wales show that 334 prosecutions were made against 550 defendants. The total assets recovered on which there are restraining orders amounted to £15.5m, while during that year assets totalling £10m were collected.

The Drug Trafficking Act 1994 and Part vi of the Criminal Justice Act 1988 as amended by the Powers of Criminal Courts Act 1995 give the Crown Court powers to make a confiscation order. A confiscation order is an order made against a convicted defendant ordering him to pay the amount of his benefit from crime. Unlike a Forfeiture Order, a confiscation order is not directed at a particular asset. It does not deprive the defendant or anyone else to title of property. The legislation gives law enforcement the authority to investigate, and the Drug Trafficking Offences Act 1994 gives them the tools to do so. (The Proceeds of Crime Act 1995 slightly amends the investigative process.) The Central Confiscation Bureau part of the Crown Prosecution Service (CPS) operates this system and once an

order has been made the CPS hands details over to the local Financial Investigation Officer, usually a Detective Constable, whose task it is to collect the assets. One of the reasons there has been an improvement in such orders is that these financial investigation officers are better trained than hitherto. Before the task would be given to a police constable who would be told to just get on with it (Bin-Salama 1996). The problem still remains of motivating the police to be more enthusiastic. It seems the CPS loses interest once they pass the information over to the them, and the police see asset collection as yet another burden placed upon them. There would be even greater incentive here if the police in Britain were allowed to use the money collected for law enforcement and research purposes as happens in America.

The number of Confiscation Orders made in England and Wales rose from 870 in 1990 to 1,560 in 1995, but has since fallen to 840 in 2000. With a total value of about £5 million in 2000, they were made in 13% of eligible offences, half the level of that in 1995 (25%). Confiscation orders were introduced in Scotland in 1988. In 2000/01, only 12 orders were made, valued at £117,300: this was compared to 17 orders made in the previous year with a value of £822,700. There were no Confiscation Orders in Northern Ireland until mid-1991. Only two orders were made in 2000 with a value of £68,000, compared to four orders in 1999 with a value of £149,359, and two orders in 1998 for £94,800.

While the overall trend in the number of orders was upwards (in 1990 there were 871 and 1995 1,562) between 1997 to 2000 there was a substantial fall in the number and value of the orders made. The amounts varied also. For example, the exceptionally high figure of £25.4 million in 1994 for England and Wales included a single order for the confiscation of £15.3 million (Corkery 2003). The important data that are missing, however, relate to the amount seized. These data are just not available. It may be all very well making orders, and the numbers of these are falling, but if they are not put into practice their value diminishes. And as I have said above, Confiscation Orders are what drug traffickers like the least.

Under Part II of the Drug Trafficking Act 1994, a customs or police officer can seize money being imported or exported where there are reasonable grounds to suspect that it is connected to drug trafficking. There were 45 such confiscation orders made, with a value of £3.5 million, in 2000/01. The value of drugs money forfeiture orders brought to account by customs in 2000/01 was £3.1 million. The value of payments made against such orders in the same period was £3.9

million. Payments made may relate to orders made up for several years previously.

Yet for all the talk, the study by Michael Levi and Lisa Osofsky (1995) showed that confiscation orders constitute but a small proportion of the estimated proceeds of drug trafficking, and the amounts recovered where orders were made were small. For example, in 1993 out of an estimated £560m from property and drug crimes confiscation orders were made for only £140m and only one quarter of that was recovered. Levi and Osofsky point to a number of reasons for this lacklustre performance, not least being the relatively small number of 'Mr Bigs' convicted and the lack of any organisational incentive for anyone to deal vigorously with confiscation matters. Unless and until these change, we shall continue to lose out on one of the most effective weapons we have against traffickers.

The proposal for Super ASBOs cited above is an admission that asset recovery under the confiscation orders and through the Asset Recovery Agency is not working. Organised crime in Britain is said to be worth about £20 billion per year and asset recovery deals with only a small proportion of that. Whereas organised crime is said to be 'widespread, vibrant and growing' (*The Times*, 18 January 2007), asset recovery appears to be moving in the opposite direction.

Chapter 7

Policing drug markets

Policing policy

In so far as there is, or ever has been, a policy for policing drugs in Britain, that policy was derived from the Broome Report of 1985 (ACPO 1985). It set out the structure for tackling the supply and distribution of drugs. For this there was to be a three tier strategy.

- Regional crime squads, addressing major distribution and operations of a national and sometimes international level.
- Force drug squads, targeting middle-level dealers and coordinating force intelligence on drugs.
- Divisional level officers, who would encounter drug suppliers and users in the normal course of their duties.

The Advisory Council on the Misuse of Drugs (ACMD 1994) noted that, within the Broome structure, the police were responsible for deciding how drug misuse and trafficking should best be tackled, presumably within force areas and according to local conditions. At the upper level the police, working alongside HM Customs, would be concerned with international crime, the international trafficker and the high-level national dealer. Middle-level enforcement, according to Broome, was to be directed at the organisations responsible for trafficking within national boundaries. In the British case, these would be via drug squads. Lower-level enforcement would be by uniformed street patrol officers. The former would be concerned with getting

the so-called 'Mr Bigs', the lower levels would be concerned with the street dealers. The ACMD also noted that concerted action (other than at the upper level) had been regarded as relatively unimportant (*ibid*. p. 12).

The Broome strategy was based on the belief that drug markets operated according to a model derived from a police officers' view of the structure and importance of policing (i.e. allowing the most important traffickers to be dealt with by the most important police officers, the less important with the less important police, and so on). Clearly the model was flawed in that there was no evidence that traffickers worked that way, but worse, it had a detrimental impact on the drug problem in Britain during its critical formative years. Street drug markets were allowed to develop and grow, and once established these are difficult to remove. The Broome model has now been discarded, but not before much damage was done. It has been replaced by other models including those which direct attention at the low-level street markets, for these are where the drugs are sold to the consumer and where novices are recruited, whether as users or dealers.

Drug markets generally

Drug markets have certain common features. Irrespective of the size or location of a market, drugs are bought and sold in the same manner as all other commodities: there is nothing unique or special about drugs. There are of course differences. Unlike most other commodities, drug markets are characterised by a high degree of immeasurable risk, by the inability to enforce contracts in a court of law, and by poor information about the product (Rydell *et al.* 1996). Nevertheless, they are markets with buyers and sellers, and as with other markets they are subject to the basic economic laws of supply and demand.

Within these markets dealers have to secure financial transactions which exist in a crooked world with no one to enforce contracts but themselves. They are always vulnerable to theft and violence by greedy business associates and protecting their transactions takes up most of their time (Bean 1995a). Most will find it necessary to employ others who are familiar with intimidation and violence or, if not, then must make themselves comfortable with the use of violence in order to collect debts and enforce discipline. In Britain, Dorn *et al.* (1992) have described how a new breed of criminal was attracted to

the drugs world where violence was an essential part of the lifestyle. Whether this really was a new breed or simply an old breed, with a previous history of violence attracted by the possibility of a share in the increasingly extensive profits, is not known. Whatever the reason, the overall effect was to make drug markets violent places where those working in them become more frightened of other dealers than of the police. They operate in a Hobbesian world where no rules or guidelines exist, except those made by themselves to serve their own interests. The problem is that once they are initiated into such a world, it becomes difficult for them to accept any other.

The lack of skills required to enter this milieu as an entrepreneur and the ease of transportation of a high profit commodity are likely to be attractive. In broad outline the drug market, like all other markets, works on credit – namely the beginner is granted credit at a certain level of interest and expected to pay back the debt within a given period of time. Failure to do so will mean certain punishment. Within this general framework there will be considerable variations in terms of the social class of the sellers, the venue and the range of credit facilities. However, the demand for repayment does not vary. And neither do the punishments for those who default.

It is generally accepted that upper-level markets, especially in cocaine and heroin, are complex, that the distribution routes used vary and that these are adjusted according to law enforcement strategies, with new routes developing as new markets are created. Higher-level dealers are increasingly involved with, or are part of, organised crime. In Britain, this means traditional organised crime syndicates but, increasingly, this will include others bound up with ethnic or local groups. For example, Turkish organised crime syndicates (who also control major distribution networks in kebab houses) are increasingly dominating the heroin trade in Britain. They have links with British nationals of Turkish origin. These organisations are difficult to penetrate, as they remain part of a close-knit community trading only with others of the same nationality and background. The NCIS has a Turkish Intelligence Unit to combat heroin trafficking. This provides a coordination point for intelligence related to Turkish heroin trafficking in and outside the UK (NCIS Annual Report 1999–2000: 25). Triads and Mafia-type organisations are well represented amongst the high-level dealers, and in August 1999 the Cocaine Intelligence Unit was formed by the NCIS to provide an overview of cocaine trafficking within the UK (*ibid*. p. 26).

There are few data on the links between these higher level dealers and those on the streets (Natarajan and Hough 2000). In America

they talk of 'kingpins', who are senior local dealers who presumably make that connection. Research is needed in Britain to establish those links. It is suspected that there will be marked variations between drugs and organisations. For example, Turkish importers may also be distributors and controlling the market at all stages. In contrast, cocaine importers may not be concerned with distribution and will hand this over to local 'kingpins'. But this is all speculation – we simply do not know. The trade is so lucrative that it is estimated 85% of British banknotes are contaminated with heroin or cocaine (Lander, *The Times*, 17 February 2007).

At the lower levels, drug markets come in one of two forms – open or closed. Open markets are characterised by their ability to provide most buyers with the basic criteria, provided of course that they look and talk like users. These markets are supported by a core of dependent users, including sex workers, with the latter being ideal clients. They have a ready supply of cash, or if not can earn it quickly which gives them a good credit rating. Sex markets support the development and buoyancy of drug markets (May *et al.* 1996; May *et al.* 1999). Closed markets operate on the basis of established social networks where drugs are sold only to known or recommended customers. Significant barriers have to be breached before a newcomer may purchase drugs. Some markets, whether open or closed, will be long-established and drawing buyers from outside the area; others will serve only local clientele. Most but not all drug markets will be in inner city areas serving mixed ethnic and transient populations (Lupton *et al.* 2002), but some will cater for middle-class clients (rock stars and the like). Others will be in rural areas, for drug taking is not exclusively an urban problem. Newcomers to rural areas seem to be the significant players here (Davidson *et al.* 1997).

At these lower levels, where street dealing dominates, dealing will differ again according to the type of drug, although some dealers are poly dealers who are willing and able to sell anything (Bramley-Harker 2001). Cannabis is typically bought and sold from individuals who come from a broad range of backgrounds and in a wide variety of settings, from inner city areas to middle-class institutions. Ecstasy dealers are perhaps more specific, where dealing more typically takes place at raves or clubs. Dance venues, whether they are warehouses, nightclubs, pubs or bars, are potentially highly profitable sites for drug dealing, whether this is Ecstasy or otherwise. Door staff who are involved in drug dealing operate in various ways, either by turning a blind eye to dealing and receiving payments accordingly, or as active dealers themselves. In a study of dealing in Liverpool and Newcastle

prior to doormen being registered or 'badged', Morris (1998) found different models of dealing. In Liverpool it was 'those who controlled the floors', meaning that a registered security firm took control of a large section of door supervision using intimidation and bribery. In Newcastle intimidation and violence were used to allow dealers to operate and sell the drugs inside a building. Morris concluded that 'about 10% of door supervisors were corrupt' (*ibid* p. 1). Registration was expected to reduce that number.

Heroin, on the other hand, is very much a street drug, although as with all others the situation changes daily, so that what is typical for today is highly unusual for tomorrow. Even so, at the lowest end of the market heroin will be bought and sold by users for whom the sale is less important as a method of generating cash than as a source for personal use. Here, the typical street seller is a user who buys an amount and uses a quantity before selling the surplus to others. Next day he or she might well buy back that surplus, paying more for it than he or she sold it for. At the higher end dealers will not be users.

Cocaine sales differ again. Unlike heroin, there is substantial middle-class demand for this drug – with the income from users coming largely from legitimate sources. The prevalence of cocaine use is growing. Heroin use remains more static, even if its use increases in fits and starts. Like cannabis, cocaine is bought and sold in a variety of social settings. For example, cocaine creates demand from some who may use relatively large quantities. Wealthy and experienced users purchase relatively large amounts in discreet transactions, usually in London (Bean 1995b), while new (relatively poor) users operate at a street level. Cocaine has become deeply embedded into a Black ethnic cultural group where its effects on the Black community have been destructive. Cocaine is not, of course, confined to the Black community: White users vastly outnumber Black users but, from our research, its impact on the Black community has been particularly destructive (see *ibid.*).

Cocaine is usually, but not exclusively, bought and sold where poverty and other social problems are common, and in this sense has much in common with heroin (Brain *et al.* 1998). In America, Inciardi and Pottieger (1995) found that street-level cocaine dealers were deeply involved in crime. In fact the greater the level of crack distribution, the greater the level of other crime commission (p. 251). They concluded that 'young crack dealers commonly violate not merely drug laws but also those protecting persons and property; and the crack business appears criminogenic in ways that go beyond

any potential it may have as a lure into crime' (*ibid*. p. 253). Their Miami study shows crack dealers as a separate and distinct group from heroin dealers. It is not certain whether this applies to Britain also.

Drug markets are wider and involve more than those who buy and sell drugs (Ditton and Hammersley 1994). They extend into the local community where others benefit. Rarely do the major profits remain local. Once drug markets become organised the profits will be taken out of an area. None the less, some of the money will be circulated locally and it is this which helps sustain the local drug community. In our research (Bean 1994) we found that one of the reasons some of the local population did not oppose the drug (cocaine) market was that it helped prop up a poor, inner city area. Derelict premises were let out to rent for use by prostitutes; poor quality fast food outlets remained open all hours and so on. However, the majority of a local population will benefit only marginally, if at all, and any disadvantages greatly outweigh the advantages (i.e. where there is harassment from prostitutes, litter of the very worst kind, and street-level dealers operating in front of young children in the neighbourhood). Drug markets are not pleasant places to have in one's neighbourhood. If and when a closer examination is made as to the extent of the tentacles of drug markets, we may find they are even more embedded into the local economy than we thought. If this is so, we ought not be surprised – after all, at the macro level drug money extends into all aspects of some national economies, so why not at the micro level too?

New markets – a note on 'Ice'

'Ice' or 'crystal meth' is one of the latest recreational drugs to arrive in Britain. It is a stimulant derived from methamphetamine. It is not new: as far back as 1991 the Home Office was concerned that it had arrived in Britain from the USA, but if it had it was only in small quantities (Bean 1991b). It was, and is, largely produced in South East Asia, or more specifically in South Korea, and was popular on the West Coast of the USA, arriving from Hawaii where it was used extensively. That it has taken a long time to arrive in Britain is due largely to the way crack/cocaine has been marketed and has retained its monopoly of supply. Yet 'ice' rivals cocaine in a number of respects: both are stimulants, and therefore not addictive in the classical sense of that term (that is, they do not produce physical withdrawal symptoms, and users do not produce tolerance). They

produce intense feelings of pleasure so there is an eagerness to repeat the experience, and both can be produced easily and cheaply.

Yet there are differences. 'Ice' is wholly a pharmaceutical product and therefore, with the correct ingredients and sufficient ingenuity, can be produced as and when it is required. Thus far it has a different distribution network: 'ice' comes from South East Asia, cocaine from South America. But the major difference here is that 'ice' is potentially more lethal – overdoses from 'ice' are common in Hawaii – and it is much more powerful. Moreover, it is likely to oust crack/cocaine as the major stimulant drug of choice because it is cheaper and more efficient to use. A small amount can be used repeatedly. 'Ice' is traditionally heated in a glass pipe and the fumes inhaled. This has an obvious advantage to the purchaser: it is not smoked i.e. the substance in question is not burned or destroyed, and if allowed to cool, 'ice' can be reheated (up to 20 times, depending on its potency) and will give off the same powerful effects.

The links with crime are as yet unclear. As a major competitor to crack/cocaine, the assumptions are that there will be rivalry over its distribution (systemic crime) and that users of 'ice' will behave in ways not dissimilar to those using crack/cocaine (psychopharmacological crime). Traditionally, in the USA 'ice' has been favoured by 'bikers' – Hells Angels – but often what is said to be 'ice' is a different form of amphetamine and much less powerful. (Pure 'ice' looks like ice crystals, whereas bikers use a more inferior amphetamine that looks nothing like an ice crystal.)

In Britain, 'ice' is a Class A drug. It is powerfully destructive, capable of producing severe paranoid reactions alongside equally severe depression. It has the potential to be the most widely used of all the stimulants and is likely to be marketed using similar networks as other stimulant drugs.

The impact of policing

Policing aimed at taking out the 'Mr Bigs' has been a major part of the strategy of law enforcement. It fits easily into the traditional notion of policing as 'chase and capture'. It was the dominant philosophy of the Broome report, where the best police officers would chase and capture the best criminals, the less competent would chase and capture the less competent, and the least competent would chase and capture the least competent criminals. This type of strategy flourishes

because capturing these 'Mr Bigs' also fits in with the demands of police performance indicators which are aimed at achieving targets based on a number of arrests. They deem it to be more worthy to arrest a dealer than to prevent a number of potential users from making a purchase.

The problem is that when caught, the 'Mr Bigs' are quickly replaced by other 'Mr Bigs' waiting to take over, or the captured 'Mr Bigs', run their operations from prison. Targeting 'Mr Big' has less impact than the police would have us believe. In a major operation, the Kings Cross project, a number of 'Mr Bigs' were arrested. It was noted how quickly they were replaced, and how little time it took for levels of dealing to return to the same level as before. Arresting key offenders may satisfy the requirements of justice but does little to ease the drug problem, whether by assisting neighbourhood protection or reducing the amounts of drugs or numbers of drug users in the vicinity. Kleiman and Smith ask 'to what essential service does Mr. Big provide to the retail dealer that someone else will not supply just as well if he is made to disappear?' (1990: 84). Their answer is that the basic financial and personnel management skills to run a drugs operation are not in short supply, no long apprenticeships are required and new organisations can quickly take up any supply shortage created by the loss of one 'Mr Big' (*ibid*. p. 83).

To make inroads into drug markets we need greater investigative capabilities than are currently being used, including greater coordination between investigators. The challenge may be technical, but it is also about style and attitude: it is about using intelligence and combining this with high quality research on the effectiveness of police operations. It is a salutary reminder that little research is available on the effectiveness of policing, except of course that which is related to partnerships and even then this is small and directed at one or two high profile operations. One of the few British studies conducted by Webster *et al.* (2001) was at the request of the Metropolitan Police on their 'Operation Crackdown'. This was directed mainly at crack houses in the London Metropolitan District. It concluded that the impact on local drug markets appeared to be limited; there was little discernible added difficulty in obtaining Class A drugs and no change in the local price. The authors go on to say 'Several street markets were disrupted although in some cases for a relatively short period of time. Although over 80 crack houses were disrupted our best guess is that most relocated or re-opened at the same premises within a very short period of time, weeks rather than months' (*ibid*. p. ii).

Perhaps a better way to start is to begin by asking: what is policing trying to achieve? Kleiman and Smith (1990) list four main objectives.

1 Limiting the number of persons who use various illicit drugs and the damage suffered as a result – psychological, physical, moral, and so on.
2 Reducing the violence connected with drug dealing and the property and violent crimes committed by users, whether to obtain money for drugs or as a result of that intoxication.
3 Preventing the growth of stable, wealthy, powerful criminal organisations.
4 Protecting the civility of neighbourhoods, and thus their attractiveness as places to work and live, from the disorder caused by drug dealing, open or otherwise (*ibid*. p. 71).

To achieve these aims various types of police operations are available. Three major structural operations will be examined here: street sweeping, focused crackdowns, and disruption with or without partnerships. They will be followed by a discussion of other operations, usually those involving individual officers (such as stop and search, test purchases, controlled deliveries and warrants). There are, of course, many others such as undercover operations, searching an offender's premises, and of course the use of informers (this is dealt with in the following chapter). First, the structural operations.

Street sweeping

Street sweeping involves what it says – a massive police presence concentrating on a specific area, ideally operating 24 hours per day. Normally, drug dealers tend not to work the same hours as most police and they also work different hours to patrol police officers. This seems to be such an obvious point as to not be worth making, but Kleiman and Smith (1990) say it is surprising how many police authorities appear not to notice this. Street sweeping is similar to zero tolerance in that, while the streets are being swept, all suspects are scooped up into the net. Large numbers are stopped and searched and all laws, however small and insignificant, are enforced, with search warrants to deal with those premises in which the police suspect there is drug dealing. Street sweeping, according to Kleiman and Smith, serves all four goals of law enforcement in that it reduces drug use, reduces crime, weakens drug dealing organisations and protects neighbourhoods.

It is, of course, not without its weaknesses. Street sweeping closely resembles an army of occupation rather than policing by consent. It can and often does produce tensions on the streets, is expensive (police forces have to work within budgets), and raises ethical questions about being too concerned with 'victims' rather than those who are responsible for maintaining the vitality of drug markets (Dorn and Murji 1992). Street sweeping may well produce an enormous number of arrests, many for minor offences, but any gains from reducing the size of the drug market might be offset by resentment from an otherwise law-abiding population who will be caught up in street sweeping and prosecuted for minor offences. The police are as likely to be accused of harassment as to be thanked for their efforts. The drug market will also likely reappear when that period of street sweeping ends.

Focused crackdowns

Focused crackdowns differ from street sweeping in that they concentrate on specific drugs, on specific streets, or on specific features of the market such as crack houses or clubs and pubs. Kleiman and Smith (1990: 89) say that eliminating drug dealing in one infested neighbourhood, thus creating an area where people feel safe, may be more valuable than reducing drug activity by 10% in each of ten drug-infested neighbourhoods. They see focused crackdowns as providing the ideal strategy: the police will move slowly from neighbourhood to neighbourhood, leaving behind vigilant citizens and residual markets small enough to be controlled with residual enforcement efforts (*ibid*. p. 89). Focused crackdowns can also concentrate on a small area. In Nottingham, for example, there are two main areas where drug markets flourish. These could be dealt with by a focused crackdown, or the police could concentrate on one drug (say crack) which is sold in a different part of the drug market and by different dealers. Or again, they could concentrate on Ecstasy which is sold in yet another part of the city. Focused crackdowns are likely to have stronger public support than street sweeping because the police are seen to be tackling a particular problem and a particular group rather than including everyone in their net. A focused crackdown on an area of Nottingham in Autumn 2000 which had been plagued by firearms was given considerable public and media support. The police, after they arrested a number of dealers who had firearms, were applauded by the residents for their efforts. Operation Crackdown in the Metropolitan District was an example of a focused crackdown.

'Focused crackdowns' concentrate on a specific drug or on specific features of the market, such as crack houses. They are not without their problems. Dealers are likely to reappear when the crackdown is over, for they know crackdowns do not last forever. For them, keeping a low profile is likely to be productive. Or displacement may occur: the dealers will move elsewhere, again until the heat is off. After all, police departments have limited resources and there are other areas and other offenders to cope with. Webster *et al.* (2001), in their evaluation of Operation Crackdown, having first said that disruption was minimal go on to say that

> The main reason for the lack of disruption to local drug markets appears quite simply to be the growing scale of demand for and supply of heroin and crack cocaine in particular. The very high profits that can be made from selling drugs mean that there appears to be no shortage of people wishing to become involved. It seems that socially excluded often young people in particular are willing to take considerable risks in return for profit. (p. iii)

However, Webster *et al.* (2001) also saw a positive side. Focused crackdowns had an impact on community safety and were approved by local residents. They cite a drug agency manager as saying, 'Since the implementation of Crackdown the initiative has been widely endorsed by the community. To a large extent Operation Crackdown is beginning to restore confidence in the police' (Webster *et al*. 2001: iii).

Disruption or low-level policing

Disruption or low-level policing is about policing street dealers and markets. The Broome report wanted this lowest level to be policed by officers who encountered drug misusers in the normal course of their duties – that is to say, by ordinary beat officers with little or no experience in drug dealing. This was never likely to be successful: dealing may take place on the street but the dealers rarely carry the drugs with them, leaving it to the 'stashers' and 'runners' to make delivery. Nor does it make best use of one of the police's main weapons – to make life more difficult for the would-be buyers and sellers. As one Chief Constable said:

> The policeman's biggest weapon is inconvenience, not arresting people. Some people call it harassing. But there is

> no way we could do our job without occasionally having to inconvenience people. If its just to stop and ask questions that's an inconvenience. (Quoted in Dorn and Murji 1992: 163)

Low-level policing aims at creating 'inconvenience', by disrupting drug markets. Unless dealers and sellers are disrupted drug markets become difficult to dislodge, and once embedded push local communities deeper into that world of drugs. After years of Broome, there is a growing recognition that street-level policing is important and has merits in its own right. The ACPO Drugs Sub-Committee, in its response to the ACMD report (1994), talk of a 'bottom up' approach which presumably means concentrating more resources to identify low-level dealers and traffickers. Dorn and Murji (1992), in an evaluation of street-level policing, say:

> At its most positive street (low level policing) could be an area which holds the key not to simply the ways of reducing the extent of drug trafficking and use, but also to the quality of life of many people whose daily lives are affected by the spread of drug sellers and drug users in their neighbourhoods. (p. 169)

Low-level policing is about making drug dealers aware of a police presence. From my experience dealers are more frightened of other dealers than the police for they rarely see the latter. If low-level policing means moving dealers to a different site, displacing them, then so be it. This constitutes an advance. It means the new site is likely to be second best as far as the dealers are concerned, otherwise they would have selected it as their favoured site, and it also means that it will take time to re-establish contacts. Dealing is about creating an atmosphere of trust, which means trust regarding the security of the deal as well as the quality of the drug supplied. Low-level policing helps destroy that trust, and makes the drug market less secure for those operating within it. The weakness of the Broome report is that it was too keen to chase and capture the 'Mr Bigs'.

Another advantage of low-level policing is that it helps keep away the novice and casual user. If the drug market is unsafe, and the point at which drugs are sold is the most vulnerable for the dealer, then uncertainty will be created, and uncertainty works against the dealer. Novices expect to be guaranteed their protection; markets that are always on the move convey a measure of insecurity which make life difficult for the dealers. No one is suggesting that these measures solve the problem, but they offer a more coherent approach

than chasing high-level dealers, busting them and then chasing their replacements. Low-level policing provides an opportunity to frustrate dealers, which in turn puts up the cost of drugs by forcing them to incur additional overheads. It also makes their dealing more furtive and therefore less satisfying for the customer. A uniformed police presence, posted strategically in the middle of the drug market, may be all that is required and is likely to act as a reassuring sign to the local population that something is being done. Whether this will eliminate dealing is a moot question – there have been reports of dealers selling drugs next to uniformed officers, literally behind police officers' backs.

Street-level policing, at its best, will include a partnership approach. This would involve local agencies, the local community (including local government), the media (who incidentally, can build or quickly destroy attempts at producing partnerships) and others. Street-level policing involving partnerships was, until recently, thought to be one of the most important developments in the move against drug markets and crime. It has become less fashionable of late, being overtaken by the development of 'Middle Market Operations' or through 'Operation Trident' which is aimed at dealing with Black-on-Black gun crime, and is also linked to drug markets. None the less, where partnerships exist they have been shown to be successful (Home Office 1993). They challenge basic assumptions which are derived from the professionals' traditional view that an agency – usually their own – can have an impact on crime. In contrast joint agency working is seen as the key. The partnership model challenges the assumption that a single agency approach has impact. For example, the police can no more deal with drug dealing by arresting the dealers (since others quickly take their place) than can the probation service by providing counselling. The way forward, it has been argued, can only be by drawing all the interested parties together, although for practical purposes the police must always have a major input (Home Office 1993; Edmunds *et al*. 1996).

There is little doubt that partnerships are a potent weapon against local drug markets. And in spite of the increasing loss of interest partnerships which received legal impetus from the 1997 Crime and Disorder Act remain underdeveloped and under researched. The Home Office (1993) puts it this way:

> Many of the measures that contribute to prevention are not within the remit of any one agency. Prevention thus depends on

> action by many different agencies and this will be most effective when co-ordinated by a formal partnership. Such partnerships can share and mobilise resources, generate commitment and enable the contribution of individual agencies to be targeted to best effect. They are most successful when served by one or more dedicated staff skilled in developing proposals and implementing action. (p. 1)

There is clearly a need to develop the partnership approach, and a further need to evaluate the partnerships that are being undertaken. Difficulties are immense – getting such partnerships going, agreeing on a common approach, and above all, deciding when a project is to be ended. The starting point must be a shared agenda involving a common understanding of the philosophies underlying the work of different agencies. For example, the police's experience and perception of drug users may not correspond to that of the local residents or traders – the police may be over-concerned with 'Mr Big', and the residents with the low-level drug sellers. Moreover, probation officers might see a conflict of interest between their wish to rehabilitate offenders and the public's desire to move drug users out of their area. It is this lack of fit between agencies that creates the most difficulties.

Critics of partnerships always point to the way they displace drug dealing to new geographical areas and also question the levels of community safety during and after a project. In addition, they question the value of the changes that can be made to the nature of drug markets as a result of the partnership approach. These criticisms are predictable; whenever a crime reduction project is claimed to be successful there will always be critics who raise the question of displacement. That should not detract from the message that the partnership approach, where it has been properly implemented, is a potent weapon against drug markets. It demonstrates that there is nothing inevitable about these, that they can be controlled, and that something can be done about them.

The Kings Cross project, the results of which are largely unpublished, is a beacon of its kind. There the local community's drug markets were seen as disturbing and distasteful, bringing crime (usually prostitution) and littering the streets with discarded syringes. Kings Cross is an area in London that large populations pass through each day. It is also characterised by a vigorous local population who demanded action. The result was a programme which began with the

simple but somewhat radical assumption that a partnership approach was called for and that no single agency could deal with the problem on their own. Community responses demanded a coordinated effort between the various bodies, leading to a partnership defined as 'an association between a number of individuals, groups or agencies to pursue a common goal' (Lightfoot 1994).

Briefly, the Kings Cross project involved the police, the local authority (although in fact there were four local authorities responsible for Kings Cross), a representative of the local community, and voluntary associations. The police had the largest presence, but they soon found the local authorities had more powers. They could close down hotels, move bus shelters (where dealers were hiding to make their sales) and shut down all night fast food outlets. However, the biggest problem was to get agreement about policies, about which way to move forward and represent the interests of the local population. The tactic here was to decide on a strategy, make the move, and (say) arrest all the major dealers, then watch to see how long it took to replace them. Or alternatively to arrest the non-drug taking, daytime prostitutes and then measure the local reaction, then move to the next strategic point and evaluate that, and so on. The result was a highly successful project, albeit an expensive one, where major lessons were learned. One of the lessons for the police to accept was that a good day did not mean 'busting' a main dealer, but that dealers were simply not able to sell their drugs.

Low-level policing meets the four part criteria set out above in that they limit the number of people using drugs, reduce the violence in the drug markets, prevent the growth of stable criminal organisations and protect the civility of a neighbourhood. Or at least these were the results from Kings Cross. The problem, however, is that our conclusions are based on one project which may not be typical and it may not be possible to replicate it. We need more projects of this type and more evaluations to show how best to proceed.

Further tactics

I will now turn to more personal tactics. Tactics such as street sweeping or low-level policing rely on concerted action by a local police force. Yet we ought not to forget that most arrests come as a result of individual officers, perhaps in the street, through a stop and search procedure where an officer suspects an offence has been committed, or through an arrest where an offender is searched in a police station and drugs are found. Or through an Exclusion Order where a custody sergeant can, if he has the necessary grounds, include

in the bail conditions areas where the dealer may not go until the case is resolved. The courts can in turn put the same or additional conditions on dealers to be excluded from the same areas. Data on these orders however are slim, almost non-existent. And of course these so-called 'personal tactics' can be, and almost invariably are, embedded and coordinated in the structural ones described above.

First, stop and search. The police have a number of powers given them to search a suspect. They can be searched before being arrested, following an arrest, and in a police station where strip searches and intimate searches can be used. Or a suspect's vehicle can be searched, or a suspect's premises may be searched following an arrest. I want to deal specifically here with the power given to police to stop and search a person in the street, i.e. before, not following arrest. This is an old chestnut going back at least to the Wootton Report on cannabis in the 1960s, raising then the same questions as are being raised now, such as the rights of citizens, the opportunities given to the police to harass certain social or ethnic groups and the enormous opportunities for abuse. Set against these criticisms is the point that illicit drug taking is a 'victimless crime', i.e. a willing exchange of goods or services, meaning that where there is an absence of traditional victims enforcement is made additionally difficult. Accordingly, owing to the consensual nature of the offence, it is reasonable to assume that special powers are needed.

Prior to current powers under the Police and Criminal Evidence Act 1984 (PACE), the Metropolitan Police Act 1839 gave the power to a Police Constable (or the owner of the property involved) to arrest without a warrant persons suspected of committing certain property offences. Section 66 of the Metropolitan Police Act 1839 states:

> … and every such constable may also stop, search, and detain any vessel, boat, cart, or carriage in or upon which there shall be reason to suspect that any thing stolen or unlawfully obtained may be found, and also any person who may be reasonably suspected of having or conveying in any manner any thing stolen or unlawfully obtained … (Metropolitan Police Act 1839 s.66)

A stop in the street whether of a motorist or a pedestrian, is really an interview conducted by a police officer, who has chosen his subject, and the time and place to stop him, on reasonable grounds (Powis 1997: 162; Quinton *et al.* 2000). On what basis then should the 'stop and search' be used? A police officer meets someone in the street and decides to stop and search him.

> To do this, an officer must have 'reasonable suspicion' and this can derive from a number of circumstances. It can be the demeanour of the suspect, his gait or movements, whether he is carrying something suspicious, the state of his dress, the time and place where he is. For any combination of reasons, therefore, an officer may decide to undertake a search and he will normally ask the person concerned if he is prepared to agree to it. (para 105, Report to the Advisory Committee on Drug Dependence)

There are exceptions under terrorist legislation. Where a constable has carried out a search in the exercise of his powers he must make a written record (Home Office 2004).

The Stop and Search Action Team Strategy 2004/05 stated that in 2002/03 there was a 13% arrest rate from stop and search but complained that 'this figure includes finds for drugs and so on which were not the original reason for the search' (Home Office 2004/5 p. 10). To view 'stop and search' as less than effective when drugs are found, albeit if the reason for the search were different, surely misses the point. Although only 13% of stops resulted in arrests presumably other crimes were also deterred. Robinson (1983) regards 'the "stop" as the greatest weapon the police possess and clearly the policeman "working and stopping" on the street, who is in a position to make the greatest impact in the prevention and detection of crime … but the powers to stop, should be used carefully, but without hesitation' (p. 14). As indeed they must, as under PACE the police must have reasonable grounds for suspicion to stop and search. Research on stop and search before PACE shows how the police used 'stop and search' to target certain groups, mainly young and from ethnic minorities. Tensions about stop and search resurfaced following the MacPherson report on the death of Stephen Lawrence, where stop and search was again seen as having more to do with asserting dominance over specific socio groups than detecting crime. These problems remain, and presumably will always remain as long as the legislation remains, and there is no suggestion it will be repealed.

Test purchase operations are likely to produce the most successful results (on a *pro rata* basis), if only because an officer buys the illegal drugs and then that officer or another secures the arrest. That the evidence was obtained by way of a trick or subterfuge is no matter. The Court of Appeal held that the mere fact that this evidence was obtained in this way did not automatically lead to its exclusion: it said officers were not required to fight their opponents with one hand

tied behind their backs. 'There is indeed ample legal authority that some tricks are permissible, particularly if the defendant is merely detected doing what he would do anyway despite the trick' (Fortson 2002: 346).

A test purchase operation is where officers pose as drug users and through a range of methods are able to buy drugs from a dealer and thereby secure evidence. This differs from a so-called 'reverse sting', where officers aim for the opposite – they pose as dealers and try to put off customers from trying to buy drugs. In Chapter 8 I discuss 'Informers', linking them to under cover officers. The point made there is that the two work closely together but officers, if they work undercover, are likely to penetrate further the higher reaches of criminal networks. However, at the street level the aim is more modest – to take out local dealers. I know of no research which is able to assess their effectiveness, whether in terms of resources or otherwise, but the police clearly retain a strong faith in test purchase operations and use them regularly to break up drug dealing. It has been strongly suspected that test purchases result in high conviction rates, with dealers likely to plead guilty.

Next there are controlled deliveries, or more correctly Postal Packet Importation and the Tactic of Controlled Deliveries. The legal framework is found in Section 105 of the Postal Services Act 2000. The tactic of controlled delivery has been used for at least 30 years. Article 11 of the United Nations Convention 1988 (*Vienna Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances)* gave formal recognition to the tactic, 'for the use of controlled deliveries at international level and paves the way for "clean" deliveries' (Fortson 2002: 99). It had been used long before then by HMCE, but following changes in their work priorities during 2001 it became apparent that intelligence and opportunities for arrests were being lost because of a lack of Customs and Excise resources to carry out controlled deliveries.

Importation of controlled drugs, firearms and illicit documents by mail has been identified as a growing means of trafficking. Importation by mail appears to produce the lowest risk for the traffickers, and it is the least expensive. There are two types of delivery. A 'clean' delivery involves the substitution of an innocuous substance for the controlled drug in question. This technique is often used in drug trafficking investigations. A 'clean' delivery has the obvious advantage of removing the offending substance from circulation and preserving vital evidence, while allowing the investigation to run its course without the risk of losing the drug if the operation goes

wrong. Substitution normally takes place in the country where the offender is likely to be apprehended and tried. If a substitution takes place abroad then technically this would mean that the substance being imported was not a controlled drug and therefore no offence has been committed, as before an offence has been committed there has to be proof that prohibited, restricted or dutiable goods have been imported.

The second type, the more traditional 'controlled' delivery, is different in that the drugs are allowed to move freely down the chain of supply. Drugs detected in one country are allowed to travel across national frontiers in order to identify and obtain evidence against those involved in international drug trafficking. Fortson (2002) notes that a EU Committee reported in 1986 that 'controlled deliveries were rarely used because of legal restrictions in some countries or rivalry or mistrust between law enforcement agencies'. This Committee reported again in 1988–89, and said that since 1986 the 'situation had improved' (p. 100).

Data on the effectiveness of controlled delivery are not forthcoming, but it is suspected that there has been an increase in the number of seizures, although whether there has been a corresponding increase in arrests is less clear. There are numerous evidential difficulties in turning seizures into arrests. Once a parcel has been opened there is no way of knowing who opened it, or whether it was opened before it was accepted by a suspect. Indeed, many of those arrested during a controlled delivery have been released due to insufficient evidence. From the traffickers' point of view, controlled deliveries are a cheap way of transporting drugs (a 1kg parcel from Columbia to the UK costs about £50) and the technology is not yet available to be able to pick out all packages which contain illegal drugs. Of course not all controlled deliveries originate from abroad. Parcels can easily be sent throughout the UK, offering local dealers the opportunity to distribute small amounts to new markets or to remote areas. There is always the risk that dealers will have infiltrated the postal services, and it is not beyond the realms of possibility that dealers will have set up their own distribution companies. Incidentally, as with other covert tactics, test purchases and controlled deliveries must be ECHR compliant and must adhere to the Regulation of Investigatory Powers Act (RIPA 2000).

We now come to warrants. The legal position is complicated, as there are different types of warrants and a number of different legal provisions allowing the police to search premises. Prior to the implementation of the PACE Act 1984 the police had no general

power to obtain a warrant to search for evidence, only under specific powers through a variety of statutory provisions. Section 8 of PACE changes that. The police now have powers to apply to a justice of the peace for a search warrant in respect of premises under Section 8 of PACE. The granting of a warrant under this section is confined to cases where there is reasonable cause to believe that a 'serious arrestable offence' has been committed. This may also include a major drugs supplier or a person concerned in the unlawful importation/exportation of controlled drugs where substantial gains are suspected to have been made.

For these purposes what is interesting about warrants is, paradoxically, the lack of information about their effectiveness. Literally hundreds of warrants are issued by the courts annually, for a variety of offences, yet no one has the faintest idea of how many lead to an arrest or come to any sort of successful conclusion. The courts seem not to follow them up, or indeed to show interest in the outcomes. They simply grant them and take matters no further. The police seem to be the same. No one knows how many warrants are refused by the courts, and if so on what grounds. It is strange that such a key feature of jurisprudence should remain untouched.

Of course once a covert operation is running, of whatever nature, police have other tactical options, either of a human or a technical nature, to help keep the flow of information going. These may involve surveillance of dealers or drugs.

Assessing the effectiveness of policing

Within the range of tactics described above some questions must be put forward. How effective are they? And, following on from this, to what extent do the police make use of the tactics available? The answer, in general terms, seems to be that proactive policing (i.e. plain clothes officers using test purchases and so on) is more likely to use a range of tactics and to be more successful in terms of convictions than reactive policing (i.e. uniformed officers using stop and search and so on). The difference is not just about the settings in which arrests take place, but the level of experience and expertise of officers. Not surprisingly, uniformed officers seemed less sure of their powers and are less familiar with the activities of dealers and users than their plain clothes counterparts.

Even so, amongst the proactive group it is suspected that officers do not always make full use of their powers or of the range of tactics

available. So, for example, what do police officers do when they arrest offenders, and following from this, which tactics do they use (if any) to follow up on the initial arrest? An offender may be arrested as a result of (say) a test purchase (primary tactic), which could lead to a search of the offender's premises (secondary tactic), or of the offender's car (tertiary tactic). Or an offender may be arrested having been found to have drugs in his car (in this case a primary tactic), with a notebook full of addresses found on him, leading to a search of the offender's premises (secondary tactic). Or, an offender is 'stopped and searched' in the street (primary tactic) and drugs, together with a set of scales and an address book are found on him. These could lead to a search of the offenders premises' (secondary tactic) and a warrant for the search of other premises (tertiary tactic). What seems to happen is that proactive officers are more likely to use secondary and tertiary tactics than reactive ones, but even then do not do so as often as they might.

There is no doubt that these tactics are important tools for modern policing and will continue to be so for the foreseeable future. Yet as to the question of how best the police should deploy their resources, the standard answers are based on an amalgam of local knowledge, intelligence and anecdotal evidence. And of course the traffickers themselves change their methods regularly – they now use various surveillance techniques and sophisticated methods of observation (Dorn *et al.* 2005) – and are always striving to be ahead of the game. Covert policing is a powerful weapon to be used against them, but it needs careful evaluation if it is to be used effectively.

In Britain, economists such as Wagstaff and Maynard (Wagstaff and Maynard 1988; Wagstaff 1989) have asked questions about the extent and costs of resources used by the enforcement agencies that are devoted to drug work and the corresponding effect enforcement has on prices at each level of the illicit drugs market, as well as the operation of these markets. Studies building on this type of research are to be welcomed. Peter Reuter *et al.* (1990) put it this way: 'That drug markets vary a great deal across drugs and over time points to the need for a theory of how these markets function – in particular a theory of what determines who enters the market and how much such persons earn for participation' (p. 20).

Reuter and Kleiman (1986) talk of a theory based on risks, when risks affect prices. We do not know, for example, how many successful deals are completed and what risks the dealers take. It is likely that about one deal in every 80 or 100 leads to an arrest, and this is irrespective of the type of drug being sold. If that is so, what

effect has it on dealers and prices if one in 40 deals leads to an arrest, or one in 20, or even one in 10? How much extra policing would be required to change the ratio of successful deals, and would the costs be worth it? What are the effects of putting dealers in prison? Typically, the answer has been not a lot, yet Peter Reuter states (2001) that paradoxically the effect on reducing demand may be greater than on reducing supply, if only because its hard to replace old junkies who consume quite large quantities of drugs.

We have learned much from the Broome days which typified what Kleiman and Smith refer to in another context as ‘a collection of activities in search of a strategy’ (1990: 104). The Metropolitan Police are active in disrupting middle-level drug markets (Pearson and Hobbs 2001) and claim considerable success if this is measured by the amounts of drugs seized. Of course what constitutes a ‘middle-level market’ is always open to dispute, but there is a large gap needing to be covered between that seen as the province of agencies concerned with interdiction and low-level markets involving street dealers. Pearson and Hobbs (2001) say that middle-level markets should concentrate on the area where foreign-based importation groups are linked with UK-based distribution networks and this is what seems to be happening. As such, to concentrate on middle markets means that the point at which the high-level dealers hand over the drugs to important intermediaries is now being covered, at least in the Metropolitan area. Other developments in London show that the Metropolitan Police have also learned the value of disruption and of low-level policing. As part of this strategy they distribute leaflets to householders giving details of the latest arrests, explain their tactics and the nature and extent of local policing activities. The aim is to unsettle the dealers and prevent them taking the initiative. Policing by disruption is preferable to sitting back and allowing dealers to set their own pace.

Kleiman and Smith also say:

> In principle the right way to choose a drug policy for a city would be to describe the problem, invent some alternative approaches to addressing the problem, predict the costs and the likely results of each approach, and choose the least painful. Then after a while measure the results and compare them with the predictions. Unexpected results or new situations would call for changes in policy. (Kleiman and Smith 1990: 102)

They add that no police force has anything resembling an accurate

description of the drug problem nor is there a well worked out body of theory or experience to allow predictions of the likely results of alternative approaches (*ibid*. p. 102). The best that can be done is to have as much data as possible available on users and sellers, from the top right down to street level. Then and only then can a measure be made of the impact of enforcement.

The question then is how far does British policing approximate to the ideals of Kleiman and Smith? It is certainly emphasised by Jacobson (1999) in *Policing Hot Spots*, where he says a crucial element for success comes from a detailed analysis of the drug market in order to determine the appropriateness of various forms of intervention, a point also made by May *et al.* (2000) who said source-led policing was seen as the most cost effective. Of course other factors were also important, such as the police being sensitive to community relations and being able to persuade other agencies to cooperate. But high quality data remain the critical variable, especially if the police wish to incorporate long-term effects on the local area as most initiatives are eroded over time (Jacobson 1999).

One much trumpeted strategy has been Operation Crackdown, and although successful in terms of arrests and drugs seized it does not meet many of the requirements of Kleiman and Smith. An evaluation of the early stages of Operation Crackdown showed it had led to 1,600 arrests and had produced some early, albeit not too encouraging, results (Webster *et al*. 2001). And yet, as said earlier, in spite of these arrests the impact on local drug markets appeared to be limited, with little discernible added difficulty in obtaining Class A drugs (cocaine, heroin) and no change in the local price. Moreover, some police officers believed that the diversion of police officers to Operation Crackdown had allowed an increase in other street robberies, although where local street robberies were directly related to local crack sales there had been a reduction in these. A later version involving 33 police forces in England and Wales, which ran from 12 January 2005 to 31 March 2005, was not formally evaluated but was also hailed as a success. The then Home Office Minister called it 'a great success' in that 'it delivered real benefits to local communities and has made a massive improvement in the quality of life of local people' (Home Office News and Publications: Operation Crackdown Final Results, 11 August 2005). Without an in-built evaluation these claims cannot be substantiated, although the operation was a success at one level in that it led to 170 crack houses being closed and 1,471 people being charged with Class A supply, with over £3m cash assets

seized alongside large numbers of firearms and over 450lb of cocaine and heroin.

Operation Crackdown might not meet the requirements given Kleiman and Smith but at least it showed the police to be doing something, that is that they are not always on the back foot, a view echoed by the ACPO lead on drugs and Assistant Commissioner of the Metropolitan Police who saw it as 'a demonstration of the police and government's commitment to target and reduce the supply of Class A drugs' (*ibid*.). But more is required. Modern policing is, or should be, data led, for without an understanding of the nature and extent of the market it is difficult to see how policies can be constructed. Also, without agreed definitions comparisons are difficult. In a visit to London from New York in 2002, Mayor Guiliani said the most important lesson learned under his administration was the accurate appraisal of crime statistics. He said under Compstat (a project in New York concerned with crime reduction, including drug use) he received weekly crime statistics for every precinct in the city, broken down into daily statistics. This, said London's Mayor, was in sharp contrast to the Metropolitan Police Service, which 'published crime statistics only quarterly' (K. Livingstone, cited in *The Times*, 23 March 2002). (Thames Valley Police now use Compstat.)

There are many reasons why the British police seem not to be 'data-led' in the way officers are in New York. One is the absence of an empirical tradition in British policing. Experience, intuition and an over-reliance on traditional methods remain dominant. In order to produce better models we need better data to inform them (Kleiman and Smith 1990: 103). One way to start would be to collect more information about drug enforcement, which will include data on the number of users and sellers, police operational practices, police tactics, and so on. That, as Kleiman and Smith say, would suggest a new seriousness about developing responses to the drug problem (p. 104). That also means producing a valid and reliable database. From there we could move forward.

That database would need to include data on offenders (basic socio-demographic details including nationality), police tactics, decisions by the Crown Prosecution Service, and the outcomes of arrest, plus any information on prices and purity to see how drugs are moved throughout a given area. Included also would be detailed police intelligence, as we already know that success is related to the ability to locate, generate, and acquire large volumes of high quality intelligence which leads to an understanding of the dynamics of the market (Townsley and Smith 2005). Convictions are no longer the sole

criteria for operational success. Townsley and Smith also emphasise the importance of managing the media, and developing marketing techniques similar to those used against domestic violence. Gone are the days when the police could stumble into a drug market, or use a few undercover officers to arrest a few dealers, and then believe the job was done. Nowadays an understanding is required of the dynamics of the market, alongside an identification of significant operators and a knowledge of potential points of evidence (Townsley and Smith 2005: 31–2).

The demand for better data is a recurring theme but little attention is paid to it. Van Duane and Levi (2005: 135–6) point out that within the law enforcement area they repeatedly experienced low interest in quantitative data and the valuation of same. When the importance of such data was suggested they say the response was usually one of little interest if not sullen resistance in repeatedly asked questions such as 'Why should we know all that?', or 'If we know does that help the detective or prosecutor in his daily tasks?', or worse still 'If all that becomes known I will have to answer a lot of nasty questions'.

It is this that gives the whole game away. Yes, good quality data do raise nasty questions such as 'What is the response of the police in (this or that) borough to an increase in the supply of certain drugs?' or 'What tactics are the most or the least successful?' or 'Which branch of the Police Service arrests the most drug dealers? The uniformed branch or CID?' or 'Why does the Crown Prosecution Service insist on downgrading certain types of offences from supply to possession and how can we improve matters?' Moreover, good data from the police help direct and formulate policies. How else will government departments know what is going on? But then, when the Home Office itself admits its own data are not up to standard, i.e. that one in five data sets collected or collated by the Home Office is inadequate (*The Times*, 16 January 2007), the mess we are in is all too apparent.

Policing professional organisations

There are many ways in which professional organisations police their members. The most obvious is where the organisation or professional body requires its members to conform to certain professional standards. Failure to meet those standards can result in erasure from the register of that professional organisation and the corresponding loss of all the rights and privileges registration confers. Another method is where

the government demands of the professional bodies that they require members to accord to certain practices it may stipulate from time to time.

The first here is more common. For example, the General Medical Council will discipline members who over prescribe, take substances such as morphine, or have an alcohol problem. Where those physicians prescribe for themselves or their families, or over prescribe for their patients, they may be referred to the Professional Conduct Committee of the General Medical Council who may decide to erase them or 'strike them off the register'. The activities of these physicians, though important especially in the manner in which medical practice is viewed in Britain, do not in the scheme of things greatly affect the drug problem, although over prescribing must always be a matter of concern. Of greater importance as far as policing is concerned is the second of those matters which relates to government directions to the professional bodies.

Under the money laundering regulations financial institutions, including professional financial operations such as those in law and accountancy, are required to disclose to the police, and eventually to the Economic Crime Unit (ECU) of the National Criminal Intelligence Service (NCIS), all transactions which are suspected of being part of drug trafficking. English legislation imposes a duty to report suspicious circumstances relating to money laundering and this applies to all persons, not just to those working in financial institutions. These data are analysed by the NCIS and then disseminated to the relevant financial investigation units. In practice, this means that each police authority will be required to act on the information provided, although how and to what extent priority is given to this information is another matter. Nevertheless, although there is a duty on all persons to give the required information, in practice those at the forefront will be the professionals (lawyers, accountants, and so on).

Traffickers, in addition to using the latest technology, will also use and can afford to use the most highly paid lawyers, accountants, bankers and the like to provide them with the appropriate expertise. These professionals give the traffickers financial advice relating to investments, setting up shell companies and so on. They also help traffickers avoid detection (US Department of Treasury 1992). Money laundering and all that is associated with it are almost wholly dependent on these professional advisors. Professional privilege and confidentially help sustain and support the activities of these professionals, with little interference if any from the appropriate professional bodies, or so it seems from the official figures.

Recruitment of these professionals into the world of trafficking seems fairly common – or if not, then sufficient enough to continue to service the drug trade. Like so much else in the field one can only speculate on such matters; there is little or no research evidence upon which to draw. Recruitment of these experts is probably achieved when an able lawyer or accountant finds his business failing, or is unable to provide for his own expensive lifestyle. This sort of professional becomes an easy target, and as with corrupt police officers, once recruited they are unlikely to break free, at least until they cease to be of value to those who have recruited them. It probably costs the traffickers and dealers little to recruit such people – a one-off payment to remove existing debts and a foreign holiday perhaps might suffice. The traffickers would, of course, still pay for subsequent professional services undertaken but their rewards would none the less be huge. As noted in the 1992 US Department of Treasury report on money laundering:

> among law enforcement representatives, there was almost universal presumption that traffickers and cartel money launderers can usually afford to hire the best lawyers, accountants, etc., an advantage which provides them with additional sources of expertise … (US Department of Treasury 1992: 291)

Or as the former US Attorney General Meese said:

> It takes a professional – lawyer, an accountant, a banker with all the trappings of respectability – to manipulate these sophisticated schemes. (Quoted in Beare 1995)

'Manipulation' in this context also means defending suspects when they are charged. Beare and Schneider (1990) list some of the services provided by these professionals:

- providing a nominee function
- incorporating companies
- conducting commercial and financial transactions
- managing and physically handling illicit cash
- coordinating international transactions
- buying and selling property.

The special privileges granted to lawyers, seen as necessary to protect the lawyer/client relationship, act as a shield and barrier

against them when they engage in a variety of criminal actions (*ibid*. p. 331). This is less so for accountants and bankers, but even here these professions have jealously guarded client relationships and any attempts to intrude have met with resistance by the relevant governing bodies. In the USA, lawyers are required to notify the Revenue Service about their clients. This had been vigorously resisted and had been seen as a step towards greater outside regulation of the profession, which incidentally the lawyers claimed violated their attorney–client privileges. The US Presidents Crime Commission on Organised Crime asked for more 'stings' and electronic devices to further break through that otherwise impenetrable shield.

In comparison, professionals in Britain have escaped lightly. The major professions involved, law and accountancy, have successfully avoided too much outside regulation, and clearly want to keep it that way. The British government sees the solution as lying within the professions own governing bodies – the Law Society, the Institute of Chartered Accountants and the like. These bodies have considerable powers and can exert considerable influence. In Canada, for instance, the Canadian Law Society has been particularly active in this respect and provides a beacon when it comes to assisting with money laundering regulations. In contrast, their British counterparts have been reluctant to assist and lawyers and accountants cooperate rather less than they ought (at least if Table 7.1 is anything to go by, where over the years the numbers of disclosure by lawyers and accountants have been rather small).

The NCIS report for 1999–2000 shows the extent of financial disclosures over the five years 1995–1999 (NCIS 1999–2000). In 1999, the Economic Crime Unit (ECU) of the NCIS received about 14,500 reports of suspicious transactions. As shown in Table 7.1, the banks provided most of these, accounting for about half of all financial disclosures in 1999 (with rather more in 1995, but this seems a rather odd year when the amount rose to nearly 63%). The NCIS report states that there was a disparity between the number of UK authorised banks, the usual high street banks, and the number of banking institutions making disclosures. In 1999 only 125 deposit takers reported suspicious transactions to the NCIS out of a possible 554 regulated firms. Furthermore, 78% of all disclosures from banks were made by ten institutions. This represents 39% of all the disclosures received by the ECU. The NCIS notes that

> although high street banks might be expected to be more frequently targeted by criminals to launder their proceeds, it

Table 7.1 Disclosures by the financial sector 1995–1999

Financial sector	1995	1996	1997	1998	1999
Banks	62.84%	48.4%	49.5%	44.05%	49.91%
Build soc.	18.95%	28.67%	20.7%	20.49%	12.61%
Bureaux	4.48%	6.96%	17.5%	19.09%	20.79%
Insurance	4.57%	3.03%	3.7%	4.5%	4.11%
Solicitors	1.53%	2.03%	1.9%	1.97%	1.77%
IFA	1.27%	2.54%	3.8%	3.39%	2.01%
Credit inst.	1.53%	2.03%	1.9%	1.97%	1.77%
Gaming/bet	None	1.11%	0.7%	1.53%	2.42%
Accountant	0.31%	0.51%	0.3%	0.74%	0.58%
Regulators	0.13%	0.23%	0.2%	0.21%	0.25%
Others	5.46%	6.59%	1.7%	4.02%	4.43%
Auction houses	None	None	None	None	0.25%
Asset management	None	None	None	None	0.19%
Credit cards	None	None	None	None	0.12%
Securities	None	None	None	None	0.56%

Source: NCIS (2000)

> remains a concern that some banks make few, if any suspicious transaction reports. (*ibid*. p. 21)

Solicitors and accountants produced few disclosures and taken together they only amount to 2.3% for 1999 (1.77% for solicitors and 0.58% for accountants). The NCIS says

> The ECU continued to work with accountants and solicitors to raise the level and quality of financial disclosures that are received. Although the Unit is starting to see some signs of improvement in the quality of disclosures in this area the numbers received remain low. Education within these sectors will continue to remain a priority for the forthcoming year. (*ibid*. p. 21)

The NCIS might be sanguine about the outcome and the likely beneficial effect of education as a means by which the numbers and quality of disclosures will be improved, but the history of professional regulation, especially when it is seen as restricting professional freedoms, suggests it will be an uphill struggle. Professions do not like this type of pressure placed on them, and resist attempts

at self-regulation when they involve acting against their short-term self interests. Nor do they do not want to be seen to act as a sort of state control system. At present they have a moral duty to, say, report a cheque fraud – but not a legal one. Imposing a legal duty on them to report suspicious financial transactions takes them one step further along the road to becoming law enforcement agencies. Money laundering substitutes a moral duty for a legal duty, and this they find burdensome.

One wonders how long they can continue to use such a tactic. Estimates from the G7 countries show that the drugs trade generates more than the GDP of any European country, with about £73billion going through the world's banking system each year. We could reasonably assume that much of this goes through important financial centres such as the City of London. We could also reasonably assume that we have already reached the stage where there has been permanent damage done to some of our social and financial institutions. Perhaps it is this which will finally persuade governments to tackle the problem. As things stand, law enforcement organisations such as the NCIS have their own financial services departments or internal organisations where they investigate financial irregularities without waiting for the professional organisations to take the lead. They can and often do secure authority to examine a company's books and to seize in order to inspect any assets that may be relevant. The NCIS Annual Report lists some spectacular successes in this respect (NCIS 1999–2000) and however successful this may be, it will only be a poor substitute for what might be were the professions more accommodating.

Tribunals

There is another sense in which the professions are policed but this applies only to the medical profession and is through the tribunal system. Tribunals have a long history, going back to at least 1926 and the Rolleston Report. (For a discussion on tribunals see Bean 1991a.) The current position is that tribunals were established under the 1971 Misuse of Drugs Act and supplemented by regulations under the Drugs Tribunal Rules of 1974. Briefly, the powers of the tribunals under Section 13 of the 1971 Act are concerned with irresponsible prescribing, where physicians who do so may loose their licence to prescribe, and as there are links with the General Medical Council this will almost certainly be brought before the Professional Conduct Committee where they will be charged with serious professional

misconduct. This carries the maximum penalty of being erased or struck off the medical register.

This process begins as a result of routine monitoring by the Home Office Drugs Inspectorate who will notice irregular or over prescribing of certain drugs. This is followed by a visit from the Drugs Inspectorate, with about 300 physicians visited each year. These advisory visits usually have an immediate effect, as about 90% of the physicians involved will bring their prescribing down to acceptable levels. For the 10% (or 30 or so) that do not do so, the next step involves an official written warning that they may be taken before a tribunal. This tends to reduce those 30 to about six or seven. At this point the Home Office will have clear evidence of irresponsible prescribing; prescriptions will have been analysed and any patterns determined. The six remaining physicians will then be brought before a tribunal. They may be legally represented but by then their number will have been reduced to about three, as the others will have asked that their names be taken off the medical register prior to any hearing. Tribunals can only proceed against registered practitioners. Under the regulations those few remaining physicians will almost certainly be given Directions from the Home Office, i.e. they will have their future prescribing severely restricted, as well as having to go before the GMC.

Critics say the system is too protracted with a built-in bias towards the professional physician. Moreover, they say the whole system is conducted in a gentlemanly way typical of assessments of middle-class deviants, but quite different from the way we deal with those from the lower classes. These criticisms aside, tribunals raise other questions which surround the right of physicians, with little or no experience of drug users, to be permitted to prescribe at all. This applies equally to drugs such as Valium as well as for heroin. It is not just the gross over prescriber we should worry about, it is those physicians who prescribe rather more than they ought and prescribe when there is no good reason to do so. And that includes drugs such as Prozac, the long-term effects of which are still not known.

Chapter 8

Informers and corruption

Informers are not unique to the world of drugs and trafficking but their activities throw up new questions and put others into greater relief. Definitions of informers vary. The US Drug Enforcement Agency (DEA 1982: 55) defines informers as 'any non-law enforcement person who supplies information about criminal activities to a police officer'. In Britain, the Regulation of Investigatory Powers Act 2000 (henceforth RIPA) includes informers as a 'covert human intelligence source' (henceforth CHIS), defined as someone who establishes or maintains a personal or other relationship with another for the covert purpose of:

- using that relationship to obtain information or to provide another person with access to that information; or
- disclosing information obtained by the use of that relationship or as a consequence of that relationship.

A CHIS might be an informer, an agent or an undercover operator. Here we are concerned only with the informer (and not with the so-called 'public-spirited informer' who gives information, usually on a one-off basis and who does not seek a financial reward). It is the professional informer who is of interest here, who seeks either financial rewards or a reduction in sentence in exchange for information about other offenders. The *Codes of Practice on Informant Use* (Home Office 1999) define an informer thus:

> an individual whose very existence and identity the law enforcement agencies judge it essential to keep confidential and who is giving information about persons associated with criminal activity or public disorder. Such an individual will typically have a criminal history, habits or associates and will be giving the information freely whether or not in the expectation of a reward, financial or otherwise. (para. 1.14.1)

And a participating informer is defined (*ibid*.: para. 1.14.2) as: 'An informant who is, with the approval of a designated authorising officer, permitted to participate in crime which others already intend to commit.' The first definition places emphasis on the need to protect the informer's identity as well as noting that this type of informer will usually be someone who is or was an active criminal, and who has been given approval to commit a specific crime in specific circumstances in order that others are convicted. Within the world of drugs, the participating informer is particularly useful, as possession and supply are victimless crimes with no 'victim' to make a complaint.

At a time when policing claims to be increasingly intelligence led, the value of informers cannot be doubted. Yet informers operate in that murky world where accusation and counter-accusation are commonplace, and where mistrust and deceit are the tools of the trade. John Grieve (1992) says, after years of experience as a police officer dealing with drug offenders and informers generally, he can only conclude that the drug scene is imbued with treachery. He believes there are more informers in the drug field, in aggregate and proportionate terms, than in any other area of crime. The problem for the police, according to Grieve, is how to stem the flow of information, not to acquire it, and how to use that information appropriately. Yet how do we deal with the informer who is prepared to deceive those who are his or her colleagues? And what will he or she do to those who are not his or her colleagues? Here I want to look closely at the special problem of informers in relation to the drugs field. I also look at corruption and informers, as corruption and drugs are closely linked.

Traditionally, the police have been reluctant to talk about informers. They fear that disclosing their methods and secrets will jeopardise operations. The obvious response is that outsiders do not want to know the details or have access to confidential material, but they are entitled to know that the methods fit basic legal requirements, are cost effective and are appropriate to basic standards of justice. Moreover, the more the police try to hide their activities, the more will the rest of us be suspicious and think they are up to no good. Too often the police seem to take pride in their secrets, believing this adds to that

aura of being special. Giving secrets away takes away some of the mystery. It also shows up failures. There has until recently been no guidance on how to handle informers – experience was seen to be the best way to learn. This led to some spectacular successes but to some equally disastrous failures. Under the RIPA, new procedures have been introduced aimed at reducing the risks, and matched by a new sense of openness. Both are welcome yet they would have not occurred a decade ago.

The legal authority for informers

As noted above, until recently there was no formal framework for the regulation of informers, although legal decisions created precedents for their use and conduct. The introduction of the Human Rights Act 1998 changed that with its demands (under Article 8 of the European Convention on Human Rights) that law enforcement be examined from the viewpoint of the citizen. Article 8, which asserts the 'right to private and family life', has led to a radical rethink of the situation. The UK government's response has been to produce a formal legal instrument to meet the demands of the Human Rights Act that allows informers to be retained. The RIPA was rushed through Parliament in time to beat the Human Rights Acts in October 2000 (Neyroud and Beckley 2001). Informers by their very nature violate their subjects' 'reasonable expectations of privacy' (Article 8 of the European Convention on Human Rights), so that when through a deceptive relationship an informer covertly uses that relationship to obtain information or covertly discloses information obtained through that relationship this is an infringement of the subject's rights (Neyroud and Beckley 2001: 166).

The RIPA provides the police with a legal framework that allows them to use informers. Informers in the RIPA are not defined on the basis of the evidence they provide but on what they do. They are called a 'covert human intelligence source' (CHIS), which places them alongside other covert operations such as undercover policing. The RIPA permits informers to operate under certain basic conditions. These are as follows:

1 *Subsidiarity*. The means of investigation should cause the minimum interference with the privacy and rights of the individual.
2 *Compulsion*. The outcome can only be achieved by the use of a specific registered source.

3 *Accountability*. The use of a registered source must be in accordance with the proper systems of accountability.
4 *Legality*. The investigatory method must not be unlawful.
5 *Proportionality*. The use of a registered source must be commensurate with the seriousness of the offence.

Points 1 and 2 are relatively straightforward. Subsidiarity means that minimum interference is required, which extends to collateral intrusion (i.e. that the privacy of other persons is also considered). Compulsion means an informer must be a registered source. The third point, accountability, has far-reaching consequences. It requires the introduction of an administrative system whereby the police must introduce checks and supervision of the informers and their handlers. The basic principles are supervision and control, which mean *inter alia* that an informer is not the property of one police officer but a resource deployed for the benefit of the law enforcement agency to which the informer reports. Point 4 is straightforward, but point 5 on proportionality requires consideration to be given to any adverse impact on the community (including the confidence of the community) which may arise as a result of the use of an informer. In practice this means a risk assessment must be made at certain key stages of the investigation, including an assessment of the overall impact of the operation. When the risk is too great, the operation must be stopped.

For the first time in Britain, formal recognition is given to the use of informers; formal procedures are to be implemented for their use and conduct, and the RIPA requires informers and handlers to comply with existing legislation. This means informers are supervised and controlled more closely than hitherto and some of the risks are removed, whether to the police, the informer or the community. No system can completely eliminate risks, and dealing with informers is always going to require skill, care, integrity and, above all, being able to anticipate the dangers, but the RIPA tries to reduce those risks as far as possible. Informers are by definition a risky business.

Protecting the informer

Protecting the informer's identity has always been paramount and must remain so. The legal authority for this is found in *Swinney & Another* v. *Chief Constable of the Northumbria Police 1999* where it was held there was a duty of care owed by the police to take reasonable

care to avoid unnecessary disclosure of information an informer had given to the police. The claim was in respect of information given by a witness about a murder inquiry but which found its way into the hands of one of the suspects, resulting in threats and harassment to the witness. It was also held in an earlier case (*Hill*) that 'The public interest will not accept that good citizens should be expected to entrust information to the police without also expecting that they are entrusting their safety to the police'. Failure to provide that protection will not only compromise the informer but also deter witnesses and others from coming forward. This duty of care exists at all stages of the informer's contacts with the police. It is particularly important during the trial where there is extensive pressure to disclose the informer's identity.

The police can point to legal authority involving the granting of public interest immunity (PII), which allows them to seek from the court the right not to disclose the informer's identity nor their methods of work. These legal authorities for PII stem from three important cases: first, *Attorney General* v. *Briant 1846*; secondly, *Marks* v. *Beyfus 1890*; and, thirdly, *Hallett* v. *Others 1986*.

In the first (*Attorney General* v. *Briant 1846*) it was held that 'a witness cannot be asked such questions as will disclose the informer if he be a third person… and we think the principle of the rule applies to the case where a witness is asked if he himself is an Informer'. In the second (*Marks* v. *Beyfus 1890*) the judge went beyond the 1846 decision and reaffirmed that the Director of Public Prosecutions is entitled to refuse to disclose the names from whom he has received information and the nature of information received. He said:

> I do not say it is a rule which can never be departed from; if upon the trial of the defendant the Judge is of the opinion that the disclosure of the name of the informant is necessary to show the prisoner's innocence, the one public policy is in conflict with another public policy, and that which says an innocent man is not to be condemned when his innocence can be proved is the policy that must prevail.

This judgment reaffirmed the earlier rulings found above. More recently in *Hallett* v. *Others* (1986), the judge said disclosing the identity of an informer to the defence is not required unless it is necessary to avoid a miscarriage of justice. The appellants appealed against their conviction for importing and being in possession of cocaine from Germany as to the court's ruling that the identity of the informer should not be disclosed to the defence.

These rulings began to be challenged by the defence claiming that protecting the identity of informers produces injustices for their clients. They asserted that an accused has the right to know and cross-examine those making the accusations. In *R.* v. *Turnball 1976* and *R.* v. *Taylor 1994*, the judgments tipped the balance back towards the defence. In *Turnball* the court ruled the identity of the informer should be revealed if it was relevant to the defence case, and added that verbatim records of the PII applications should be made available to the Court of Appeal. In the second (*Taylor*), the judge ruled that a defendant in a criminal trial has a fundamental right to see and know the identity of his or her accusers, including witnesses for the prosecution, and this right should only be denied in rare and exceptional circumstances.

There the matter rests, at least for the present, except that in *R.* v. *Agar* the court held that if a defence was manifestly frivolous and doomed to failure, a trial judge might conclude it must be sacrificed to the general public interest. Occasionally the defence had become involved in what were called 'fishing expeditions' aimed at identifying whether or not an informer was involved. In *Agar* the defendant appealed against his conviction for possession with intent to supply after he was arrested in a trap set by the police and an informer. The judge refused to allow details of the trap to be put to the jury. However, the judge said that, if there was a tenable defence, the rule of public policy protecting the informer was outweighed by the stronger public interest in allowing a defendant to put forward a case.

The point at which the balance is struck is always going to be difficult for it must meet the needs of the prosecution witnesses and the fairness of the trial. The pendulum is likely to swing back and forth as one judgment follows the other, the first in favour of the prosecution only to be reversed in favour of the defence. The informer's safety has to be set against the rights of the defendant.

Included, too, is the safety of witnesses, who are not informers (at least in the sense defined here), and who need guarantees of safety – otherwise they will not come forward. Informers whose identity is compromised may require witness protection (Bean 2001c). Every major trafficking operation involves an informer; for some, a witness protection scheme will be required. For how long and in what form (i.e. whether the family will need to be relocated with a new identity in another country or whether a short-term programme would be sufficient) depend on a number of matters, including the nature of the criminal organisation. It is said triads and yardies have long

memories. Not all on witness protection are informers, and not all informers require witness protection – but witness protection is for those who need it and it encourages others to come forward to give information. Schemes must operate according to the highest standards of secrecy for, in the world of drugs and crime, violence is all too common and informers know they pay heavily for the information provided to the police, even if sometimes that leads to a reduction in their sentence.

Reducing the sentence

The value of informers is well recognised – by none other than the Lord Chief Justice:

> For many years it has been well recognised that the detection of crime was assisted by the use of information given to the police by members of the public. Those numbers might be either professional informers who gave information regularly in the expectation of financial or other reward, or public spirited citizens who wished to see the guilty punished for their offences. It was in the public interest that nothing should be done which was likely to encourage persons of either class from coming forward. (*R.* v. *Rankine 1986*)

Not only that but, as Lord Justice Bingham said, there were rewards too, particularly when it comes to drug traffickers and dealers:

> It was particularly important that persons concerned with the importation of drugs into the UK should be encouraged by the sentencing policy of the Courts to give information to the police. An immediate confession of guilt, coupled with considerable assistance to police could therefore be marked by a substantial reduction in what would otherwise be a proper sentence. (*R.* v. *Afzal*, reported in *The Times* 14 October 1989)

In this case, a sentence of 7½ years was reduced to six years. There was not, however, an expectation for a reduction in sentence just because the offender was an informer. Reductions had to be related to Index offences. In *Regina* v. *Preston and McAlery* (reported in *The Times* 14 December 1987), Mr Justice Farquharson in the Court of Appeal said that:

> What the courts should not take into account therefore as a result of this judgement is evidence of information given by an accused person which does not relate to the crime of which he now stands. The proper course to be taken was that where information is given by an accused person which does not relate to the crime of which he is charged then that is a matter which the authorities can properly take into account, but it is not a matter for the Court to consider in mitigation of the sentence passed.

Information to the court is given in what is called a 'text'. The text sets out any assistance given by an informer and details about how the informer was recruited. Here, *R.* v. *Taylor* is relevant where the defence claimed it had the right to know the nature of the text and, of course, the name of the informer. In an important judgment (*R.* v. *Piggott 1994*), the court held that it was no longer a matter of discretion by the police as to whether an informant text was issued. The defendant has the right to have all relevant information put before the court in mitigation.

In so far as a reduction in the sentence was possible, claims by the defendant had to be supported by the police. In *R.* v. *X 1999* it was held that a defendant's unsupported assertions were not likely to make any difference to the sentence. The courts had to rely on the completeness and accuracy of the report, and the greatest of care had to be taken in the preparation and presentation of such a text.

Informers: who are they, and how to control them?

There have been many attempts at classifying informers' motives (see Billingsley 2001a), but there is probably as wide a range of motives as there are informers. Motives are likely to include revenge, pressure from the police, an active enjoyment of the role, the associated power that comes from being an informer and fear of a heavy sentence. Those involved in drug dealing are likely to seek ways to eliminate competition and, of course, what better way to do so than through informing? Financial inducements (mainly small at about £30 for information leading to a conviction and paid only after a successful arrest) are clearly not sufficient, although of course some receive much more where the information leads to the arrest of major traffickers and dealers. Street-level dealers will be concerned with more local, mundane problems, in which case something else must drive them

along and this is usually the protection and extension of their drug markets. This is what makes them dangerous.

Dunnighan (1992) provides one of the few pieces of information on the type of people who become informers. In a survey of detectives and their informers in one police force area, he found the typical informer to be male, under the age of 30, unemployed and with previous convictions (also, incidentally, the typical criminal). Dunnighan (*ibid.*) also noted that about 30% of all informers will be drug users who will also inform on a wide variety of crimes other than drug use. A more detailed study by Roger Billingsley (2001b) largely confirms these findings. He found that most informers were male, young and with criminal convictions, and over half were unemployed. Women informers constituted about 20% of his population of informers; there are no national figures on the gender ratio (Nemitz 2001b: 99).

Controlling these informers is now a much more ordered affair. Informers are allowed to operate only if they are registered and act according to defined procedures. Handlers must be trained and all contacts with the informers recorded; where payments are made to the informer, another handler must be present. Procedures are tight, largely as a result of some catastrophic blunders when informers were out of control.

Of the different types of informer described earlier in this chapter, it is the participating informer who creates the most problems, whether it be for the handler, the controller or the court – the more so in the drugs field as participating informers must know a great deal about the crimes of which they inform. The problem for the police is that the participating informer is also the most useful for he or she 'goes beyond mere observation and report' (Grieve 1992). Or, put differently, the informer needs to be 'dirty' to be useful, which, in the drugs field, means continuing to act as a trafficker or dealer where the more the informer is involved in drug dealing, the more valuable will be the information.

The problem is to decide the appropriate level at which participation should be permitted. In *R.* v. *Birtles 1969* it was ruled that the police are entitled to make use of information concerning an offence already 'laid on' (i.e. to be committed in any event) with a view to mitigating the consequences of the proposed offence (e.g. to protect the proposed victim). It may be perfectly proper for the police to encourage the informer to take part in the offence, but the police must never use an informer to commit an offence he or she would not otherwise commit.

Victimless crime is difficult to detect by conventional methods.

Informers are therefore central to police operations and, of course, these informers will know more about dealing if they are part of that network. This means they must continue to deal, sometimes in ways that might be 'laid on' and sometimes not. The central dilemma is how to obtain information, control the informer and yet allow the participating informer the necessary leeway to continue.

In the murky world of informers, how difficult is it to know where the truth starts and ends? Some dealers claim they have a 'licence to deal' from the police, and those who do not claim they know others who have a licence. These so-called 'licences' are said to be given to informers who, in return for information, enjoy a favoured relationship with the police. The police, somewhat naturally, deny they issue 'licences' but 'licences' are mentioned so often as to suspect they do, at least in some form or another. Moreover, some dealers will say informers are able to learn about police methods and operations, thereby having an unfair advantage. In fact, some say they are placed there by higher-level dealers for that purpose. Other dealers say they take advantage of the informer's licence and use their houses to sell their own drugs, believing the informers had been granted some form of immunity. Where such claims exist and are true, the police have lost control; the informers are able to dictate their terms and the police are left to accept what is given to them. Once control has been lost it is difficult to regain it and, with a loss of control, there is also a loss of respect.

The introduction of new procedures and an emphasis on 'tasking' (i.e. requiring the informer to provide information about what the police want to know and not what the informer is prepared to give) have helped to change the ethos. Tasking produces greater control; it requires the informer to act under instructions and not to operate as a free-floating agent able to produce information the informer thinks fit to give. Those informers not producing the tasked information are deregistered, which increases their vulnerability and makes them less able to receive protected status.

Informers and drug dealing

All drug markets have informers – the police would not be able to operate without them, and are clearly grateful that informers are numerous and generous with their information. Yet how effective is the informer system, and are informers in the drug world likely to have a different impact on the overall level of drug offending from

those informing in other types of criminality? Might it be that the use of informers makes the drug problem worse, when it would not, say, make armed robbery worse? (Billingsley 2001b).

As a general rule we can assume that, whenever dealers provide systematic information on other dealers operating at the same level or above, those informers are extending their own dealer networks (Bean and Billingsley 2001). Their aim is to extend their networks to the point where they, as dealers, are increasingly difficult to prosecute, for they will then operate at an organisational level, rarely being in possession of the drugs. Understandably, the informer system makes some people uneasy. For example, Goldstein (1960, cited in Billingsley *et al*. 2001) gives three reasons to be wary of informers. First, he says police hesitancy to implicate informers encourages others to commit crime. Secondly he believes informers are encouraged by the police to continue to commit crime, this being especially damaging to those in the early stages of their criminal careers. Thirdly, he sees the practice of using informers as leading to widespread disrespect for the criminal law. Others doubt their effectiveness. They believe informers rarely penetrate to the high levels of trafficking organisations, this only being achieved by undercover police officers. They also believe informers increase the level of narcotic crime by making accusations against low-level dealers in order to eliminate them. This they see as particularly damaging to young offenders and others equally naïve about drug dealing because it brings them into the court system with all the deleterious impact court appearances have (*ibid*., cited in Bean 2001b: 30).

These arguments must be taken seriously. Goldstein (among others) believes informers rarely reach the upper levels, for organised crime can be stopped only through extensive police work using undercover agents. Other critics point to the number of crimes committed by participating informers and note they inform for their own benefit rather than for that of the police. They believe that leaving horizontal informers in the system leads to trouble, which is likely to increase levels of crime rather than reduce it (*ibid*.).

In response to Goldstein and others, we may say that whilst informers may not always be able to penetrate the highest parts of the organisation, the undercover operator often needs the assistance of the informer as a means to gain entry. In fact, working alongside undercover operators might turn out to be the best combination, where the one assists the other. At street level it may be true that informers make things worse, but the solution is not to cease using them but to impose more stringent controls. At upper levels things

may be different, but each case presents the opportunity of leading to deeper levels of penetration in the criminal organisation. The aim is to move beyond horizontal prosecution – the so-called 'sidewalk-level dealers' – to vertical prosecution that reaches higher-level dealers and meaningful levels of crime.

We must wait for research to help answer some of these questions but, in the meantime, we should welcome the changes introduced to establish greater measures of control over informers and the efforts made to offset some of the earlier criticisms. At the moment, however, we must expect the numbers of informers to increase, especially in the drugs field, and we should be aware that however distasteful we may find the actions of informers, the police and the courts recognise them as a necessary evil.

The special case of juveniles

We may find it distasteful for juveniles (i.e. those under 18 years of age) to become informers but many choose to do so and some choose to inform on their friends and family, including their parents. Juvenile informers come in various forms. For example, a juvenile may give information on a school friend who has enticed away her boyfriend. This is likely to be a one-off piece of information and relatively innocuous in the overall scheme of things. Alternatively, it may be the case where a parent is a burglar or a relatively important local drug dealer, in which instance the information will be of greater interest to the police. Motives will vary; it may be spite, as in the case of the young girl who has lost her boyfriend, or it may be to earn money to purchase drugs, in the case of the young person informing on his or her family. Or it may be prompted by a wish to be rid of a parent or guardian who may be persistently violent to the family. Alternatively, as Teresa Nemitz (2001b) shows, informers, especially women informers, might give information as a way of protecting themselves and their family against domestic violence; children will do likewise.

The police will be reluctant to ignore this information, especially if it comes from a source they think is reliable. Moreover, if they are to make an impact on the high rates of drug use amongst young people, they must inevitably seek information from those familiar with that world – and that means informers of the same age. The question is not about whether juveniles should be accepted as informers (although some police forces do not accept them) – the question is how to regulate their use in ways which make it more ethically acceptable.

Under the RIPA, a statutory instrument (2000, no. 2793) was laid before Parliament on 16 October 2000 and came into force on 6 November 2000. Briefly, this instrument regulates the use of juvenile informers under the age of 18 and provides special regulatory powers for those under the age of 16. In line with the language of the Act, informers are referred to as a 'source' or CHIS. For informers under the age of 18, the instrument says that a risk assessment must be made at the time the source is authorised, and the risk assessment must be by a police officer of superintendent rank. Under para. 5 (ii), that risk assessment must demonstrate that the 'nature and magnitude of any risk of psychological distress to the source arising in the course of, or as a result of, carrying out the conduct described in the authorisation have been identified and evaluated'. The risks must be justified and properly explained to the source.

For the juvenile under the age of 16, no authorisation for the conduct and use of the source may be granted if (1) the source is under the age of 16; and (2) the relationship to which the conduct or use would relate is between the source and his or her parent or any person who has parental responsibility for him or her (para. 3). Informers under the age of 16 may be authorised (i.e. registered) but an appropriate adult is required to attend any meetings with the superintendent, and an appropriate adult means a parent or guardian, any other person currently responsible for the juvenile's welfare or any other responsible person aged 18 or over.

These regulations do not stop the police from taking note of the juvenile's information against family members. What they say is that the juvenile will not be authorised (i.e. registered). In practice, however, this means they cannot proceed. For example, assume they take notice of the child and arrest the father for burglary. If the defence asks about the basis of the information that led to the arrest, the police will have to disclose their source. The defence will then say, rightly, the investigation was unlawful. That of itself is bad enough but without registration the juvenile is not given the formal protection of a duty of care (as provided by *Swinney & Another* v. *Chief Constable of the Northumbria Police* (1999)), although it would be reasonable to suppose that all juveniles would receive a duty of care from the police under any circumstances. A likely outcome, then, is the juvenile will supply the information as before but the police will not act on it. It would be unreasonable to expect them to ignore it so they may seek other ways to circumvent these regulations. Paradoxically, in order to protect the juvenile, these regulations may have the opposite effect. As noted above, sometimes that information is given to secure the juvenile's own (or other family member's) protection.

The regulations for juveniles generally (i.e. whether under 16 or not) are about providing information against those outside the family. They require a senior police officer to be present and an appropriate adult. The definition of an appropriate adult is that taken from the Police and Criminal Evidence Act (PACE). This is hardly satisfactory, including as it does 'any responsible person over the age of 18 years'. One would think some reference should be given to the suitability of the person to act as an appropriate adult: suitable in the sense of knowing what to do or say, how to respect confidentiality for all concerned, including the police, and understanding the juvenile's situation. It would seem to require a rather special sort of person trained in the art of knowing how to react to a delicate situation yet not damaging the information to be given. The lack of training of appropriate adults generally makes it likely that those used will be local authority social workers or probation officers who may be sympathetic to the child but who come from organisations rarely sympathetic to the police. If juvenile informers are to be protected yet permitted to provide information, which may after all lead to the conviction of serious offenders, suitable appropriate adults are required who are trained and who are capable of acting in ways best suited to the task in hand. Otherwise it seems again as if Britain is producing the correct procedures then emasculating them by failing to provide the levels of support necessary for them to function.

There remains another pressing ethical question that centres on payments to be made to juvenile informers. The problem is the police may reward the juvenile quite handsomely in some cases when there is every reason to believe the juvenile will use the money to buy drugs, or spend it on gambling. Some police forces have tried to get round this problem by staggering the payments (i.e. paying only small amounts at any one time); others pay for the information with food vouchers or by some other means to assist the family. This is not always acceptable to the juvenile who, say, may be a heavy drug user, homeless and have a liking for cocaine. There is little the police can do if they want the information. They would be helped if the regulations set out the conditions under which monies can be paid and if they were required to clarify this with the juvenile concerned. Presumably, the regulations would say something like this: vouchers will normally be paid and only in exceptional circumstances will money be given and then only with the approval of a senior officer of assistant chief constable rank. That may not solve all the problems but it might ease some of them.

The use of juvenile informants carries particular risks, whether

to their safety or psychological development, and the police have rightly been provided with detailed rules and procedures for dealing with them. Authorising officers are required to give close attention to questions of proportionality – that is, to determine whether the use of a juvenile informer can be justified. This use must be on the basis that it is commensurate with the seriousness of the offence. The younger the informer the more pressing is the decision about proportionality. In every case, the controlling police officer must be satisfied the juvenile understands what is happening and has had the risks clearly explained. If the juvenile's identity is compromised, he or she faces additional obstacles: juveniles cannot usually move to another area and they cannot protect themselves against violent drug dealers. Carole Ballardie and Paul Iganski (2001: 113) show that most police officers in their study solved the problem of juveniles by not registering them – hardly a solution in the circumstances. The move to tasking using dedicated informer units will help reduce that practice, though it may still appear, albeit fitfully.

We may not like using juveniles as informers, might find it morally repugnant, but juveniles will keep coming forward with information. Clearly it is wrong if financial inducements or gifts are offered as inducements to give information, and so the best we can do is provide clear guidelines about how they should be handled and controlled. After all, the peak age of crime is 15 years, and the peak age group 14–17 years. If the police are expected to make inroads into levels of juvenile crime, they must expect to use informers to help them.

Corruption

Drugs are easy to transport and easy to hide, and small quantities produce massive profits. It is this message that Roy Clark (2001) graphically describes in his study of police corruption. He says corruption can be found in all organisations, including those within the criminal justice system, especially where drugs and informers are involved. He thinks the police have recognised this more than most and have unfairly been seen as the most corrupt because they have publicly displayed their anti-corruption activities. The police have also recognised where the dangers are, and Clark makes it clear that other agencies that refuse to accept that corruption exists are building up trouble for themselves by failing to turn over the stone to see what lies under it. Corruption can never be eliminated but it can be reduced. Clark (*ibid.*: 38) again:

> The risk of allowing police officers to come into regular contact with criminals under controlled conditions is therefore justified. On almost every occasion the contacts and resulting police actions are conducted according to high ethical standards. There are however rare occasions when standards fall, supervision fails and people become vulnerable to temptation. Under such circumstances the dangers of informers and police officers becoming corrupt are high.

Clark gives other examples of corruption, whether in the Crown Prosecution Service or HM Customs & Excise, and they almost all involve drug dealing. The incentive to bribe officials and engage in corrupt practices is a common and important feature of the contemporary drug trade. The large amounts of money and, from the trafficker's point of view, the need to launder that money, as well as finding better means of distributing the drugs, have meant that bribery and corruption are endemic. The bank clerk who is paid by the trafficker to look the other way or to fail to report large cash deposits, or the police officer who does not patrol a section of the coastline on selected evenings, operate at the low end of the corruption pyramid. At the upper end are the professionals, the lawyers and accountants able to promote shell companies or to engage in sophisticated trading techniques. Even higher are the corrupt politicians – some at the very top, whose practices promote and extend corruption nationally.

Some of the corrupt practices in relation to the drugs trade in the Caribbean and South American region have been documented (Paternostro 1995). For example, in 1994 the US Attorney General's office filed in excess of 15,000 criminal corruption investigations against Colombian officials, including 21 Colombian Members of Congress. Although Colombia and the USA signed a Mutual Legal Assistance Treaty in 1900, Colombia has failed to ratify the treaty and it has not entered into force (Presidential Determination 1995). It would be wrong to single out Colombia; other countries have been found to have similar levels of corruption.

Corruption is thought to be most extensive in the producing and distributing countries (e.g. in South East Asia, Pakistan, Burma, etc., the Caribbean and South America). Levels of vertical corruption are thought to be less common in non-producing countries, although the BCCI Bank proved to be a notable exception. Corruption can be defined in legal terms as 'behaviour which deviates from the formal duties of a public role or violates rules against the exercise of certain types of private practice' (Nye 1970: 566–7). It is the abuse of a position for

personal gain. Accordingly, corruption damages public interest as it is dysfunctional to the workings of an organisation, whether involving the law, business or whatever.

Almost all definitions of corruption have been in functionalist terms, where corruption is viewed as dysfunctional to the workings of an organisation or national economy. There have been challenges to this legal definition (Lo 1993), where the view is that functionalist legal definitions are rarely broad enough to cover the whole spectrum of corrupt practices. Many actions lie in a grey area where corruption in the legal sense would not exist or where it is not dysfunctional but may be neutral or, at best, valuable. The handling of informers is a case in point. Skolnick (1984) argues that the enforcement pattern of 'working up the ladder' creates room for wide discretion to be given to narcotics officers who try to protect their informers by holding back information from their superiors. As a result, says Skolnick (*ibid*.: 124), opportunities are always there for corrupt practices and are always a problem. Insider trading is another grey area where corruption is always going to be near the surface, and what is and what is not a corrupt practice is open to debate. Also, the professionals such as lawyers and accountants noted below as well as bank clerks are likely to be operating in similar situations to the insider traders. If the law requires all cash deposits of £5,000 to be notified and a depositor repeatedly places £4,999, should the bank clerk ignore this?

Using a conflict perspective, Lo (1993: 153), in a study of corruption in Hong Kong and China, says corruption can be seen as more variable than that defined in moral and legal terms. It is, he says, determined by the actions of powerful political groups who are able to influence public opinion: 'If a political group succeeds in persuading the masses that a specific policy is in their interest its corrupt practices would be exonerated' (*ibid*.: 153). He goes on (*ibid*.) to say that as 'the dominant class has the capacity to mobilise the mass media and government institutions it is always in an advantageous position to articulate its own interests'. As an example he cites the Tiananmen Square massacre where the Chinese Communist Party claimed that counter-revolutionary riots had been suppressed to maintain law and order to uphold the people's interest when in fact it was the people's voice and freedom that had been suppressed (*ibid*.). Whether this is an example of corruption or simply of naked manipulation of power is debatable.

Clearly there is a point to be made about the way in which corruption is or is not defined by the dominant group – and the

activities of some Caribbean governments illustrate this. Even so, it is not clear where such an argument takes us. If the definition of corruption varies from society to society (depending much on the political and economic structures and historical changes, as Lo would have us believe), then corruption can only be examined as another form of cultural relativism. Yet modern capitalist societies require large measures of conformity on those wanting to trade on the international market. The bank teller who takes a bribe in London is as corrupt as the bank teller taking a bribe elsewhere – hence the value of a functionalist theory. It may not be the only theory but it is likely to be the one most appropriate to drug trafficking that is, after all, about financial exploitation.

It is important to understand the structures that promote corruption. Organisations that are not corrupt or have no vertical corruption will, none the less, be prone to corruption if supervision is lax or if managers are not aware of the possibilities of corruption occurring. The poorly supervised bank clerk will not report a large cash deposit, the poorly supervised police officer will not report a cargo landing on his or her part of the beach, or the poorly supervised lawyer or accountant will accept a new client without asking too many pertinent questions. But they will report if supervision is close. On the other hand, Peter Reuter (1991: 17) sees the incentive to bribe as being not related to supervision but to the intensity of law enforcement: 'The greater the probability of long prison terms and loss of other assets, the more aggressively a dealer will seek out officials who can mitigate those risks and the more money he will be willing to offer such mitigation.' His conclusion is that active law enforcement induces corruption: 'This is one of the potential costs of more intense enforcement in raised corruption potential, particularly among the front line enforcement agencies' (*ibid*.).

Corruption and policing

Roy Clark (2001) gives the typical profile of the corrupt police officer in these terms: he (it is very rarely a woman) will be a very active police officer, usually with a reputation for being successful, having 'done a number of good jobs' and continuing to work at that pace. He will have served as a police officer for about 12 years and will have reached a reasonably high or middle rank. He will be divorced, probably paying a heavy maintenance allowance, or will have other similar monthly expenses. He will be working in one of the specialist

detective units and will meet criminals who have ready access to large amounts of money.

It is difficult to believe that many police officers started their careers with the aim of becoming corrupt. More likely, they began with all the usual idealism of someone starting out in public service. What, then, goes wrong? How does an otherwise honest, hard-working police officer become corrupt? Almost certainly by gently sliding into corrupt practices beginning, first, with such matters as securing a lighter sentence in return for a relatively small payment. This is done by changing the records or finding other ways to avoid prosecution. Once involved it is easy to move to larger sums of money from more serious criminals and the point is soon reached where it is difficult (if not impossible) for him to regain his earlier reputation – and as a corrupt police officer he has lost control and becomes the employee of the offender population.

Clark (*ibid*.) describes the changes the corrupt police officer goes through from being honest and in control of the offender to being corrupt and in the offender's control. In the Metropolitan Police investigation he identified 'a new and more sinister problem' (*ibid*.: 41) with evidence that 'there was a complete reversal of the roles of the police officer and informer. The informer … became the recipient of police intelligence whilst the police officer became the informer.' He describes it (*ibid*.) thus:

> It became clear that this reversal process led to the criminals adopting many of the elements of police practices which relate to the recruitment and use of police officer informers. It was found that the criminals developed their own policy or set of standards which closely mirrored the accepted law enforcement practices. These include the active recruitment of informers, protection from exposure, the use of pseudonyms, an acknowledgement that intelligence is to be shared, the tasking of informers, the provision of more than one handler, and reward in cash commensurate with the intelligence provided.

Paradoxically, it is the informer who provides the police with information about corrupt police officers. Clark says informers have been an important source of information, introducing several lines of inquiry and adding significantly to others. He says there is no such thing as honour among thieves; rivalry, jealousy and the settling of old scores create high levels of instability within criminal circles and ensure a constant stream of information to the police. He adds (*ibid*.:

48): 'Informers are also a vital component of any strategic response to corruption.'

For the trafficker and high-level dealer, corruption comes cheap. The police officer on the Caribbean island or the bank teller in a London bank when asked to look away at the opportune moment will not expect to receive a great deal of money. Clark describes an employee from the Crown Prosecution Service who was sentenced to six years' imprisonment for giving away the identities of 33 police informers. He had received just £1,000, although the court heard he expected to receive more (*ibid*.: 45). There is no point in the bank teller receiving £1 million for that would draw attention to his or her activities and would be counter-productive. More likely, he or she will ask for enough to pay off existing debts, to buy a car and to go on holiday. And he or she will be hooked for life with no possibility of escape. In that sense corruption is a one-way street, dysfunctional to the organisation and dysfunctional to the corrupted – but highly functional and cost-effective to the corrupter.

It is reasonable to ask to what extent we should fear an extension of corrupt practices. Will corruption through the drug trade overwhelm our institutions, whether financial or otherwise? Peter Reuter (1991) is optimistic; he sees the fractionated structure of drug law enforcement as being its salvation. It means no force has exclusive criminal enforcement responsibilities (the police share much with Customs and Excise), and the often-cited lack of co-ordination between the agencies turns out to be but one aspect of the risks facing corrupt police: 'Taking money from dealers has become risky in an environment in which the individual paying the bribe has a reasonably high probability of being arrested by another agency' (*ibid*.: 18). Wing Lo (1993: 163) sees the solution in terms of changes in the dominant group so that all can contest the validity, target and purpose of the legal and moral censures of corruption.

The research evidence such as there is suggests that, in modern societies, drug dealers are unable to purchase the systemic and comprehensive protection that was available to many of their earlier bootlegging and gambling predecessors. Modern drug-dealing organisations in a country such as Britain are basically fragile and always subject to serious threats from law enforcement (Reuter *et al*. 1990: 24). Of course, whilst they operate they do considerable damage, but they are always likely to be confined and always likely to be seeking new forms of corruption. The evidence to support Reuter *et al*.'s optimistic view in the face of the growth of organised crime needs to

be evaluated. A comprehensive study of corruption – how it occurs and how it can be controlled – would seem to be necessary.

If, as is often claimed, about one third of all crimes are cleared up as a result of informers and, for drug crimes, the percentage is thought to be higher, informers play a key role in any police strategy. If the trafficking cases are disaggregated and counted separately, the percentage is likely to be much higher still. There is no suggestion the use of informers will decline but every indication it will increase and, almost certainly, change to meet the contemporary demands of law enforcement. Nowadays crime generally, and drug taking in particular, has a more international dimension, where the movement of drugs and the movement of criminals require a different approach than hitherto.

Conclusion

In October 1997 the UK government published *Rights Brought Home; the Human Rights Bill* and said it intended to incorporate the EU Convention on Human Rights into UK law. The use of informers was affected by the EU convention, particularly Article 8, which provides for the right of privacy. An informer clearly violates that right. Introducing legislation in the form of the RIPA resolved some of these difficulties and provided an opportunity (through speedy amendments to other legislation) to control and supervise informers generally. The old days have gone when police officers learnt how to handle informers as they went along and then claimed an expertise in such matters that was never put to the test. In their place is a new set of rules, infinitely more bureaucratic and cumbersome but with many more safeguards for all concerned.

The link with corruption has been well established and the impact of corrupt police officers well understood. Drugs, corruption and informers seem to go together; not always found together but, when they are, they can produce the most destructive consequences. At present there is no realistic alternative to the use of informers but there is a point to be made about the way they are handled and controlled. Clark (2001) says that any form of unethical or criminal behaviour involving an informer can now be detected, and long prison sentences invariably follow for the corrupt officer. He adds (*ibid*.: 44) that if high standards are allowed to fall, the courts would lose confidence in the informer system and that the consequences of this loss in confidence to policing would be massive. Conversely, the benefits to organised crime would be vast.

Chapter 9

Women, drugs and crime

Rarely in this book has reference been made to gender or even an acknowledgement made that gender is an issue. Obviously, this is not the case – gender *is* important. For example, Table 1.4 (on p. 9) shows that, of the 40,181 people starting agency episodes in the six months ending 31 March 2001, 29,669 were men and 10,512 were women (or about 25% of them were female). The ages at which women begin drug use are similar to those of men, the peak age group being the early to mid-20s. The drugs taken are also similar – although some American studies show that women are particularly fond of cocaine. However, Edna Oppenheimer (1991: 38) notes that the ratio of women to men coming to treatment in Britain is about 1 in 3. If this reflects the numbers using drugs generally, then probably about 25% of drug takers are women.

As noted in Chapter 1, data from the British Crime Survey (BCS) show there is a gap between the male and female rates and that this gap appears to be widening. Whereas female rates remained steady at 19% in 1999, for males it increased by 5%. Women also tend to enter treatment earlier than men, and often more successfully. Yet are these differences sufficient to warrant special policies, treatment programmes, policing or whatever? Do women drug users differ in a qualitative sense from their male counterparts and, if they do, is a different approach or a different set of standards required? In trying to answer these questions we face the obvious handicaps that, paradoxically, also apply to men: there are few good research studies that provide the necessary data. If 1 in 3 or 1 in 4 of the drug-using population are women and the services provided are failing, something

clearly needs to be done and adjustments made in whatever areas are appropriate. But which and how?

At one level, of course, there are no differences. As Oppenheimer (1991) points out, women who misuse drugs are subject to the same risks as men. They will experience the same forms of ill-health, will die from the same overdoses, will experience the same severe weight loss, will have the same hepatitis B and C illnesses, will suffer the same muscle wasting and will be subject to all the other diseases related to the same chaotic lifestyle and the poor and erratic nutrition as their male counterparts. Yet in other respects their medical problems are unique, the most obvious being those related to pregnancy and childbirth and the effects of drugs on the unborn child. Related to these are the social norms surrounding being a mother and the plight of children whose mothers are substance misusers.

The aim here is to look at some of the matters surrounding women and substance abuse in order to highlight certain selected features that have received attention in the literature and in Parliament. Increasingly there is a developing interest in women's issues, especially concerning the number of women drug users in prison and in the treatment facilities inside and outside the criminal justice system.

Women, health and social norms

Women who use drugs are likely to be of child-bearing age; this will create additional problems for them and the unborn child if and when they become pregnant. A number of drug users do become pregnant, but how many and how many give birth as opposed to seek a termination is not known. Sheigla Murphy and Marsha Rosenbaum (1999), in their study of pregnant women on drugs, show how, for a variety of reasons, these women did not practise birth control – one reason being that the combination of long-term drug use and erratic eating habits resulted in menstruation cessation. They did not believe they could conceive and, when they did, it was sometime before they recognised it; they often attributed morning sickness to drug withdrawal (*ibid*.: 52–3).

Generally speaking, once they have conceived there are two main sets of problems: those occurring during pregnancy and those affecting the child immediately after birth. Of the first, Oppenheimer (1991) says that while congenital abnormalities occur primarily during early pregnancy, some drugs can affect the growth of the foetus and its post-natal behaviour producing mental problems (especially where

exposure to drugs occurs later in pregnancy). She says (*ibid*.: 39–40) that even after delivery maternally ingested drugs can gain entrance to the neonate through feeding on mother's milk.

Women drug users who are pregnant face additional complications to their already chaotic daily lives. If their major source of income is through prostitution, pregnancy will reduce their earning power. If they are 'busted' they will try to hide their pregnancy from the police and courts, fearing they will be remanded in custody to receive medical treatment. They know their lifestyles give cause for concern, especially if they are intravenous drug users. In the USA that concern is additionally justified. Many US states have public health laws where pregnant drug users can be detained until they give birth – and presumably a decision is also made about whether the mother may keep the child. The law operates as a form of preventative detention or preventative containment. In California (as in many other states), drug use during pregnancy can be interpreted as child abuse, and hospital staff are required by law to initiate child protection or law enforcement referrals (Murphy and Rosenbaum 1999: 107). The aim of preventative containment is to produce a 'drug-free baby', thereby reducing the complications including the health costs of a child born of a drug-using mother.

The second set of problems surrounds the mother's future contact with child-care agencies and health services. Contact with the criminal justice system is also a potential minefield. Murphy and Rosenbaum (*ibid*.: 105) say that women must choose to disclose or not disclose and, in doing so, must confront their two biggest fears: first, that their babies might be born seriously impaired and secondly that their babies might be taken away from them – 'In the long term was it better for the baby to tell or not to tell?' (*ibid*.: 133).

Sometimes the role conflict works to the woman's advantage. There are some women drug users who recognise there are conflicts between being a 'junkie' and a mother and resolve this in favour of being a mother. If this is the case they seek treatment and are likely to be successful, the more so if they want their children returned to them to reconstitute their family. Murphy and Rosenbaum (*ibid*.: 58) describe how some women who had assumed they were infertile saw their pregnancy as a cause for joy, a living proof their drug use had not impaired their reproductive capacities: 'These women viewed their pregnancies as opportunities to change their life styles, almost as if the pregnancy was a special gift to provide them with new hope and resolve.' Male counterparts rarely see parenthood as sufficiently important to choose in favour of being a father rather than

a junkie. Accordingly, they have fewer demands to make them grow up. Perhaps that is why women seek treatment at an earlier stage than men (Anglin and Hser 1987a). Yet whilst a few see pregnancy as an opportunity to change for the better, many do not. Whatever advantages pregnancy brings to a small number of women, for the vast majority it brings 'seemingly never ending guilt' (*ibid*.: 7). They recognise that bringing up children in that unstable, violent world is likely to produce the same unstable, violent world for them as adults. Murphy and Rosenbaum (1999) describe – in that all too familiar way – how these pregnant mothers had been systematically abused as children and were being systematically abused as adults. They see the same prospects for their children. Yet many of the women in the Murphy and Rosenbaum study decided against an abortion. Pregnancy and motherhood offered them another chance of mending their flawed identities and of returning to a conventional role:

> For those women who had already been mothers and lost custody of their older children the decision to have another baby was another chance at being a good mother. Their decisions not to abort were often influenced by their guilt and remorse over past abortions or having failed in the past. (*ibid*.: 65)

The baby offered an opportunity to do it right this time. Whether they were any more successful remains to be seen.

Women who are drug users and have young children living with them know they are at risk of having those children taken into care. Welfare workers rightly protect children, especially young children, from the dangers moral and physical of a mother who is a drug user. If she has a partner, that relationship is likely to be unstable where the demand for the drug interferes with any relationship between the adults. Each adult will believe the other is exploiting him or her by not giving them their share of the drugs – especially so where they are heroin users or are taking other addictive drugs. Fear, suspicion, distrust and violence are common to these relationships. Young children brought up in that atmosphere are bound to be damaged, psychologically at least. If as often happens the woman addict resorts to prostitution, the risk of HIV infection adds to the dangers.

Once the children have been taken away, as many are, it becomes an uphill task to get them back. How does a woman who was once a drug addict show she is reformed, has appropriate accommodation, is able to bring up children in an adequate way and convince everybody she will not return to drugs? Doesn't everyone know that 'once a junkie,

always a junkie'? Increasingly it will become harder and harder to reclaim the children. American legislation requires children who have been in care for 18 months or more to be considered automatically for adoption. The days are long gone where a mother could expect a child to remain in care for a number of years and then be able to reclaim it when she was ready. If this type of legislation is introduced into Britain it will work as in the USA – that is, reduce the mother's window of opportunity giving her less time to show she is suitable.

Oppenheimer (1994: 86) shows how the social norms surrounding the sexes differ widely so that a woman who becomes an addict violates those norms surrounding the expectations of her sex and gender roles. Or as Murphy and Rosenbaum (1999: 134, 135) say, losing her child and being regarded as unfit to reclaim it means the woman is being labelled an unfit mother. This has horrendous consequences of personal and social condemnation and social isolation. Failure to perform mothering responsibilities is tantamount to failure as a woman.

Broom and Stevens (1991), in their study of women drug dealers, say sex and gender roles and the structural position of women in society have been neglected by male researchers. Putting it more forcibly, they say research has typically failed to consider how women's lives differ from those of men. They believe one reason why drug abuse is viewed with such condemnation in women is that intoxicated women fail to perform one of their major roles – which is to act as 'God's police' by keeping men in order:

> The social expectation that intoxication is permissible for men but not for women has a long history in Australia where … sexual stereotypes have had it that respectable women must function as 'God's Police' imposing restraint, civilisation and decorum on men who would otherwise behave in barbaric and anti-social ways. (*ibid*.: 26)

That being so, presumably like all who were once beyond reproach and who acted as 'God's police', their fall will be regarded as all the more blameworthy and reprehensible. They will get little sympathy from others (men included), who will be merciless about such failings. The point is that male drug users can more easily reclaim their status; women find it harder to do so, especially where the label was that of a junkie. However, there are ways to avoid the stigma. Girl gang-members, in the study by Hunt *et al.* (2000: 350), protected their feminine status yet were able to drink more freely because they did so by:

> partying with the girls. On such occasions they did not need to worry about their drinking behaviour tainting their reputations nor did they need to worry about men taking advantage of their inebriated state. The context free from the presence of men was the only situation in which the women found themselves acting in an environment where the wider society's double standards on female drinking did not operate.

Whilst Broom and Stevens (1991) see the problem in terms of a flawed identity, others (such as Rosenbaum 1981) see the woman drug user as trapped in a world that offers little to them, except drugs, and few ways of escape. Their world has less to do with having a flawed identity and more with the reduced number of options available to the addict as she becomes more involved with the drug world. Rosenbaum (*ibid*.), in one of the classical studies of women and drugs, describes the woman's position as the 'career of narrowing options'. She goes on to say (*ibid*.: 49):

> Heroin expands her life options in the initial stages and that is the essence of its social attraction. Yet with progressively further immersion into the heroin world the social psychological exigencies of heroin create an option 'funnel' for the woman addict. Through the funnel the addict's life options are radically reduced until she is fundamentally incarcerated in an invisible prison. Ultimately the woman addict is locked into the heroin world and locked out of the conventional world.

Rosenbaum implies that 'the career of narrowing options' applies more to women than to men. She suggests that, when women are locked out of the conventional world, they find it more difficult to return or suffer greater hardship through that isolation. They mix only with other drug users, mostly men but of the type who will exploit women as and whenever they see it is in their interests to do so, or other women in a similar condition (i.e. junkies). Whether this is always so or only for American heroin addicts is a moot point. Clearly there is a shortage of comparable data for Britain, not just for heroin addicts but for women who take other drugs such as cannabis, LSD or ecstasy. Is their status similarly flawed to the point where they are reduced to that same career of narrowing options? We do not know. There is in Britain a view that women drug users are rather more fortunate than men. They are less likely to be given severe sentences for offences than men but they are less criminal anyway, and their drug taking is

explained as being promoted and sustained by men. What is needed are some sound ethnographic studies describing the women's position, showing how that may differ from their American counterparts and seeing, too, if it varies according to the drug of choice.

All of which easily leads to a note of pessimism surrounding the woman drug user, a pessimism that is often misplaced and unjustified. The positive side is that women drug users seem to have more pressure on them to make them 'grow up' than do men, and often that is what pushes them into treatment. They can and often do break out of that 'career of narrowing options' and have a success rate in treatment that is no worse than for men and often rather better (Oppenheimer 1994). It is never going to be easy for women drug users. Many of the pregnant women in the Murphy and Rosenbaum study (1999) were recipients of violence, poor parenting and poverty: 'For these women the American dream – a nurturing family with two kids, two cars, and a house with a garden and a white picket fence – was indeed a distant dream' (*ibid*.: 17). They conclude their study (*ibid*.: 157) with the view that:

> The greatest threat to effective parenting and child survival is a system that perpetuates poverty, violence, hardship and desperation. Rather than indicting pregnant drug users for their addictions and compulsions we should do well to look at their impossible conditions in which these women and their children are forced to live their lives.

For younger women, those in the 15–21 age group, it would seem that greater possibilities exist of being able to return to more conventional roles, especially if the drug-using episode is brief with little harm (i.e. not becoming pregnant) and the drugs taken were more of the 'soft' rather than the 'hard' variety. Yet for some young girls it is already too late. In our unreported study of young prostitutes in Nottingham who are drug users, preliminary results indicate there are about 60 young girls acting as prostitutes, aged between 12 and 16, many already in care, almost all are drug users (being supplied by their 'pimps'), and some of the pimps are women. It is difficult to be other than pessimistic about their future; their identity is already permanently flawed and their hopes of achieving conventional roles remote. How does a young drug-using prostitute, perhaps no older than 15 years, in care and has been so for nearly all her life, being 'pimped' and dressing in ways that emphasise her youth in order to attract paedophiles, expect to get out of that type of world? Her future, in whatever form it comes, will almost certainly be bleak.

Women drug users, crime and prison

In a written parliamentary answer it was said that, in March 1996, there were 2,120 women prisoners in England and Wales. In March 2000 the figure had increased to 3,392 (*Hansard* 2 May 2000: col. 922). Why the increase? The answer was that it was almost all due to drug offenders. Lord Bach explained: 'That does not mean possession of drugs but the selling of drugs and sometimes the importation of drugs.' He then went on to state what feminist criminologists have railed against for years – that 'There can be some mitigation for women – they can for instance be under pressure from male partners' and added, less controversially, 'but these are serious offences which are a danger to other women and to other people in general' (*ibid*.: cols. 923–4).

On 31 January 1999 there were 825 women in prison for drug offences (data taken from a written answer to the House of Commons on 24 February 1999). It is interesting to compare the women drug offenders serving 12 months or more as a proportion of other sentenced women prisoners serving similar sentences. On 31 January 1999, there were 782 women drug offenders serving 12 months or more out of a total population of 825 women drug offenders (or 94%). This compares with 1,868 other women offenders who were serving 12 months or more out of a total population of 2,391 (or 78%) (*ibid.:* col. 308). In other words, women serving 12 months or more were more likely to be drug offenders than others – 94% compared with 78%.

Some of these women drug offenders serving 12 months or more are foreign nationals. Many are charged with unlawful importation of drugs (448 of these were serving 12 months or more). The point prevalence figures for that day in January 1999 were that 274 foreign nationals were serving sentences for drug-related offences in England and Wales. However, on 31 December 1999, some 11 months later, that figure had risen to 312, serving an average sentence of 6.7 years.

The foreign nationals serving long sentences for drug importation have been the cause of much interest and concern. In the early 1990s, these women came mostly from Nigeria but after drastic action by the Nigerian authorities the numbers dropped steadily and, by February, were down to about 20. Most are now from Jamaica. Ian Burrell (reporting in *The Independent* 21 February 2000) says women smugglers from Jamaica are being arrested so frequently at Heathrow and Gatwick airports that they account for 1 in 16 of the female prison population in England and Wales. He reported that there were 184 Jamaican women in jail serving ten years or more, and that those from Jamaica are over-represented and are five

times greater in number than any other nationality in women's prisons. Back in Jamaica the traffickers are 'targeting mothers with no criminal records. They are targeting hospitals in the Caribbean to recruit women who need money for medical treatment' (*ibid*.). The money is presumably for their families as well as for themselves.

These foreign nationals distort the figures for women offenders in England and Wales as, of course, do drug offenders generally. They accentuate the already-rising rate of female prisoners and, with so many serving long sentences, they produce a lop-sided female prison population. What sort of problems these women create for their families and children back home we can only guess. Stories abound of their naïvety and gullibility. One was of a courier or 'mule' as they are called from Nigeria who, having been told heroin was legal in Britain, declared her cargo at Heathrow and was promptly arrested. This is probably apocryphal but perhaps not too far off the mark. If, as Burrell says, the trafffickers target those women wanting medical treatment, there will always be a ready-made pool of potential recruits who are in similar desperate straits and prepared to take the risk. We do not know how many successfully deliver their drugs and return crime free.

Interestingly enough, the problem seems not to be confined to Britain. Huling (1996) reports that a high percentage of women in prison in Latin America were detained or sentenced under drug-trafficking laws. In Cuenca, Ecuador, it was 62%, in Guayaquil, Ecuador, it was 40%, in Rio de Janeiro, Brazil, it was 28%, in Caracas, Venezuela, it was 51% and in Los Teques, Venezuela it was 43%. Presumably there would be similar figures for prisons in South East Asia.

For the other prisoners (i.e. the non-drug offenders in prisons in England and Wales), many have a drug history and some have a serious drug problem. On 3 July 2000 it was reported in *Hansard* that, in 1998–99 when almost 16,000 women were screened on reception into prison by health-care staff, 3,091 completed drug detox programmes and 413 completed alcohol detox programmes. Moreover, the minister (Paul Boateng), in a reply to a written question, reported a study undertaken in 1997 that indicated that in the year before entering prison, 36% of women on remand and 39% of sentenced women reported engaging in hazardous drinking, and 54% of women on remand and 41% of sentenced women reported some degree of drug dependence (*Hansard* 3 July 2000: cols. 70W–72W). This is a considerable proportion of imprisoned offenders who require treatment whilst in prison.

There is little information to allow comparisons to be made between men and women prisoners. A study by Brook *et al*. (1998) on 995 un-

convicted prisoners randomly selected from all prisons in England and Wales (750 men and 245 women) shows that, before arrest, 145 (19.3%) men were dependent on street drugs compared with 72 (29.4%) women. There were 91 men (12.1%) and 16 women (6.5%) who were solely dependent on alcohol. Seventeen men (2.3%) reported injecting drugs during the current period of imprisonment compared with four women (1.6%). Out of the 995 subjects, 235 (24%) wanted treatment whilst in prison – 172 men and 63 women. Extrapolating this figure to the prison population generally, the authors concluded that 1,905 prisoners (male and female) wanted treatment for their substance abuse whilst in prison.

The treatment of women prisoners has long stimulated interest and controversy, whether of drug offenders or not. The accusation is that women prisoners are given too much treatment and usually of the wrong sort. For example, it has been a source of concern that women prisoners generally have been over-prescribed neuroleptics and other heavy tranquillisers such as Largactil. A debate in Parliament was on the motion that:

> this House is gravely concerned at evidence of the over prescribing of damaging and addictive medicinal drugs in women's prisons … [that] neuroleptic drugs are routinely prescribed to young women prisoners who mutilate themselves, and that medicinal drugs are used as pacifiers which move prisoners from non addictive illegal drugs to highly addictive medicinal drug use. (*Hansard* 22 October 1998: col. 1400)

This debate was initiated by Mr Flynn, a member who had previously taken up the cause of over-prescribing neuroleptics and tranquillisers for women prisoners. He did not get the result he required but did succeed in bringing this to public attention. In an earlier question he wanted to know how many prescriptions for Largactil or Melleril and other anti-psychotic drugs were issued. The reply was that:

> The prison service recognises that many women received into custody have complex medical histories and have very often already been prescribed the types of medications cited … Efforts are being made to reduce the prescribing of major and minor tranquillisers and neuroleptic drugs except where their use is clinically essential (*Hansard*, *Written Answers* 14 July 1998: col. 98).

There it seems is where the matter rests – at least for the time being. It still leaves open the question: what is 'clinically essential'? How is that to be interpreted? To use terms like 'clinical judgements' walks around the problem, for they imply there is something definitive or scientific about these judgements when they could as easily represent the less than unbiased views of the physician. That prescribing and over-prescribing in women's prisons have been a long-established practice is not in doubt, and questions about that practice need to be asked. Mr Boateng again:

> We believe that it is important to ensure that in prisons there is a regime that does all that it possibly can not only to keep drugs out – that is why we emphasise creating in some prisons completely drug free wings where it is possible to provide the necessary alternative to counteract offending – but to educate prisoners to come to terms with their drug misuse that led them to be there in the first place. (*Hansard*, *Prisons and Drugs* 10 December 1998: col. 540)

This statement applies equally to men and women. It does not answer the question about prescribing in women's prisons nor, perhaps, was it intended to. That efforts are being made to reduce prescribing is to be welcomed, although many would say not before time.

Women as users and dealers

Anglin and Hser (1987b) say women tend to report first drug use at a later age than men and are frequently initiated into use by their male partners, who are often their main suppliers in the course of their addiction. They go on to say that women report a briefer transition from first drug to addiction. Anecdotally, it seems women tend to be more rapacious in their drug use, at least in the initial stages, but then for the reasons given above are more likely to see the dangers. There is also a current belief that women who see themselves involved in a mission to save their menfolk from the evils of drugs invariably finish up addicted. They also become heavier users than their men.

Distinctions need to be made between middle-class drug users and others. Middle-class women cocaine users (the drug in question is almost always cocaine and the studies almost always American) say that women use drugs for recreational reasons to add to their lives or 'just for fun' (Sterk-Elifson 1996). Cocaine is seen as the perfect lady-like drug (Greenleaf 1989). There are no unsightly injection marks

and no pressure to hang around bars to obtain it. 'Also it's slimming, you're not in a stupor, you don't slur your words, and you can carry it around in your cosmetic case just like the lipstick.' Or, as one user said, 'I can feel this good and lose weight too' (*ibid*.: 12). The problem comes when the demand for the drug begins to get out of hand or when they begin to feel and recognise they are losing control. What then? Sterk-Elifson (1996) says women at this point begin to recognise they must give up the myth of using just for fun. They are then faced with a number of dilemmas: 'If their use is discovered the women might lose their jobs, their relationships, and if they are mothers the custody of their children. The women do not want to lose what they have; they want cocaine to add to their lives not destroy them' (*ibid*.: 72). The other problem is that once the drug use begins to get out of hand, women become less selective about their partners. Their decision is then based more around cocaine than the quality of any prospective relationship (*ibid*.: 70).

Outside this rather protected middle-class world, Morgan and Joe (1996) suggest that women users, with very few exceptions, are restricted to passive or victimised roles in a social world dominated by men. Their drug use is limited to their relationship with men and they rarely consider that their use was shaped by choices outside their gendered relationship. Some (a small number) become dealers, and a few are successful. In our study of drug dealing in Nottingham (Bean and Wilkinson 1988), we found a small number of women dealers who successfully operated using their boyfriends or current partners to collect debts and enforce discipline. These women changed partners regularly and the street talk was that they informed on them to remove them, either because they were not up to the task or because they were likely to take over the business. Similarly in their study of women crack users in New York, Johnson *et al*. (2000) found that crack-using women in Harlem claimed (and were so observed) to be relatively equal to male counterparts in their performance of street-level distribution roles as sellers or low-level distributors.

Morgan and Joe (1996) identified what they called the 'citizen dealer' who was mainly middle class (or aspiring middle class) and who was living in the mainstream of social life, regardless of the drug being used or the level of dealing. They also identified the 'outlaws', whose lifestyles were such as to be significantly immersed in deviant activities and who were living marginal lives. The former were either high-level dealers – in this case usually selling amphetamine that provided them with a major source of income – or part-time dealers selling to a small selective group of friends while maintaining regular employment. They

felt pride in their accomplishments as dealers. Being 'able to retain or return to a measure of stability and respectability they were found to be living in good neighbourhoods. They had money, often a husband and family and sometimes a regular job' (*ibid*.: 132). In contrast, the outlaw dealer fitted more closely the view of women as operating in a passive and victimised role in which men dominated their social world. The outlaws come in one of two forms: either as victims when they are heavy users often working as prostitutes whose dealing is to make a living to furnish their own supplies or as survivors. Whether as victim or survivor, the life chances were limited, all had previous convictions and all lived marginal lives (*ibid*.: 135–42).

Most studies see women dealers as more likely to be outlaws than citizens. They support the view that the position of women in the drug world is 'parallel [to] the division in the straight society' (Broom and Stevens 1991: 27). Typically, Broom and Stevens describe women as prostitutes and couriers, whilst men occupied the high-prestige position as dealers. Johnson *et al*. (2000), in their ethnographic study of Brooklyn, reported gender and ethnic biases directed at women. They found that crack-using women were left with virtually no option other than sex work, primarily because they would not be hired as day labourers by crack-selling crews (*ibid*.: 35–6). Whilst women may resist male domination as best they can, none the less, Murphy and Arroyo (2000) argue that women are at a decided disadvantage when they try to enter and operate in the drugs markets. What they called 'ambient violence' or emotional violence (or simply physical abuse) was an all too common occurrence. They say that in the subculture of addiction, masculine values relegate women to secondary roles, making them dependent on the dominant males. Drug use, ambient violence, gender roles and inadequate retaliation capacities meant that most women did not sell for long periods of time (*ibid*.: 105).

The emphasis in the research suggests that women are in the minority when it comes to dealing: there is no suggestion they become dealers at the highest level nor that they are high-level traffickers. However, things might be changing. Dunlap and Johnson (1996) think there may be more women dealers coming forward so that, whereas women have traditionally been on the demand side of drug markets (i.e. working as prostitutes in order to purchase drugs), they may increasingly be moving into the supply side. If so, this would mark an important development.

Women in treatment

There is general agreement that drug-using women have different treatment needs from their male counterparts. How and in what form is difficult to say; too often it depends on the drugs taken, the lifestyle and their perceptions of themselves based on their life experiences. Certainly the reasons women enter treatment seem to be different from those of men – although, once in treatment, outcomes remain comparable. American research suggests that, for men, the routes into treatment are invariably through the criminal justice system whereas, for women, they are through counsellors or social workers. Grella and Joshi (1999) studied gender factors associated with having a history of drug treatment; this involved a study of 7,652 individuals admitted to the national Drug Abuse Treatment Outcome Study (DATOS). They concluded (*ibid*.: 385–6) that: Prior drug treatment among men was associated with factors related to family opposition to drug use and support for treatment, whereas for women prior drug treatment was associated with anti-social personality disorder and self initiation into treatment. Moreover, treatment initiatives among men appear to be facilitated by social institutions such as employment, the criminal justice system and one's family. In contrast treatment re-entry among women was associated by referral by a social worker suggesting that family service agencies can facilitate women's entry.

In other words, men were pushed into treatment by threats but women entered after counselling. If so, this supports the general view that drug-dependent women have treatment needs different from men, and that these needs should be recognised and dealt with. Too often the accusation is that they are not. At its worst, women in treatment are seen as there to assist with the treatment of men ('Would someone take the part of this man's wife/girlfriend/mother in this next role play' type of situation). Slightly better but no more helpful is the assumption that women are to receive the same therapeutic inputs as men, which may be wholly irrelevant ('All he [the therapist] keeps saying is that patients should exercise and receive more controls. It's because I had too much control from my father/husband/boyfriend that I became a drug user in the first place' type of comment). Greenleaf (1989: 7) reports that women are more passive and depressed about their situation than male drug users in treatment: 'They're just not dealing with their problems and are not assertive about how they feel about things.'

Wellisch *et al*. (1993) note the shortage of data on women drug users, especially on those women in treatment. They believe two models of treatment have emerged: the first is an empowerment model where women are encouraged to perceive themselves as actors rather than victims, able to direct their own lives. The second is more practical, aimed at providing women with coping skills that will permit them to make the desired changes to their lives. These may relate to their status as parents (single parents and otherwise) or to family planning, alongside assertiveness and vocational training. The aim is to recognise the failings of women drug users (defined as 'a combination of inadequate and maladaptive social-behavioural and cognitive skills' (cited in *ibid*.: 8)) and yet remedy these whilst, at the same time, treating the substance abuse. Wellisch *et al*. argue that all treatment programmes for women, including those for women in prison, should, irrespective of the main theoretical formulation, contain the following components:

1 Provide the means for women to maintain or re-establish contact with their children.
2 Provide vocational training and career opportunities in higher-paying fields for women.
3 Ensure women offenders receive adequate health care.

Wellisch *et al*. (*ibid*.: 23) say that many women do not understand the child-care system or how to present their case. Also, there may be shame and resentment from both mother and children, which makes it difficult to re-establish and maintain contact. Visiting their mothers in prison is never an edifying experience for children, but that will be the only way to continue the relationship so it has to be done and made the best of. However, in the last few years the climate has changed and the rights of the child are being seen as increasingly important. For whilst every effort must be made to assist the mother to provide a life for herself and her family, the onus is on her to make the necessary changes to her life. She must make the effort; she must get off drugs and stay off if she is to be allowed to have her children back. She must convince the authorities she is serious, and that her intentions are firm about accepting treatment and about staying drug free. There are limits to the amount of time children can be expected to wait for their mothers to make the decision. They, too, have a life to lead and have the right to be brought up in a drug-free environment with parents who place children above the importance of using drugs.

In the second the aim is to persuade the women drug users to think about training for higher-paid jobs and away from seeing themselves as capable of working only in the traditional low-paid industries generally reserved for women. Wellisch *et al*. (1993) say that most women are the sole providers for their children, rarely receiving help from the fathers. Worse than that, most at the time of arrest or at the end of any sentence were less equipped to earn a high wage than many men in a similar situation (*ibid*.: 23). Opportunities are available. Sometimes all that is needed is for women to have the confidence and encouragement to train and apply. Their motivation is not in question; the hurdle to be overcome is more about self-belief than anything else.

Finally, access to health care is, for obvious reasons, less of a problem in Britain than the USA, but the point needs to be made, none the less. Wellisch *et al*. (*ibid*.) say that women have special health problems, such as those relating to gynaecological care, alongside the need for mammary examinations. In addition, women dependent on drugs are likely to have sexually transmitted diseases, which may include being HIV positive and that will need special attention. They also say that, since a large number of female drug users have also been subject to sexual abuse, counselling and psychological support are also required (*ibid*.: 24).

These three components are regarded as essential in any treatment plan for women drug users. How far they are part of the programmes for treatment in Britain is not known – nor is it known the extent of support they could expect from significant others in their families or friends. There is a suggestion that little support is forthcoming; indeed, Grella and Joshi (1999) report that women should expect little support from their partners and family members. They say they will more likely receive opposition, which sometimes includes intimidation and threats. That being so, the task is greater and the level of pessimism mentioned earlier increasingly justified. Hence, Wellisch *et al*. (1993: 25) conclude that 'it is incumbent on policy makers to increase treatment availability and to the extent that current knowledge permits, optimise the effectiveness of treatment programmes'.

A note on juveniles

Helene White (1990), in her review of the literature on drug use and delinquency in adolescence, concludes that although the findings are sometimes equivocal and sometimes outright contradictory, several of

the contradictions may be due to the differences in measurements and samples. Writing in 1990 she concluded (p. 240) that there are four convergent views that emerge from the literature:

1 In adolescence, general forms of drug use and delinquency are not causally related but are spuriously related because they are both types of deviant action in which adolescents engage.
2 Adolescents are heterogeneous in terms of their levels of substance use and delinquency, and the occurrence of both behaviours.
3 The majority of adolescents have no or only minor delinquency involvement regardless of the extent of their substance use.
4 Peer group influences are the best predictors of delinquency and drug use.

In the decade following these comments a number of changes have occurred. The so-called four convergent views no longer seem relevant, especially that which sees the relationship between drugs and crime as spurious. The links for this age group seem more pronounced. However, before looking at that in more detail, some points need to be made about juvenile offenders generally.

In Britain (as in all Western European-type countries) the peak age for delinquency is 15 and the peak age group is 15–18, followed by 18–21 and then 18–24. The peak age for boys is slightly younger than for girls. This has been so for almost as long as records have been kept, and confirmed by almost every research study. The ratio of convicted boys to girls is about 4:1; boys also tend to commit a wider range of offences than girls. The peak onset age is 13–16 while the peak desistence age is 21–25, but of course many offenders continue to commit offences after this. An early onset of offending predicts

Table 9.1 Age and gender of users starting agency episodes, 6 months ending 30 September 1998

Age group	Male	Female	Total
<15	175	74	249
15–19	3,353	1,517	4,870
20–24	6,845	2,570	9,415
25–29	6,788	2,190	8,978

Source: Derived from Department of Health (1999: Table C2).

that a boy will follow a serious criminal career. The majority of offences committed by young people are property offences but most offenders are versatile: people who commit one type of offence have a significant tendency also to commit other types (e.g. violent offenders also commit non-violent offences) (see Farrington 1997).

The onset of drug abuse is a little later (i.e. delinquency often precedes drug abuse). Although some young people begin taking drugs at a very young age (12 or 13 years), the peak age of onset is 20–24. However, a sizeable number began drug taking – called a starting episode – earlier. Table 9.1 gives the age and gender of users 'starting agency episodes' in the six months ending 30 September 1998 for those classified as addicts. Thereafter the rate is reduced, and dramatically so once over the age of 34 years. In Table 9.1 the ratio of male to female drug takers is about 3:1 and remains so for all ages – incidentally, up to the age of 64+. The peak age is 20–24. Data from the British Crime Survey in 1998 show that young people aged 16–29 reported the highest level of drug misuse (Ramsey *et al*. 1999). There, some 49% indicated that they had taken a prohibited drug at some time over the last month or year. For the 16–29 age group, this figure was 25% in the last year and 16% in the last month (*ibid*.).

Generally speaking, therefore, criminality proceeds drug use by four or five years, at least as far as is shown by the peak age for both morbidities is concerned. However, it is likely that *serious* drug abuse begins at an earlier age, as does delinquency, thereby skewing the prevalence and incidence. Research shows extensive drug use amongst juveniles: between 40% and 57% of adolescents treated for substance disorders had also committed delinquent acts. What is also alarming is the high rate of mental disorder in these populations, especially where drug use was of early onset (Nemitz 2001).

The first point made by Helene White (1990: 240) is that drug abuse and delinquency are not causally related – she says the relationship is spurious. This, however, is not supported by other research mentioned above or of the type of 'criminal career' research undertaken by David Farrington. Farrington's conclusion (1997: 399) is that offending is one element of a larger syndrome of anti-social behaviour that arises in childhood and tends to persist in adulthood with numerous differential manifestations. This is the most detailed and comprehensive research programme on juvenile delinquency. It is methodologically sound and theoretically relevant.

Farrington defines a criminal career as a longitudinal sequence of offences committed by an individual offender (*ibid*.: 361). It has a beginning (onset), an end (desistance) and a career length in between

(duration). The criminal career approach operates on the basis that not all people from the same geographical area commit offences, or even those within the same family. The question, then, is: why do some and not others? The aim is to study human development over time, which means investigating how one type of behaviour facilitates or acts as a stepping stone to another. Farrington gives the example of hyperactivity – not a criminal offence – but hyperactivity at the age of two may lead to cruelty to animals the age of six, shoplifting at ten, drug abuse at 14 and violence at a later age (*ibid*.).

This type of research shows how an anti-social syndrome, of which drug taking and delinquency are but two features, is tied into a wider set of behaviour. In the Cambridge study Farrington found that some delinquents tend to be troublesome in their primary schools, tend to be aggressive and frequent liars at 12–14, and bullies at 14. By 18 they tended to be anti-social in a wide variety of respects, including heavy drinking, heavy smoking, heavy gambling, and using prohibited drugs. In addition they tend to be sexually promiscuous, often beginning sexual intercourse under the age of 15. Delinquency, of which drug taking is but one part, is dominated by crimes of dishonesty and is one element of a larger syndrome of anti-social behaviour which arises in childhood and persists until adulthood.

Desistance (which, for offending and drug taking, seems to coincide) generally takes place in their late 20s, although heavy alcohol consumption is likely to continue throughout their lives. Farrington lists a number of reasons for desistance from crime: the cost of crime (long prison sentences), the importance of intimate relationships with the opposite sex (yet many will have been divorced by the age of 30 and fail to support their children), increasing satisfaction with their jobs and becoming more settled as they grow older (*ibid*.: 374). There is little research on desistance from drugs; anecdotally it seems that by their late 20s many drug users will take 'early retirement' – drug use, it seems, is a demanding career with numerous disappointments, numerous periods in prison, high rates of depression and few prospects. (There is also a high mortality rate, estimated at about 27 times than for the age group as a whole.) Drug users talk of the 'straw that broke the camel's back' or 'turnaround time'. That means that the cumulative impact of numerous periods of imprisonment catches up with an offender: he suddenly decides to stop. How and why such changes occur at the particular time remain unclear, but 'retirement' tends to be an abrupt decision and, although there may be occasional relapses, drug taking as a lifestyle ceases. Alcohol use, however, does not.

The essential features of criminal career research are that offenders, which include drug takers, differ significantly from non-offenders in many respects, including impulsivity, intelligence, family background and socioeconomic deprivation. The most persistent chronic offenders could be predicted as early as the age of two (i.e. individuals at risk can be identified with reasonable accuracy). The precise causal connections are still not known and most of the research is confined to males.

In one important respect, the problem of juveniles is a problem of the manner in which a large proportion of substance misusers have the responsibility for the care of children. Substance misuse may not necessarily lead to problems in child care or the neglect or abuse of children (Department of Health 2002), but it often does. NTORS (Gossop *et al*. 1998) found that 47% of drug misusers entering treatment were responsible for children aged 18 or under – over 90% of females presenting for treatment were of child bearing age. The evidence suggests that parental substance abuse is associated with a higher risk of involvement of families in care proceedings, and children of substance misusers are more vulnerable to substance misuse than children of non-substance misusers (Department of Health 2002: 146).

The Department of Health (*ibid*.: 146–7) provides a catalogue of failings due to the impact on the children's physical and emotional health of substance-abusing parents. First is the birth itself:

> The foetus is at risk of harm due to substance misuse through the direct effects of drugs or alcohol: infection, lack of adequate antenatal care, poor maternal health and nutrition … Opiates and cocaine cause an increased risk of obstetric complications including low birth weight, still birth, prematurity and neonatal withdrawal.

After birth the following are likely to occur: 'Inadequate stimulation, an increased risk of Sudden Infant Death Syndrome, poor care and nutrition and exposure to domestic violence.'

In late life, school-aged children have an increasing risk of developing the following: 'behavioural problems including truancy, adjustment problems, poor academic achievement, and school exclusion.' When they are older, children of substance-abusing parents have a greater risk of developing 'mental health problems, comorbid psychiatric disorders that are a consequence of or are worsened by substance misuse [which] can have a negative impact on parenting

(e.g. psychosis, depression) often making the parent emotionally "unavailable" to the child' (*ibid*.).

Children who are brought up in substance-misusing families face additional problems (local addiction units are now treating the grand-children of methadone-maintenance users). They are likely to spend periods in care, and their physical health may also suffer. We have not taken it upon ourselves to determine the outcome of children in these substance-abusing families. Notwithstanding that, problem drug use generally often begins with children under the age of 15 years, and some of these will be problem drug users by the time they are 18. Presumably many will simply stop taking these substances and come to no harm, but some will not: hence the need for good longitudinal studies to see what the effects are on those who continue to take drugs.

As far as the criminal justice system is concerned, astonishingly the youth court system in Britain appears not to have made provisions for juvenile drug users. For example, drug use is not mentioned in the large number of provisions found in the Crime and Disorder Act 1997. There are parenting orders, orders that deal with unruly children, etc., but these are not tied into a debate about children as drug misusers. This omission is all the more noticeable when set against the conclusions reached in American drug courts – namely, that it was neither possible nor practicable to transplant drug courts on to the juvenile justice system without adjusting to the special demands of children. That is to say the treatment of juveniles is qualitatively different from that of adults. Treatment must include treatment of the child's family for without agreement and support from the parents and family members, treatment programmes are quickly undermined. Similarly, children in treatment have to be separated from their peer groups lest treatment is also undermined, albeit for different reasons. Most of all, children should not be seen as young adults but as children. Children are children. Treatment for children requires a different approach and schema that are more labour intensive than with adults and a great deal more complicated. Yet the rewards are also greater. A child treated successfully will be cost effective in terms of future criminality and be a significant success in terms of a reduction in the extent of drugs to be consumed.

In Britain, the *UK Anti-drugs Coordinator's Annual Report 1999–2000* has a section on young people and another on treatment (Cabinet Office 2000). In the first, considerable attention is given, rightly, to prevention and drug education in schools, the latter linked to primary health-care professionals. These programmes take various forms, most

are imaginative and many will improve the levels of drug education and prevention. There are programmes which include targeted drug prevention focusing on young people at risk. These are important given the data which came out of the schools' survey of drug prevalence carried out by the Office for National Statistics (cited in *ibid*.: 47). The survey was carried out among more than 9,000 pupils aged 11–15 in about 340 schools in England. Results show that 7% (about 1 in 14) had used drugs in the last month prior to the survey. In 1999, of pupils aged 11–15, there were 12% who had used drugs in the last year. Cannabis was by far the most likely drug to have been used; fewer than 0.5% of 11–15-year-olds had used opiates (heroin and methadone) in the last year, but 3% had used stimulants, including cocaine, crack, ecstasy, amphetamines and poppers. This gives some indication of the extent of the problem, but which children are those who stop using drugs and which are those who will not are the key questions here.

Chapter 10

The legalisation debate

The major positions – ideal types

Ethan Nadelman believes that a wisely implemented drug legalisation policy could minimise risks, dramatically reduce the costs of current policies and directly address the problems of drug abuse and crime (Nadelman 1995). His critics say legalisation offers a high risk, dangerous alternative, it would lead to more health problems, to an increase in usage, and a further increase in crime (see Inciardi and McBride 1989; Wilson 1995). Clearly, the debate attracts extreme positions. It is often plagued by political influence and coloured by streaks of self-righteousness, all of which make it difficult to arrive at a clear assessment of the various positions.

Drug policy can be seen as lying on a continuum with prohibition and legalisation at the extremes, where decriminalisation, harm reduction, and medicalisation lie somewhere in between. All have their subdivisions. So, for example, amongst those supporting medicalisation some might want all users to be prescribed their drug of choice, while others may want to provide heroin substitutes (such as methadone or buprenorphine) only to heroin users. Or, some who are promoting decriminalisation might want minimum involvement by law enforcement agencies, while others will be more concerned with altering the way drugs are classified. With these limitations in mind the aim here will be to set out as ideal types the essential arguments for the five major positions, and then comment briefly on their strengths and weaknesses before proceeding to a more general discussion.

We will begin with *prohibition,* the target of all that follows. Prohibition reflects current government policy where legal controls prohibit the possession, sale and cultivation of certain drugs. The 1971 Misuse of Drugs Act divides controlled drugs into three categories. These determine the maximum penalties for unauthorised possession, supply and other offences (see pages 54–5 of this volume for details). Substances are selected whenever parliament decides their non-medical use is harmful and the list expands accordingly, for example 'ice' is one of the latest to be added and is a Class A drug. So what began as a few controlled drugs under the 1920 Dangerous Drugs Act has, by the twenty first century, grown to well over 100 (see Bean 1974). Sentencing practices, generally speaking, reflect the divisions, although Ecstasy (MDMA) as a Class A drug tends to attract sentences for possession as if it were a Class C. While there are general issues about which drugs are to be included, and questions about the value of the divisions, the debate tends to centre around a small group of drugs, of which heroin, cocaine, amphetamine and cannabis are prominent, but even then cannabis has tended to dominate.

Prohibition derives in part from Britain being a signatory to the 1961 UN Single Convention, and the 1971 Convention on Psychotropic Substances, the requirements of which are to control the possession, manufacture and import of certain drugs, although each country has some latitude as to how it goes about things.[1] I do not want to make too much of this here, but it remains a point worth noting. It would be extremely difficult for Britain to unravel its obligations to such a UN body. Since 1912 the problem of drug addiction has been seen to require an international response, and that position remains (see Bean (1974) for a discussion on how drugs such as cannabis were first included under the 1920 Dangerous Drugs Act). Indeed the problems posed by drug use are worldwide and probably beyond the capacity of any individual nation state to take effective unilateral action.

Britain's obligations were clarified by the House of Commons Home Affairs Committee which said, 'The UK is one of many signatories to several International treaties on drugs, which constitute a fairly restrictive cradle around our own legislative regime' (House of Commons 2002a: para. 265). This Committee then added, rather interestingly, that as the Commission on Narcotic Drugs is the central policy making body within the UN the government should initiate a discussion with that Commission 'of alternative ways, including the possibility of legalisation and regulation to tackle the global drugs dilemma' (*ibid*. para. 267). This put the Home Affairs Committee out of line with the government which replied immediately, restating

unequivocally its prohibitionist stance 'We will not legalise or regulate the use of any presently illegal drugs. Nor does the Government envisage any circumstances in which it would do so' (2002b: 10). That makes the prohibitionist position clear, at least for the immediate future.

The prohibitionist position is best summed up by the government's reply in the Third Report from the Home Affairs Committee (2002b: 2.):

> Drugs are responsible for the undermining of family and community life. The misery drug misuse causes cannot be underestimated. Drug misuse destroys the lives of individuals, families and communities. It destroys potential, and hope, and preys on the most vulnerable – from devastated countries like Afghanistan to the poorest in the UK, and on our most vulnerable young people. Drug misuse contributes dramatically to the volume of crime, as users take cash and possessions from others in a desperate attempt to raise money to pay the dealers. Very often jobs and homes are lost, friendship and family ties are broken. Where children are involved there is a danger of abandonment and neglect.

Accordingly, prohibitionists say governments have a duty to protect their citizens, especially young children and juveniles, from such harmful effects. The Drug Trafficking Act 1994 introduced mandatory minimum seven year sentences on conviction for the third time of a trafficking offence involving a Class A drug. These were a deterrent against usage, but also promoted a culture which said drug taking was wrong, the culture being as important as the controls. Where appropriate, controls also require users and others to be tested and/or treated. Remember, say the prohibitionists, the majority of people, including the young, do not take illicit drugs.

If the central platform of the prohibitionists is to avoid harmful effects, what if they are confined to the individual user? After all, most people who take drugs come to no harm. Opponents might say drug taking is recreational and therefore a self-regarding act, and accordingly not a matter for governments, or indeed anybody else. They might accede drug taking is dangerous – but then so is riding a motorcycle, and being a mountaineer. To this the typical prohibitionist response would be that drug taking is more than a self-regarding act, it is other regarding – having deleterious effects on others. Ask any parent whose child is a user. Also, it imposes huge

costs on public health facilities. And even if self-regarding, they will say, governments have a duty to protect their citizens from harmful actions. Here the use of seat belts is a prime example, but there are many others, e.g. building regulations, or demands that we save for our old age pensions. Prohibitionists will also claim we do not live in a society where governments can slough off their responsibility to protect us against harmful actions, even if a loss of liberty results. This represents the ancient concept of *parens patriae,* literally the state as father to the people, which was originally invoked for chancery lunatics and wards of court, but it also applied in many areas of the Welfare State, providing strong and persistent precedents.

There would be few *gung ho* prohibitionists in Britain who want to follow the zero tolerance, 'three strikes' sentencing system of the USA, but they might resist attempts to downgrade certain drugs, or drastically reduce the severity of punishments. In 2004, many prohibitionists opposed the formal decriminalisation of cannabis from a Class B to a Class C drug, which they said represented a retreat, and they predicted greater usage – it had already been informally decriminalised where simple possession invariably led to a caution. To them, formal downgrading implied that drug use was acceptable. They believe their fears were justified, for there were claims, mostly by the police, that downgrading led to an increase in use, particularly amongst schoolchildren.

A central platform of the prohibitionist is that legalisation would lead inevitably to a dramatic increase in use, with dangerous social and personal consequences. 'Inevitable', because an increase in use always follows an increase in availability, and *inter alia* legalisation does not take account of the powerful traditions of modern capitalism, which include the ability of an entrepreneurial system to create, expand and maintain high levels of demand (Inciardi and McBride 1989: 270). Nadelman (1995) accepts there will be an increase, but he disputes how much and from which social group it will come. Inciardi and McBride say it will bear most heavily on the poorest members of society, especially within the ethnic minorities who are amongst the heaviest users. Legalisation, they say, is an elitist and racist proposal, increasing levels of dependence in ghettos where it would serve to legitimate the chemical destruction of an urban generation and culture (Inciardi and McBride 1989: 279). They also fear letting the genie out of the bottle, for once let out there is no easy way to put this back in. Reprohibition is not an easy option, or as Kleiman and Saiger put it somewhat sardonically, as Humpty Dumpty demonstrated not all processes are reversible (1990: 544).

Decriminalisation is about reducing legal powers and legal sanctions, and where appropriate removing them altogether. Those supporting decriminalisation do so from many different standpoints, but usually agree that the current legal sanctions for drug users are wrong in principle and for most drugs are excessive. They also say that that prohibition is wasteful, whether in terms of the cost of enforcement or to the criminal justice system, especially where it leads to lengthy prison sentences on users and dealers. Decriminalisers also believe sanctions can exacerbate an already difficult situation by criminalising many users who would not otherwise be criminals, or by punishing them in ways that deepen their criminal involvement, i.e. sending them to prison, thereby contaminating them through contact with more severe criminality.

Dealing first with the argument that existing punishments are wrong in principle, and to make things easier, we can concentrate on possession offences: decriminalisers rarely want reduced penalties for supply offences unless the amounts involved are small. A typical decriminalisation argument was put forward by Barbara Wootton in her (1968) report on cannabis on what can also be called the 'depenalisation' of certain offences (1968: 29, para 90). She said, 'our objective is clear: to bring about a situation in which it is extremely unlikely that anyone will go to prison for an offence involving only possession for personal use or for supply on a very limited scale'.

Barbara Wootton saw the possession and supply of small amounts of cannabis as not warranting a severe sentence, a typical decriminalisation position. Michael Schofield in his reservations to her report wanted greater precision. He favoured spelling out the sentence according to the weights and amounts of the drug involved (see p. 36–39). His reservation was not accepted but the general decriminalisation argument was. This report came at an interesting time for there was then a strong tide of opinion favouring harsh sentences for cannabis, one of the arguments being that cannabis was a 'gateway' drug, i.e. leading to the use of more serious drugs such as heroin. In spite of that, the decriminalisation argument held sway. The report generally, and the decriminalisation argument in particular, had a major impact on policy – not only were the penalties for possession of cannabis such as to exclude prison sentences for the possession of small amounts of the drug, but the report almost certainly stopped Britain going down the American route by embracing their 'War on Drugs' policy and its excessive 'three strikes' sentencing guidelines, although the 1994 Act comes close to reversing that. Equally important here was that it implied that whatever solution is adopted it will almost

certainly need to be revised, for drug laws evolve and need to change over time. Barbara Wootton said 'It is our explicit opinion that any legislation directed towards a complex and changing problem like the use of cannabis cannot be regarded as final' (*ibid*.: 3).

Most decriminalisers do not want drugs to be free of all sanctions, they are not out and out legalisers. They are selective, seeking to reduce sanctions on some drugs, invariably basing their arguments on utilitarian considerations such as the effects of use and the costs, social and otherwise. So as in the Wootton Report they might want cannabis to be reduced to, say, a Class C drug, which it now is, or they may seek to downgrade all possession offences. Yet there is also a strong retributive element to decriminalisation, albeit rarely acknowledged. For example, the Wootton report said this or that offence no longer deserved this or that punishment. She says possession of cannabis does not deserve a prison sentence. Others might say it does. If so, how are we to reconcile the differences? In practice, what decriminalisers seek is to promote a new consensus, or in retributive terms produce a new tariff, which of course is precisely what the Wootton report achieved. Critics however saw this as an example of a powerful elite setting the punishment lower than was justified. It certainly provoked hostility from those who sought a heavier punishment.

The second major platform in decriminalisation is that it is wasteful of resources. Most decriminalisers would say prosecuting minor drug offenders takes up an inordinate amount of police and criminal justice time, where these resources could more usefully be employed elsewhere, not the least providing treatment facilities. In this they are at one with other critics of prohibition such as medicalisers and legalisers. More than that, they say the type of sentences used in say, 'The War on Drugs' are not only undeserved (in the retributive sense), but wasteful in that they keep offenders in prison beyond a date when they will be active criminals. What the decriminalisers are able to do is challenge existing orthodoxies and require those at the heavy end of prohibition (those supporting lengthier sentences) to justify their position.

Harm reduction lies somewhere between legalisation and prohibition (Goode 1999). It has, however, become a catch-all concept. In its pureist form, it is about finding ways to reduce the harm of drug use, emphasising a public health model for lowering risks and consequences. Its philosophical foundations are Benthamite utilitarianism, although this is never acknowledged. Bentham urged the importance of deterrence and the value of reducing levels of

unhappiness due to crime. He saw it as an advance if an offender could be persuaded to commit less serious offences than hitherto. So too with harm reduction – better to encourage those who inject to use sterile needles rather than non- sterile ones, or to take cannabis rather than cocaine. Harm reduction becomes a way of reducing the risks inherent in drug use, while recognising that drug use is a chronic condition not easily abolished by sanctions or education.

Sadly, harm reduction has become entwined with numerous political positions and as its critics tirelessly point out, and with some truth, it has often become an apology for the drug culture or a cloak for a less strident form of legalisation. On the face of it, harm reduction should assume a central position somewhere between prohibitionists and legalisers but often appears more sympathetic to the latter. One critic calls it 'a hijacked concept that has become a euphemism for legalisation. It's a cover story for people who would lower the barriers to drug use' (McCaffrey, quoted in Kleber and Inciardi 2005: 1384). If it has, and I think it has, its position is weakened. Its strength has always been to acknowledge drug use as a chronic condition and in so doing it stresses the need to reduce crime and improve health, the latter by such measures as needle exchange schemes to reduce the risk of users passing on HIV/AIDS by sharing injection equipment. If harm reduction is to achieve its potential it needs to promote a clear statement about future direction – is it within a prohibitionist framework, or is it a step towards legalisation? Muddying the waters as at present helps no one.

None the less, at its basic level harm reduction has much to offer. No one expects the drug problem to be resolved speedily. Reducing health risks and the damage to family members especially the children of addicts and to victims of the crimes of drug users, must always be laudable activities. Yet which harms are to be given priority? Is health to be preferred to crime? The two might conflict, as when sterile needles are freely provided leading to an increase in addicts. If so, how best to proceed?

Medicalisation is multi-faceted. At one level, drug users are seen to suffer from a disease (the Rolleston Committee, for example, said heroin and morphine addicts should be treated as sick people, and in need of medical treatment which may include the prescribing of heroin). If drug use is a disease then the obvious aim is to treat and prescribe rather than punish, although medicalisers might wish to retain punishment for those violating the system i.e. selling legitimate supplies. And of course this constitutes the basis of the so-called 'British system', from the 1920s onwards although practised rather

less energetically after the late 1970s. Vestiges of it remain: about 500 heroin addicts still receive maintenance supplies and methadone has been prescribed regularly throughout. Official policy is that substitute prescribing of methadone and other opioid drugs in long-acting oral preparations is the main medical treatment in the UK for heroin users (Department of Health 1999). Medicalisation is, however, not without its critics, some of whom point out that users on prescribed methadone are no less addicted than when on heroin. (Some see methadone prescribing as the means by which the white criminal classes are sedated.) None the less, methadone prescribing remains the most common if not the most acceptable form of medicalisation.

A different form of medicalisation is about providing the drug of choice to addicts or regular users – prescribing is to be by physicians. Stripped of its dross, this latter position boils down to a pro-public health and an anti-crime crusade (Schmoke, 1990). Prohibition, it is said, forces users into crime by their need to fund a habit, and in so doing produces a large and unwieldy prison population. It creates additional social and economic costs, particularly health costs. Medicalisers share much ground with legalisers, but they are not necessarily one and the same. Some medicalisers want to prohibit non-medical supplies and track down illegal markets but others do not (see *ibid*. 1990: 519), and some legalisers use medicalisation as a back door to their programme. All, however, emphasise the importance of medical prescribing as a means of securing better health and reducing crime.

Apart from the obvious unfairness to alcoholics and tobacco addicts who cannot get their drugs on prescription, medicalisation promises much. But how much can it deliver? The answer depends on which form of medicalisation one chooses, and how far down that route one wishes to travel. In Britain in the 1960s over-prescribing was rife and criminality was extensive. It was not just the problem of a few over-prescribing doctors, but of many who prescribed rather more than they ought. For the problem is this – prescribe too little and users seek alternatives, prescribe too much and they sell off the surplus. And even when the doctors get it right, some users will still sell off supplies only to buy them back later – the addict crime of the 1960s was largely made up of these types of drug offences (Mott 1992: 83). In the late 1960s, about one third of 'registered' addicts i.e. those receiving drugs on NHS prescriptions, were in Brixton prison. And of course addicts still had to feed themselves, pay rent and so on, often paid for by criminality. However, on the credit side there were few examples of drug markets as we now know them and little

in the way of illegal imports. These gains have to be set against any increase in use.

Finally, there is *legalisation*, which is about removing legal controls. The term is often used as if it was synonymous with decriminalisation for of course were all legal controls to be removed then decriminalisation would be complete, but the two concepts are not always that close. I may be in favour of legal controls but could regard the sanctions as being too harsh, or I may say that legal controls should be preserved for this or that drug, but not for others. And if certain selected drugs were medicalised this might placate some legalisers, e.g. Arnold Trebach (1982) who specifically wants heroin to be available on prescription in the USA, especially for terminal conditions (it is available in Britain). However, legalisation as used here is more specific. It means repealing legislation that prohibits the recreational use of controlled substances, invariably those under the 1971 Misuse of Drugs Act.

So, why legalise? Five main reasons are usually offered. First, legalisers say prohibition cannot be justified on moral or jurisprudential grounds. They say no one denies that taking drugs involves a degree of risk but many activities involving risk are not prohibited, and anyway adults should decide for themselves what risks to assume. And even if certain drugs involve risks, ought these to be sufficient to ban their use? If there are risks then at least we are entitled to know what level of risk should be met, and which drugs meet that risk. Not all banned drugs produce high risks, though some may. Even so, whose rights are being violated by acts of recreational drug use? If I choose to behave in ways whereby my recreation contains self-destructive elements that surely is my business and my right, and if those harms also involve the potential for harming others, as when I ride my motorbike or climb a mountain or race my Formula One racing car, then so be it. We accept the possibilities of these harms to others as the price to be paid for freedoms. If so, then how and in what way are drugs different? To say, as some do, that drug users are poor parents, unreliable employees, bad neighbours, and have serious health problems, may all well be true, but none of these activities are criminal, although they may be undesirable. And as shown in an earlier chapter, the link with crime is at best tenuous except of course for systemic crime.

Second, current policies are failing. That is to say, in spite of every effort the number of drug users continues to increase, with little or no prospect of an immediate reduction. That being so we ought not continue with policies so obviously unworkable. And if these are not

working then change them, including the legislation, for prohibition is now part of the problem. Prohibition makes things worse.

Third, interdiction and other methods of reducing supply, including law enforcement, are also not working and are very expensive. Only about 10% of illegal imports are interdicted, with little prospect of that increasing given the nature of our national boundaries, unless of course interdiction is able to close a monopoly supplier, but there is little chance of that happening. If the prices of drugs are measures of the effectiveness of law enforcement then this is further evidence that the policy is failing; prices continue to fall in spite of vigorous policing of drug markets. So, say the legalisers, the cost of law enforcement including that of criminal justice vastly exceeds its worth (see also Mugford 1991).

Fourth, prohibition increases criminality, not simply by penalising possession but by encouraging extensive criminal networks of supply. The greatest beneficiaries of the drug laws are organised crime say the legalisers (Nadelman 1995: 325). Not only does prohibition increase crime rates, it increases the pressure on the criminal justice system to an unparalleled degree, leading to a massive increase in the prison population with little or no benefit to anyone, including the offenders or the criminal justice system. Legalisation would reduce criminality, reduce the use of drugs and improve the quality of urban life, i.e. by removing drug markets and their associated evils, such as prostitution, as well as police corruption and so on.

Finally, prohibition increases health risks. Critics of prohibition say amongst the most dangerous consequences of prohibition are the harms that arise from the unregulated nature of illicit production and use such as health risks, especially HIV/AIDS, but also from hepatitis, not to mention the deaths caused by overdoses when there is no control over quality and amounts. The costs, both human and economic, take up a disproportionate amount of health care resources – better to spend these on drug treatment say the legalisers. Prohibition promotes health risks. Legalisation would make drug use less risky, promote better health and consequently lower death rates (Department of Health 2001).

The two major sets of arguments

These five points provide, I think, the main thrust of the legalisers' position, at least and in so far as it is possible to summarise such a wide ranging set of arguments promoted by a wide ranging set of

critics. However, taking an overview of the debate it is possible to distinguish two major themes – the first a moral and philosophical one, and the second, more sociological, and criminological, or what is often called 'consequential' but which is basically utilitarian.

Moral rights

What can be called the 'moral right' argument is about the right to use recreational drugs as an essential freedom in a democratic society. This is less dependent on consequences and more so on the basic assumption from which all else flows and the validity of the analysis, but of course it cannot escape the consequences entirely. Unless, that is, one accepts the views of Thomas Szasz (1974) that drug control is itself an illegal activity and the consequences are irrelevant. He is not concerned with the size of the prison population, corrupt officials or the like, only in the merits or defects of the argument in which he likens prohibition and the outcrop, the 'War on Drugs', to heresy laws. That prohibition promotes factually incorrect anti-drug propaganda, extols severe punishments, and denounces drug dealers in ways that resemble ancient methods of hunting heretics (see Kleiman and Saiger 1990: 534; Szasz 1974). In a less strident form the debate as set out by Douglas Husak (1992) is no less interesting and starts from a similar premise, asking a similar question such as whether the state has the legitimate authority to punish those who use drugs recreationally? Like Szasz this is not a utilitarian argument but a rights-based one, where the object is to identify the moral rights of adult users of recreational drugs (*ibid*. pp. 1–8). This clash, between a rights-based strategy and a utilitarian one, dominates thinking. Yet irrespective of any conclusions about legalisation, one merit of this debate is that it draws attention to the danger of following uncritically the views of majorities, in particular their fallibility and over eagerness to take their own preferences as the true measure of what is right and good (Kleiman and Saiger 1990: 536).

If I can summarise Husak's position I think it is thus;[2] the central question, he says, is 'whose rights' are violated by recreational drug use? Of course every genuinely harmful act must be a violation of certain rights, but if a violation occurs only in limited circumstances, as he claims with drug abuse, then prohibition turns out to be an unjustified exercise of state power over individual liberty (1992: 166). And these harmful acts, he says, invariably concern irresponsible rather than serious behaviour, and although undesirable they are not sufficient to justify criminal legislation. But what if drug use leads

directly to crime? If it did then the case for prohibition is obviously strengthened, but Husak doubts if it does and as has been shown earlier in this volume (see Chapter 2) he is correct in this assertion. The link is tenuous at best.

What of harms to one's self? Most users do not come to harm but for those that do Husak sees such harms as regrettable or unfortunate, but not a matter for criminal law. It is no business of the criminal law to concern itself in such matters, and where it does, as in so-called 'morals offences', it almost always makes things worse. Should legalisation lead to an increase in use then so be it. Whose rights are being violated if another person decides to use drugs when he did not use them before? Husak's conclusion is that the arguments in favour of acceding that adults have a moral right to use drugs recreationally are more persuasive than those in favour of prohibition.

Summarising Husak's position in this way does little justice to his carefully argued account that begins with the proposition that drug use is a recreational activity. He is of course correct to say mere dislike of an activity is not sufficient warrant to introduce legislation, and also correct to say we should not accept uncritically many of the more popular assertions that hold sway, namely that drug use always leads to severe social harms, without specifying what they are or their extent. What Husak requires is that we become clear about the justifications for banning certain substances – the more so when other recreational activities, equally dangerous, go unpunished or are even lauded. Confining himself to this type of philosophical argument is a strength of his position as he does not dabble in matters which are beyond his remit, but of course the utilitarian consequences of legalisation cannot be brushed aside. And these utilitarian consequences, especially those concerning a likely increase, are as critics point out never far from the surface.

Husak says that in order to ban the use of a drug it must meet certain conditions, one of which is it must lead to the harm of others. However, that harm must be serious, it must be more than a harm which is unpleasant, or must lead to an activity that is simply disliked. A recreational drug which adults would not have a moral right to use would have to be one which would increase the likelihood that users will cause serious harm to others, and that harm must be shown to be a direct result of the drug, i.e. not a spurious or circumstantial connection. Also, that drug must cause a significant number of users to commit offences (harms) and there is little anyone can do to decrease the probability that its use causes harm (1992: 208). Some drugs meet those conditions – Husak talks of

drugs used to 'brainwash' captured soldiers – but he also concedes that crack/cocaine might come close, whereas heroin would probably not as its use does not lead directly to crime. Husak sees systemic crime as a major consequence of prohibition, which he believes would decrease initially and would ultimately vanish once drugs were legal (p. 206).

But would it? How can he be so certain? What he emphasises is the importance of rights, sometimes coming close to asserting a natural right to use recreational substances, and accordingly he gives less prominence to utilitarian consequences. Of course reducing the problem to 'harms' is essentially a utilitarian position, and one which Husak eschews, but this is the corner in which he indeed puts himself. The utilitarian question remains and becomes: 'Does the impact of prohibition create more harms, and harms of a significant nature than would legalisation?' Bentham argued that individuals when left to themselves will pursue their own happiness at the expense of the community, and the only way to reduce potential harms and benefit the community is through sanctions, both moral and legal. That being so, there is no apparent contradiction between the utilitarian position and fairly restrictive drug legislation.

Measuring harms in this way is not easy. It is necessary to disaggregate the harms created by the use of the drugs from those created by the control system – an almost impossible task. Legalisers claim to do this, heaping almost all the defects at the door of prohibitionists. But is this correct? The closest we can get to a legalised drug world was in Britain in the 1960s when under medicalisation heroin, cocaine, methedrine (an amphetamine) and even cannabis were available on prescription. This was not a crime-free period, nor free of overdoses, nor of public health problems (including hepatitis from non-sterile needles). In spite of claims by the legalisers, and that includes for these purposes the medicalisers, that such problems would somehow mysteriously melt away, the 1960s produced a considerable number of such harms and did so in such quantities that prohibitionists might easily say were endemic to drug use and would exist irrespective of the control system used to manage it. In the 1960s the extent of harms was such as to require massive restrictions on the prescribing practices of most physicians.

Reducing harms

Would legalisation reduce harm? Assume for the moment that the 1960s were irrelevant in that we have moved on over the last 50 years

or so – would a new legalised world be harm free? The impression gained from legalisers is that it would; existing harms are seen as the responsibility of prohibition. In the light of such optimism I have separated this question into three main categories, with of course their various subdivisions, which taken together all add up to the main question which I think legalisers must answer. First, what types of commercial systems would emerge were legalisation to be successful? Second, what would be the likely increase in usage, including its impact on health and other services? Third, what evidence is there that crime and any other associated problems would be reduced? I want to answer these using a utilitarian argument, i.e. assessing the impact in terms of harms and not according to moral rights.

(a) The commercial system. First, what commercial system would emerge if drugs were legalised? This question has to be answered by including within it a reference to juveniles, unless, that is, it means that anyone of whatever age could buy drugs? Or would purchase be restricted to adults? These questions pose serious problems for legalisers; most simply hedge round them. It is after all easier to debate the position of grown-up, responsible adults than to grapple with that of children. Husak, for example, is concerned to 'understand the best principled reasons for denying that adults have a moral right to use any or all of recreational drugs' (1992: 5) and Ostrowski (1990; 1992) produces a very coherent argument along similar lines – that adults have a right to self-ownership of their bodies – but neither of them do more than briefly mention the problem of juveniles. Transform talks of 'positive education and supply constraints' for the young to inhibit their use, but does not spell out what these would be (Transform 2005).

Yet are juveniles (children under the age of majority) to be prohibited from purchasing substances, or are they to be allowed to do so in the same way as adults? Juveniles are of course in a unique position, not just because they are vulnerable but because most drug users start taking drugs as children. But if legalisation applies to juveniles, i.e. that every drug in whatever quantity and potency should be available for purchase by anyone, regardless of age (unless presumably that drug meets Husak's conditions) we have an urgent set of moral problems to consider. I cannot believe there are many legalisers keen to extend the freedom to use recreational drugs to such a group. After all, we restrict juvenile recreations in all sorts of ways, whether through their reading material, or where they can go, about what they can see in the cinema through film classifications, or about what they can drink, smoke, or wear. It would be bizarre, and

an act of great folly, to permit children unlimited access to substances such as heroin and cocaine, and wholly hypocritical when at the same time we restrict their access to so much else including alcohol and tobacco.

And for adults does commercialisation mean unrestricted access, or does it mean something akin to the regulations controlling patent medicines or alcohol? Whichever is adopted it means some form of prohibition, albeit different from that at present, but prohibition none the less and in its own way involving sets of rules. (Legalisers sometimes give the impression that legalisation means a drug world entirely free of controls.) And presumably, as before, those violating the rules would be prosecuted. In which case one can see how some current problems would simply appear under a different guise. There might even be illegal markets, which may differ in scope and intensity from those nowadays, but they would be illegal none the less. And incidentally, I am also assuming at this point that certain occupational groups, such as train drivers, airline pilots and the like will be tested for drug use, and that there will remain an offence of 'driving under the influence of drugs'.

And would all controlled drugs be legalised, including LSD, cocaine derivatives (including basuco, a highly toxic derivative of cocaine) and amphetamines (including 'ice')? Or would legalisation begin with, say, cannabis and Ecstasy, them move piecemeal to include heroin and cocaine? Presumably, the ardent legaliser would go for the former, athough I suspect most others would opt for caution. But this still raises complex questions which concern the sale and marketing of erstwhile controlled drugs. A number of models are possible. The first is for the drugs to be sold under the same auspices as patent medicines which are controlled under the Medicines Act and purchased as over-the-counter commodities. If so, then they would be produced, sold and marketed by commercial enterprises that were able to advertise, set the price and establish accepted levels of potency. Companies would then aim to increase sales through competition, and would be expected to pay taxes on the profits, in the same way as opiate derivatives such as codeine are currently produced and marketed. In this model there would be few restrictions on consumption. Another model is like that for alcohol or tobacco, both accepted as a grudgingly tolerated vice, i.e. with restrictions on the purchaser (Kleiman and Saiger 1990: 545). If so, then there would be restricted advertising, accompanied by high revenue taxes and controls over quality. Of the two models I suspect

the second would be more favoured, but that still involves a number of restrictions on its sale and use.

Even so, there is an irony about legalising drugs by using an alcohol model when there is increasing concern about levels of alcohol consumption especially among the young and the 'yob' culture created by binge drinking. And another irony too about the pressure to legalise cannabis when more and more restrictions are imposed on tobacco smoking in the belief that increased controls will produce less consumption. That apart, drug legalisers in so far as they have set out details of their programme, appear to want to move drugs along a spectrum of regulated statutes in the direction of increased availability (Kleiman and Saiger 1990: 541). The more enthusiastic the legaliser, the more the drugs would be positioned at the available end of the spectrum. The less sanguine might be more selective, perhaps retaining controls over some (basuco, or perhaps crack/cocaine) but not others.

(b) An increase in use. This leads to the second question about an expected increase in use. In saying that the problem of drug abuse is the problem of prohibition, legalisers fail to recognise that prohibition may actively keep the drug problem lower than otherwise. Prohibition in the USA dramatically decreased alcohol use, while repeal just as clearly increased its use (Kleiman and Saiger 1990: 542). Everyone seems agreed that legalisation would lead to an increase in use. There is no dispute about this, it is the one area where there is agreement with ample evidence to support it – all supply countries have high rates of use. For example, Nadelman (1995) agrees there will be an overall increase but plays down the dangers, believing that a well-designed and implemented policy of controlled drug legalisation would not yield costly consequences (p. 329). What levels of use would be regarded as acceptable, and what unacceptable? (This raises the awkward question if an increase leads to an unacceptable level what to do about it? Return to prohibition? Or something else? Reprohibition would be a difficult and expensive option.)

The trouble is that no one is sure of the extent of use after legalisation, especially a possible increase. The number of drug users who are dependent when a drug is illegal tells us little about the numbers or percentage increase or decrease of those dependent when it is legal. Assume a 10% increase in heroin and crack/cocaine use, a not unreasonable assumption albeit offering a conservative estimate none the less. This would produce an accompanying set of problems, some long term, some short term. The long term would represent

an increase in chronic use, and the short term would place pressure on public health and treatment services. We cannot assume that the present level of use is at saturation level. And what if that led to a 10% increase each year, how long before rates of use and chronic use became unmanageable? The recovery rate will always be further down the track, sometimes in excess of ten years from start up.

Assume we had a model not dissimilar to that for alcohol, that is with some restrictions on its use for juveniles but fewer for adults, involving restrictions on the purchase of drugs in supermarkets and the like. I know of no legalisers who would openly opt for this model, but they often imply something like this. If so, then might we not create a problem the size of that for alcohol. If we did that would be an unmitigated disaster (Kleiman and Saiger 1990: 542). And that is quite likely. For some drugs the rates of use may perhaps be higher than the 10% expected, and some may be lower. Crack/cocaine may be higher; we know that about one in six of all crack users become heavy users, and were this to continue under legalisation then we would have a crack/cocaine problem of some magnitude. Of course these calculations might turn out to be wildly inaccurate, grossly overstating the case, but they might not. Alcohol use is already at levels where governments are expressing concern. It is highly likely that crack/cocaine use would reach similar levels, and heroin too. These are not scare-mongering comments, but entirely reasonable conclusions given the current predicament with alcohol.

And if there is an increase will it fall on specific areas of the population or be an increase generally? The point has been made earlier that critics of legalisation say it would fall disproportionately on inner city areas and on the young, and the ethnic minorities, especially those with poor work records and an equally poor social and economic prognosis, but again of course no one knows. Critics of legalisation say this represents a programme of social management and control legitimating the chemical destruction of an urban generation and culture. On the other side supporters of legalisation see the failings as being offset by an increase in freedoms, and as the price, necessary at that, to be paid for additional liberty. That may be so, but it is also clear that there would be additional harms accompanied by legalisation, thereby challenging the oft-quoted view that prohibition produces nearly all the harms and legalisation would free us of them.

(c) Health problems. What additional health problems would such an increase bring? Again we cannot assume there would be a reduction in, say, death rates simply because the drugs are legal. Again, to use the 1960s as an example, when medical prescribing was at its

peak death rates were high with overdoses common, often caused by novice users unaware of the potency of a drug. Medicalisation did not produce the hoped-for benefits; it might have guaranteed a certain quality of heroin but it still led to a high death rate and there is no reason to suggest it would do otherwise again. The Advisory Council on the Misuse of Drugs (ACMD 2000) noted that controlled drug-related deaths have been increasing since 1980, and in 1998 were eight times the 1990 level. It found that heroin and methadone were of 'substantial significance' and neither medicalisation or prohibition had produced the hoped-for benefits.

Current health problems are bad enough, but an increase would be frightening. What we know from studies on the health of current users is that nearly two-thirds (64%) report physical health issues and 50% mental health issues, in addition to drug misuse (see Bean 2006). Small-scale surveys on drug users living on the streets, usually begging (or 'panhandling', to use the American terminology), report even higher rates. They show users have severe health problems and a poor prognosis. Over the years their major organs will have suffered and their immune systems will have been damaged. If they inject, and almost all street drug users do, they are at risk from HIV/AIDS or hepatitis. Irrespective of the types of drugs taken, the extent of their use, or whether from prescribed drugs such as heroin or methadone, the risk always remains that users may suffer from a range of health problems such as respiratory irregularities or poor dental hygiene (for example, methadone has a high sugar level which damages teeth) or excessive weight loss and muscle wasting, alongside other diseases related to a chaotic lifestyle and poor and erratic nutrition (Bean 2006).

Women face the same health problems as men – they share the same risks and dangers from similar chaotic lifestyles, except that some women face greater risks; for example, the lifestyle associated with crack/cocaine use often includes physical abuse and outright violence. Medical complications go undetected and untreated, especially amongst prostitutes who are at a high risk of cervical cancer with a history of sexually transmitted diseases. Pregnant women not only have their own health problems but risk transferring them to their unborn child. Maternal drug abuse may affect a child at every stage of its development: the utero-ovarian environment may not be optimal, the neo-natal period may be complicated by a drug withdrawal syndrome, and if substance abuse continues a child's physical and emotional development may be adversely affected by growing up in a drug-taking environment. It cannot be assumed that

these health risks will disappear when drugs are legal. However, assume that users are more knowledgeable about public health matters than before and there is a reduction in health problems. This of course would produce an important advance and a net benefit for the legalisers. But can we take that chance?

(d) A reduction in crime. What of the suggested reduction in criminality? This is often presented as the most important contribution legalisation would make, that legalisation would lead to an immediate reduction in organised crime, illegal possession and so on. Legalisation provides no role for illegal suppliers or for the economically compulsive users where in Transform's terms it is all a matter of economics. 'Illegal drugs are expensive, legal drugs are not', and 'Legally regulating drugs will largely eliminate the problems associated with illegal markets' (Transfom 2005).

Is this anything more than unbridled optimism? Might the situation be a little more complicated than that (Bennett 1989)? Transform believes that systemic crime would decrease, perhaps vanish altogether; a presumption based on the view that prohibition leads to criminality, as it did during the Prohibition period in the USA, with American prohibition cited as the paradigm case. But this is plainly wrong and any comparisons are inappropriate. American prohibition occurred in different times and with a different substrata of control, and surrounded a drug that was more than a recreational substance but also used in ceremonies, celebrations and so on, rather than used to alter individual perceptions and moods. Kleber and Inciardi (2005) say there were two important differences between Prohibition and today's system of drug control; that Prohibition was a form of decriminalisation in that it permitted personal consumption, but that more importantly it ceased to have public support, unlike modern drug laws which do have support. And they add one should be wary of accepting Hollywood's guns and gangsters depiction; there was a higher rate of increase in homicide in the period prior to Prohibition than during it (p. 1392). That apart, would systemic crime vanish or be reduced following Transform's predictions?

Almost certainly not, although some of it might, but it is equally possible that other problems would arise. There are two sorts of crime to be considered – criminality from illegal possession or supply, and that related to psychopharmacological, economic and systemic crime as defined in Chapter 2 previously. The assumption is that both would be reduced (or would vanish) with legalisation. But they are different and each requires a different form of analysis, although they do sometimes overlap.

Assume the costs of illicit supplies of, say, crack/cocaine are about ten times higher than could be sold legally. Therefore, if the legal price dropped that might go some way to removing the illegal markets, although I remain deeply suspicious that large-scale drug dealers would abandon such a lucrative exercise quite so easily – I simply cannot see them walking away from their markets in this way.[3] But for these purposes assume they would do, and so also assume that levels of systemic economic crime and the like also reduce. That, of course, would be an advance. But a fall in price would mean an increase in use, perhaps of a substantial nature, and with different drugs posing different problems. Again, legalisers talk in somewhat blanket terms about legalising drugs as if they were all the same. But the likely increase in cannabis use would be of less significance than a similar increase in heroin or crack/cocaine use. Nadelman (1995) accepts that different problems would arise for different drugs, and accepts also that the dangers associated with cannabis are less than those for heroin, but tries to soften any objections saying that for heroin the problems are not as great as many think (*ibid.* p. 329). Yet an increase in heroin use will produce an increase in addiction, with long-term consequences, whereas the problems from an increase in crack/cocaine use are slightly different, although what would be the social effects of large numbers of so-called 'crackheads' one can only guess. Cannabis is different again, probably producing fewer long-term consequences but consequences none the less. All this must be offset against any saving, financially and otherwise, on law enforcement and other harms. Moreover, legalists have to show what they would do if their policies failed. We are entitled to know that before embarking on their experiment.

On the other hand, if the legal price was kept high (say near its current illegal price) dealers could easily undercut it and there would be the same problem of illegality as under prohibition. We might then have the worst of all worlds – high use and high crime. And if that happened, what of an increase in both types of crime? The point to be made here is that the price of a drug is an important factor in its future use, almost as important as its legal status (Kleiman and Saiger 1990). It makes little sense to say that because a drug is no longer illegal all its attendant criminal baggage will somehow vanish. It will continue to be bought and sold in markets – illegality keeps the price artificially high, or at least higher than it would be otherwise. And price also determines the extent of consumption; alcohol is a case in point. To believe the crime problem would mysteriously vanish is both naïve and dangerous. A decision to legalise should not be based

on the belief that prohibition is the problem, but should be about the price of the drug and the corresponding likely consequences of change, i.e. whether the harms created by change will be fewer and less damaging than those existing by retaining the *status quo.*

What the legalisers also fail to consider is the novice or first-time user. Where will he/she get drugs legally and continue to get them until addicted? Would the novice be able to go to a medical centre and ask to try some heroin, crack/cocaine, or cannabis? Of course not, but that means first-time users must buy through the illegal markets. In the 1960s this was from 'registered' addicts selling surplus supplies and creating 'spillage', which explains why so many 'registered' addicts were in Brixton prison at any one time. And an increase in users means an increase in criminality, of illegal possession or supply, unless of course we opt for a Dutch type of model where the amount sold in single doses is regulated but supply remains a crime and where the police only bother when there is a public outcry. And what of psycho-pharmacological crime? That presumably will continue for all users whether novice or not.

These three sets of questions form the central core to the debate. Many claims are made that legalisation will solve the drug problem, or if not solve it then reduce most of its harshest features, with claims to lower its size, costs, health risks and crime levels – all central to the legalisation position. My view is that these claims are often presented as simplistic solutions, in terms which suggest they are glaringly obvious to anyone who cared to look and with legalisation able to produce instant rewards. But this is not so. There are dangers which need to be recognised, with harms that need to be acknowledged.

An assessment

How to assess the position and arrive at a conclusion? Consider first decriminalisation. Some would see it as a step in the right direction; a compromise perhaps between prohibition and legalisation. Not so Husak (1992: 210). He sees little value in this utilitarian argument. If drug users have a moral right to use drugs, as he insists they do, then drug users should be no more fined than they should be imprisoned. Decriminalisation is not an option, it only becomes one by adopting a utilitarian position, where the harms created by the punishments are greater than from the drug use. And Husak is not a utilitarian. On the other hand, retributivists might support decriminalisation on the grounds that existing punishments are too severe. The retributivist

case might well be that possession of small quantities of cannabis does not deserve a prison sentence or a stiff fine. A small fine or a caution would be more appropriate. They might say dealers are different and deserving of stiffer penalties. Retribution offers a case warranting no less consideration than any other.

Decriminalsation is rarely offered as a solution, more a compromise between the ardent prohibitionist and the equally ardent legaliser. Some decriminalisers appear to accept the prohibition framework, but want to soften penalties. Others want to decriminalise drugs because existing legislation brings users into the criminal justice system who are otherwise not criminal (an argument, incidentally, that I have great difficulty in accepting. What is so special about drug taking that makes those who break drug laws qualitatively different from other offenders? Why not give shoplifters, bank robbers or other offenders similar privileges?). And others see decriminalisation as that step towards legalisation, usually beginning with cannabis and hoping to include other drugs later. If so, they may be disappointed. Fears are already being expressed that changing cannabis to a Class C drug was a move too far.

Medicalisation is occasionally fostered as a viable model. Transform supports what it calls 'legally regulated drug markets', which it says involve users taking legal drugs in supervised centres (in effect, controlled medicalisation). Transform seeks 'the introduction of appropriate legal regulation and control of drug markets which are currently under criminal control' (2005: 15). It claims that such a system would have immediate and positive effects, including a 'dramatic drop in crime at all levels … a 30%–50% drop in the prison population … [and] removing the corrupting and destabilising influence of illegal drug profits and drug cartels from producer and transit countries' (Transform 2005). It is difficult to treat such claims seriously, especially a reduction of such magnitude in the prison population. And how were such figures arrived at? Where is the evidence to support them? And what of any unwanted side effects of legalisation? Their case is weakened by such exaggeration.

Worse than that, what is a 'legally regulated market'? If it means prescribing heroin or methadone this is done already. If it means drug users taking their drugs in supervised conditions then this is all well and good, as long as they can be persuaded to come to such centres. But they may not. What then? And how do you 'legally regulate' such a market, specifically a crack/cocaine market? Do you buy the cocaine from cartels in Columbia and change it to crack before giving it to users? Mary Ann Sieghert, writing in *The Times* (14

December 2006), seems to think one does. 'Unstable countries such as Afghanistan and Columbia, which have become almost ungovernable thanks to the distorting and corrupting effects of the drugs trade could sell their products legally to Western Governments for medical use'. (That they are ungovernable in part because high levels of availability lead to high levels of use seems to be forgotten.) Can it really be that simple – cartels to change from illegal distributors to legal suppliers?[4] And the Ecstasy market, the cannabis market, and all the other markets related to illegal drugs, how are these to be regulated when Ecstasy, for example, is usually taken in clubs and bars? Does a 'legally regulated market' mean all such drugs are to be made available whenever and wherever they are requested? If so, this hardly makes sense.

And harm reduction? This is difficult to resist if it means no more than reducing the harms of drug use. It aims to soften the impact of drug abuse, whether in terms of health, social or criminological consequences, but as such it is a principle rather than a programme (Kleber and Inciardi 2005: 1383). It becomes a programme when there are underlying aims such as a move towards decriminalisation or legalisation – there is never a suggestion it should move towards greater prohibition, but there is a suggestion it should remain within a prohibitive framework and ameliorate such adverse conditions as may appear, e.g. encourage the use of sterile needles. Ever the 'buzz' word, it has caught the eye of the current government (it is called 'harm minimisation') which wants greater attention paid to reducing drug-related deaths. And under the heading 'What Works?' the government says harm minimisation does work with provisions such as needle exchange schemes, the early identification and treatment of blood borne illnesses, and access to primary care services all helping to reduce the risks arising from drug misuse and the risk of drug-related death (HM Government 2005; House of Commons 2002a: 3, 5). Harm reduction can work with and alongside prohibition yet clash with it too, in the latter case when its provisions may soften the deterrent effect, e.g. by providing free sterile needles and thereby appearing to encourage users to inject. In the former it can assist with providing treatment, especially by working with governments to encourage high rates of take up and by keeping users in treatment programmes.

But it is the clash between legalism and prohibition which produces the major tensions and the most interesting debate. Which one is correct? If the legalisers are correct then we have wasted enormous

amounts of resources, human and otherwise, on an expensive and failed policy, as well as placing vast numbers within a criminal justice system when they should more realistically be seen as having a health problem. If the prohibitionists are correct, legalisation would be a dangerous experiment costing the lives and health of countless new users and producing a drug problem of fearful dimensions. These are not hyperbolic statements but realistic sets of alternatives.

Where then does this leave us? And the answer is that in my view the case for legalisation has not been made. Husak, for all his claims as to the rights of adults to use recreational substances cannot escape utilitarian consequences nor the demands and expectation that a prime duty of the state is to grant protection to its citizens. Drug abuse is not just an adult occupation: the peak starting age is 15, so that by the time they are adults many users will be steeped in the drug culture. Juvenile use is a massive problem, and debating the rights of adults simply walks around it.

Nor are there clear-cut proposals on the commercial features to follow legalisation. Numerous models have been suggested with none being satisfactory, for rarely is there a set of detailed proposals showing how the system would work. Too often the legalisers operate according to underlying assumptions that all will be well when drugs are taken out of the hands of the criminals and are given to the medical profession or other suitable professionals. All the evils will somehow be spirited away. That is not good enough. Nor have legalisers sought to give a detailed account as to how the medical profession would fit into any programme. It might not want to act as a crime prevention agency; some critics of the present system are already questioning the profession's role in prescribing methadone. They may want to opt out altogether. Medical prescribing is not treatment, more likely a dubious form of crime prevention. It is difficult to see how it would be acceptable medical practice to prescribe crack/cocaine to novice users, or even persistent users, and what of cannabis or Ecstasy? Where would users get these drugs? From a doctor resident in a club or bar? Of course not, but these questions need to be answered before legalisation offers a possible or valid alternative.

Of course critics of the existing system are correct, the current system falls well short of what is required – and the criticisms made throughout this volume are testimony to that. However, it is also the assumption that legalisation would somehow solve all these problems including a reduction in crime which gives cause for concern. On

what basis are these assertions made? And the answer is, as Husak and other legalisers would volunteer, because legalisation will be expected to remove the need to buy into criminal networks. But I want to emphasise this point even at the risk of repetition, where do I get my first fix of heroin? From a medical doctor? Unlikely. And my first piece of crack/cocaine, my first joint of cannabis and my first Ecstasy pill? Equally unlikely. The demand will create the market. And is it a serious suggestion that drugs will no longer be sold in criminal networks and always, or nearly always, be sold in legally regulated markets? When I am addicted to heroin, or become a regular user of a drug of choice such as crack/cocaine, will that be available on prescription? Or will I be able to purchase it in a chemist's shop, alongside Ecstasy or 'ice'? And if it will be available there, and for all the reasons mentioned earlier, will all the illegal suppliers have walked away from their markets? Of course not. No one abandons such a lucrative enterprise so readily. It will take a genuine reduction in demand, not competition created by medicalisation, to halt that.

It is the unbridled optimism of legalisers that is worrying. If the number of users increased alongside other drug-related problems reprohibition would be difficult and expensive and would take many years before the results began to appear. In my view the risks are too great when set against such a poorly argued case. But, of course, that does not mean we should be pessimistic about the current position as there is much that can be achieved. For example, prohibition can and should be linked to forms of harm reduction, especially those involving treatment, alongside an increase in economic opportunities and development. Harm reduction programmes based on an increase in educational provisions are also to be welcomed, the latter involving the persuasion that drugs are socially, economically and morally damaging, that health and happiness do not come out of bottles, that buying drugs helps foster and finance violent and ruthless sellers, and that the solution can only be through a reduction in demand. Or alternatively, constant vigilance should be given to reviewing sentencing practices with the aim to decriminalise if excessive. And as we still prescribe heroin to users, then let us review this and evaluate its outcome, and if it does prove successful then let us increase prescribing. These are not dramatic and instantly appealing programmes, rather a more measured response to a set of complex problems. But no less worthy for that.

Notes

1 The Control system set out by the Single Convention 1961 states 'The use of narcotic drugs is authorised only on medical prescription, or by medical administration, or for scientific purposes. The economic activities prior to consumption – possession, trade and distribution, and especially, import, export, manufacture and cultivation – can only be carried out by a Government agency or under Government licence or other legal authority. Import and export require Government authorisation and all activities are subject to continuing Government supervision and stringent record keeping systems. All persons engaged in regulating activities need adequate qualifications. There are restrictions on the number of countries permitted to cultivate the opium poppy and conditions under which cultivation may take place.' The Control system under the 1971 Convention on psychotropic drugs is similar to the Single Convention except it provides greater flexibility for each Government. *The Single Convention on Narcotic Drugs*, 30 March 1961, No. 6928, and *The Convention on Psychotropic Substances,* 23 February 1971, No. 9725 (UN Publications).

2 Brief summaries are always likely to distort what is otherwise a well worked out position, and it is difficult to provide a concise and accurate summary of the argument as presented by some philosophers such as Douglas Husak, for in his hands the argument is derived from a set of finely-tuned legal and philosophical principles based on moral rights and not utilitarian harms. I hope I have done justice to these in the text.

3 An editorial in *The Times* (24 November 2006) says much the same. 'It is tempting to hope that legalisation might cut out much of this violence and crime by removing most of the profit margin from the drugs barons. However, while the legalisation lobby makes a persuasive case, there is a lack of clarity about how exactly its ideas would work in practice. If harm reduction is the aim, can one be sure that harm reduction would really be achieved? Reducing prices might remove incentives for criminals to supply the market. But would it not also result in an increase in addicts, because drugs would be even more available more cheaply? Would the act of legalising in itself send a powerful signal that Parliament is condoning drug taking? And might regulated companies acting above-board not be even more effective at marketing those substances than the drug barons have been, with their access to more conventional methods of advertising?' I hope many of these questions have been covered here.

4 What *The Times* describes as a 'A Foreign Office Minister lets rip', Kim Howells said 'Its not enough to assume that if you eat muesli and go to first nights of Harold Pinter that the drug barons of Afghanistan are going to go away'. This Minister was not the first to mock the naivety of the chattering classes. In a similar outburst years earlier, the American Drug Czar made similar comments.

Chapter 11

Suggestions for the way forward

If there is a general sense of gloom surrounding the drug problem in Britain, that view is misplaced. There is nothing inevitable about the current level of substance abuse, dire though it may be; we do not have to live with high levels, any more than we have to live with high crime rates. There are a number of things we can do but most require changes in the way we do things, and change is not always welcome. Resistance can come from the unlikeliest quarters. For example, American judges in drug courts often say they do not believe British judges and magistrates will adopt the necessary procedural changes required to introduce drug courts in the UK. They could turn out to be wrong, as the Scottish and Irish examples may to some extent prove. Resistance to change may come from other quarters such as those involved in treatment who, on the face of it, would be expected to support greater measures of treatment for offenders. Or, that partnerships will be unwelcome because some criminal justice organisations are reluctant to set aside their ideological differences. Change means more than making adjustments to new ideas, it means accepting changes in status and influence.

One matter not covered throughout is that of solvent abuse. These solvents are not covered by the Misuse of Drugs Act 1971 and so strictly speaking lie outside the boundaries of this volume. This does not mean they are not a problem. The Institute for Public Policy Research in 2005 found that the numbers of young people (aged 11 to 15 years-old) sniffing glue rose from 28,000 in 1998 to 168,000 in 2005. That also in 2005 about 144,000 young people sniffed stimulants,

with a death rate of about one young person per week and with a total of about 2,000 deaths in the last 30 years, with butane lighter fuels being responsible for more than half the deaths (*The Times*, 4 November 2006). It is difficult to see how these substances can be regulated as it is said in the average home there are more than 30 abusable products, and from my experience of solvent abusers it is mightily difficult to get them off a substance once they begin abusing it. Solvent abuse requires a separate study as it is too important to be consigned to a footnote such as this.

The 1960s and beyond

Writing in 1974 on the links between drug taking and crime, I remember saying then that the relationship was complex and the research evidence inconclusive, at worst poor, and at best was able to identify only a small number of the many strands that made up the debate. Few attempts were made to establish a causal connection between the two morbidities. Today, looking back over the last 30 years, it seems we have not moved very far forward, except perhaps we now have different pictures of the drug users, and this may not be an advance. Then, drug takers were seen as victims of social and psychological pathologies. Now, they are more likely seen as predatory criminals (not entirely, but the image of the drug taker as predator would likely be dominant). Changes can be seen in small things, such as the way drug takers are now encouraged to receive treatment, not for therapeutic benefits but to stop them taking drugs. The emphasis is therefore less sympathetic now.

In addition, in that earlier period few specific questions could be formulated, so wide and vast appeared the subject and so limited was our experience. It was an entirely new problem for Britain. One question that has emerged and which remains uppermost is the links with crime. Back then the debate, such as it existed, was dominated by the rights and wrongs of the maintenance prescribing of heroin or cocaine. Did prescribing reduce or encourage criminality? The answer then (as now) was that it all depends. On what does it depend? Well, it depends on whether the drug user is 'basically criminal' – the term derived from America in the 1930s when Commissioner Anslinger said 'it was the criminal type who became the addict'.

In Britain in the 1930s the crime figures showed drug takers were not given much to criminal activity, but this had changed by the 1960s when prescribing was at its height. This was the peak of the

British System medicalisation type model. Then, Ian James the prison medical officer at Brixton Prison found that at any one time about 200 addicts were in his prison, which represented about one quarter of all known male heroin addicts. He noted too that most of these addicts sold their prescribed drugs, later buying them back having used up their personal supplies. He described most addicts as 'full time addicts whose daily routine was scoring and fixing, allowing no time for anything but casual work' (quoted in Bean 1974). They had no regular employment, presumably supplementing what they had through crime. Yet (and here was the essential point) others, about half, were also prescribed heroin and cocaine but were not criminals, whether before drug taking or later. It is this non-criminal group of drug users, especially those taking heroin or cocaine, who undermine any argument about the inevitability of the links with crime.

In the 1960s the general consensus was that about 40% of heroin addicts were 'basically criminal', defined as having criminal convictions prior to drug taking. Then, unlike 40 years later, drug takers came from two distinct groups – one representing lower social class backgrounds, whose members were antecedently delinquent before drug taking, and the other drawn from higher social class members who were not. The former group saw drug taking as an extension of their deviant lifestyle, while the other saw drugs as the extension of a world view that was influenced by writers such as Aldous Huxley where drugs provided new forms of spiritual salvation. These two groups remain. The difference then was that the middle-class group dominated, now it is that group made up of those who are 'basically criminal'. There remains, however, a sizeable middle-class group who take drugs to enhance social relationships and to produce more intense psychological experiences. For these users cocaine remains the 'champagne' drug. These are in addition to the so-called 'recreational' users who take Ecstasy and cannabis occasionally. Nowadays, terms like 'basically criminal' or 'ideologically motivated' – the latter for the middle-class group – are not used. Others are preferred, but they simply put a different label on the same product.

In the 1960s no one spoke of traffickers, or thought of dealers as importing drugs into Britain to sell for profit. The world of organised crime was alien to that period – it took place somewhere else, in Italy or the USA. Dealers, such as there were, bought and sold drugs from their friends or other users in Piccadilly Circus and the like. These were not the shadowy figures from overseas, but locals who sold their surpluses thereby creating a new group of users, who in turn found their own over-prescribing doctors and received their own inflated

supplies. In the mid 1970s, when prescribing was reduced i.e. after the introduction of treatment centres and licensed doctors, the first imports of 'Chinese heroin' appeared on the streets and with them the first traffickers and dealers in their modern form. In the 1980s the cocaine epidemic confirmed the identity of both the trafficker and dealer, and also the role of the organised criminal as a potent force in the British drug scene. Back in the 1960s the American position and policies were derided: now they are hardly distinguishable from the British.

In one respect the British system remains distinct, iconoclastic almost, in that prescribing continues, even for opiates. Controlling the prescribing habits of the medical profession remains a less than easy task, now undertaken by the Home Office Inspectorate with the assistance of the General Medical Council, but what constitutes over prescribing and its corollary of serious professional misconduct will always be difficult. During the 1960s the largest 'pusher' of drugs was the National Health Service (NHS) through its over-prescribing doctors (the heaviest over prescribers were small in number, but gross over prescribers none the less). Alongside these were another group, much larger in number, who prescribed rather more than the average. The NHS is no longer seen as an over prescriber, but over prescribing still exists. There may not be the gross over prescribing of the 1960s but there remains a number of doctors who 'prescribe rather more than the average', whether to typical drug users or to the less typical (such as those receiving repeat prescriptions for drugs such as Valium and other benzodiazepenes) and in large amounts. As before, the surpluses can be sold thus producing the same type of 'spillage' as occurred in the 1960s, when over prescribed heroin users sold their surplus supplies.

Maintenance prescribing of opiates remains, although there is probably little over presribing here. (This in contrast to methadone where the case for prescribing it as an alternative to heroin has not in my view ever been adequately made, but that is a different question.) Currently there are about 500 drug users in Britain receiving maintenance supplies of heroin. These are almost the forgotten users; no one mentions them, and no one knows much about them, yet their numbers remain steady and they continue to receive their supplies. They raise the age-old question, so dominant in the 1960s, about the role of the prescribing physician, supplying addicts with the drug of their choice. What should be the place of maintenance prescribing of heroin in any system of control? Should it be permitted, should it be encouraged, or should it be banished? If, as it appears, maintenance

prescribing is *inter alia* a delinquency prevention device, can this form of medical intervention be justified, or should prescribing be permitted only in exceptional circumstances, and if so what are they? Not much thought appears to be given to these matters, so keen are we nowadays to push drug taking into the criminal justice domain and to see the drug user as a property offender funding a habit.

There is, however, a groundswell of opinion which suggests we should return to greater levels of over prescribing – in the sense that more addicts should receive maintenance prescribing. Rarely is this view linked to the experience of the 1960s, where the system was regularly abused whether by the users or the prescribers. The lesson learned then was that maintenance prescribing must be controlled, and those undertaking the prescribing must be strictly regulated. Also, it must be understood that maintenance prescribing is not for everyone, but for those who are unlikely to seek and benefit from treatment. It is for the 'end of the road' user, not the young initiate.

Again, as far as comparisons with the 1960s are concerned, we have no reliable national database and if anything the situation has deteriorated. In the 1960s there was the Home Office Index. This peculiarly British institution was scrapped in the late 1990s, largely leaving us with the British Crime Survey, which is hardly a database. The Home Office Index was neither reliable nor valid, but it was of some value, producing interesting socio-demographic material on selected addicts over a long period. It could have been improved had there been the political will to turn it into a large-scale, national, longitudinal database, but that was not forthcoming.

Its history is interesting. It began in the early 1920s in a haphazard way when a number of addicts notified the Home Office that they were drug users and said they were receiving supplies of heroin and the like from their physicians. Other addicts followed, some asking to have their names recorded on a register. The myth of the so-called 'registered' addict was born, and was sustained throughout the 1960s and beyond. Being on the register produced no favours or privileges, but presumably the addicts thought it did, or at the very least thought it protected them in some way. In fact, it merely gave the Home Office information about the extent of drug use and the numbers on prescription (Spear 2002).

This Index illustrated the measure of trust that existed between addicts and the government in ways that are unrecognisable today. Losing that Index and trust has not been wise, for where else in the world would this happen? Where else would drug users inform a

government department responsible for their control that they had been involved in illegal activities, that they had recently used a drug illegally and wanted to change into a fully fledged protected and lawfully supplied drug addict? There were some attempts to make registration a less haphazard process. Under the Notification of Addict Regulations selected professional groups were required to inform the Home Office of users they were treating, or where they had met them in other areas of their professional capacity. This they seldom did, and mainly for this reason the Index fell into disrepute. Attempts to revive it have not been successful. As a result, a potentially valuable research and planning instrument has been lost and will not easily be revived.

Finally, and continuing with comparisons with the 1960s, the quality of research then as now was poor. It offered little help to policy makers and governments, the difference being that in the 1960s there was little understanding of the research agenda and more excuse for any shortcomings. Government policy then, as now, was based on a set of *a priori* assumptions driven by political rather than pragmatic, empirical demands. In the 1960s when drug use was rare and spoken of by only a small number of interested physicians, and a few Government officials such as H.B. (Bing) Spear, such research as existed was basic and of an exploratory and descriptive nature. There was no research tradition and little to go on, nationally or internationally. This has indeed changed; there is more of a research tradition nowadays, but whether that has intruded on government policy is another question.

Earlier research was dominated by a psychiatric world view – a fairly common phenomenon in the early stages of a new social problem. Later, as academic interest widened, other social scientists began to take an interest, but even then the range was narrow. That problem remains. For example, there are too few economists interested in drug research and too few lawyers, but rather too many of what Bing Spear disdainfully called 'policy analysts'. We badly need research on the impact of prices on drug use, on the way confiscation orders operate, on the cost effectiveness of treatment programmes and policing, and on some of the jurisprudential questions raised by current legislation. We have a surfeit of small-scale epidemiological studies showing that drug use has increased and that criminality has increased likewise, but little that sheds light on, say, the supply system or the treatment services. We have only one or two longitudinal studies able to provide data showing patterns and trends, and this is a serious failing.

We need two or three high quality research centres with guaranteed funding, undertaking a long-term research programme. Sadly, there is not the political will to push ahead with this type of programme. Instead we produce reports by committees, where the enthusiastic amateur holds sway. The journalist and the celebrity are given more credence than the researcher. It is a recipe for going nowhere except to re-examine and debate the same old questions – usually these seem to be about whether cannabis should be legalised or if its penalties should be reduced. There are more pressing questions than this: about the quality of life on drug-ridden housing estates, or the levels of violence by dealers (whether on dealers or by dealers) or the impact of drug abuse on fragile communities. Yet as long as we continue with this type of blue riband committee where members are experts in other fields, in fact in almost any other field but substance abuse, we shall make few advances. The opportunities are there. We have a government strategy, and public recognition that something must be done if the next generation is to be protected from the drug scourge. If we waste this opportunity now it may not easily come again.

Contributions from the drugs and crime debate and beyond

What can the drugs and crime debate offer to help promote a reduction in drug use? The answer is quite a lot, and in what follows I want to add to what has already been written together with the appropriate recommendations e.g. greater use of confiscation orders, better police data, and so on. We may not know much but we know a great deal more than before, and we are beginning to know what we do not know. We are also becoming increasingly aware that the problem changes daily. In the USA drug use is declining, but largely among students and the White middle classes, not in the inner cities among the Black and ethnic groups where it remains, defying all obvious and apparent solutions, wreaking havoc as before. This may be Britain's immediate future but the long term is more difficult to predict. Yet we can, if we try, affect that too.

A comment by James Inciardi and Duane McBride sums up for me the essential elements of the current position. I want to pick up some of these points throughout.

> In the final analysis drug abuse is a complicated and intractable problem that cannot be solved with quick fix approaches tended to by politically appointed boards. Deploying more patrol

> boats in the Caribbean or diverting additional high technology military hardware will not guarantee an end to or even a slowing of the war. Intercepting drugs at the border or cutting off illegal drugs at the source are praiseworthy goals but they are likely impossible ones. And pressurising source countries into compliance with U.S. objectives is also an elusive task, even when there is willingness. (Inciardi and McBride 1991: 75)

So, what then is the answer? Or rather, what is the answer in terms of the drugs and crime debate? Inciardi and McBride say that as it is impossible to eliminate the supply of drugs more attention should be focused on the demand side of the equation. For without users there would be no drug problem. Accordingly, we can expect only limited success from supply side policies, such as interdiction, law enforcement and criminal justice. That view would be echoed by John Grieve, an experienced police officer concerned with drugs in London who once said a good day for the police was a day when the problem was no worse, with such days being few and far between (Grieve 1993: 8).

Yet sound as this argument seems we should not lose the appetite for interdiction or enforcement, even if we recognise that reducing the supply side of the equation cannot solve the problem. The police are already on the back foot, as it were, and reducing their capabilities including their belief that enforcement is a worthy exercise helps no one. Of course they could do better and in the chapter on policing I have suggested ways in which improvements can be made, not least through a greater commitment to data-led policing. Also, undermining the profits by a more efficient confiscation policy would help. We should not forget Peter Reuter's comments that interdiction and supply-side prevention help push up the price and accordingly help reduce drug use. It is simply not true that interdiction is a useless exercise, as some critics would have us believe.

But before looking at what can be done, and before concentrating on the demand side, we can begin by saying what does not work. One obvious failing was a policy, now thankfully abandoned, of sending police officers into schools to frighten children about the effects of drugs. This was a popular approach of the 1970s and clearly does not work – the children often knew more than the police. Nor does the related so-called 'Scared Straight' programme work, where young people on the edge of criminality (drug abuse) meet convicted offenders (addicts) who have landed up in gaol. It creates more interest than fear, and more excitement than deterrence.

And neither, it appears, do programmes such as DARE (Drug Abuse Resistance Education), where children are taught to say 'no to drugs'. These programmes come in various forms. For example, the DARE programme in Nottingham was run by the police who teach the courses in primary schools (I would add at enormous cost, probably about £750,000 per annum), but there are other, much smaller ones run by different agencies. To say these do not work is premature, rather we do not know if these programmes work as rarely have they been evaluated, except by DARE itself which hardly gives confidence that the findings were unbiased. Some of the smaller programmes have been evaluated and whilst early results have been encouraging, the long-term effects are not yet forthcoming.

Nor have Drug Action Teams demonstrated their value. They were borne out under a typical New Labour view of the world, that a problem can be solved by throwing money at it and by seeking a new organisation to run it. The cost of DATs is enormous, but I suspect the output and value of that output are small. They have not been evaluated, but were that to be the case I suspect DATs would be found to have only limited success, and the majority of it not cost effective.

We also know what does not work in the criminal justice system. That is, we know that fining drug users, placing them on probation, or sending them to prison has little effect. For without a built-in treatment programme, and there are none for fines and few for probation and prison, we can expect few successes. And anyway, long-term street addicts are unsuitable for fines, or for probation, as indeed are almost all drug users; they rarely pay fines, and probation is unlikely to have sufficient impact. Everything we know about probation and the way it works says that it cannot be the answer for drug use. As for prison, again without a built-in treatment programme prison on its own is likely only to hold back drug abuse until release. Fortunately, there are some imaginative and successful treatment programmes in prison nowadays (see Bean and Nemitz 2004). They go some way to offset the experience of most drug users that a prison sentence merely suspends drug use rather than treats it – and often not then, as drugs are available in the prisons as well as the special hospitals (such as Broadmoor, Rampton and Ashworth).

On the other hand, *The Times* (9 September 2006) reports on a survey by the Metropolitan Police and the prison service's Professional Standards Unit on the 'sizeable corruption problem' in at least seven English Jails and says the problem 'may well be growing'. Corruption, 'whereby an officer would form a close relationship

with a prisoner that involved supplying the prisoner with drugs and contraband' would lead to 'the prisoner in turn supplying to the rest of the wing' (*ibid.*). Matters come to a head, however, when 'Over time other prisoners become jealous of the power exercised by the supplier. They pass information to honest officers which leads to the removal of the corrupt member of staff'. Sadly, that is not the end of the matter, for 'Another corrupt officer is corrupted to fill the void' (*ibid.* p. 4). In one swoop corruption undoes all the good provided by the imaginative programmes.

It will not be easy to solve such problems. Corruption, whenever and wherever it appears, is difficult to detect and even more difficult to erase. Yet in our eagerness to resolve such problems we may be tempted to go down other routes, one of which carries another sort of danger. It is that which places all else, including public health matters, above basic civil liberties. I am thinking here of preventative treatment, sometimes called preventative containment, which is used to detain drug users *qua* drug users, that is without there first being a conviction for an offence and without the safeguards provided by due process of the criminal law. Typically, preventative treatment permits detention in a hospital for as long as it is necessary to cure the addiction. In this way drug abuse becomes a public health measure; it is seen as a disease, albeit self-inflicted, which if left untreated will absorb disproportionate amounts of health resources to the detriment of the non-addicted population. Preventative treatment is widely used in the USA, especially where the drug user is pregnant and especially so when they are taking heroin or cocaine. So if left untreated, the argument goes, the patient will incur extensive health care costs, not just for herself but also for her child. Better therefore to detain early, i.e. before giving birth.

Going down that route, in my view, leads to an unjustifiable loss of liberty. I accept there are certain health care costs but these must be borne as the price to be paid for liberty. After all, we bear health care costs for other dangerous activities (riding a motorcycle, mountaineering and the like), so why not for pregnant drug users? I am aware there are precedents in that certain diseases require notification, and permit civil courts in Britain to detain a person until cured, but drug use would not in my judgement meet the necessary criteria for such a detention. After all, why select drug abuse? One suspects it is more about mere dislike than anything else, but mere dislike is not a sufficient justification for such controls. Preventative detention circumvents the normal safeguards provided by the criminal law, coming dangerously close to providing a new control system

based on behaviour adjudged on anti-social and financial terms. To misquote Brenda Hoggett, in effect this creates a special sort of crime called ‘anti-social financial disorder’. If so should we not admit to it (Hoggett 1984: 70)?

What then can be done? Or to put the question in a more appropriate form, at least for a book on drugs and crime, how should the criminal justice system help reduce the drug problem, other than through the usual demands of punishment, i.e. deterrence and detention?

And the answer is there are numerous things that can be done. I have grouped these under two main headings – integration in criminal justice and demand side reduction. In the first we can and should operate a more integrated system involving treatment and criminal justice services. There have been endless discussions about the need for integration – it was identified by the Carter Report (2003) – but little has been done. Integration is more than having lunchtime meetings with senior organisation personnel; it requires a short- and long-term effort. In the short term, to get organisations to agree on an agenda, and in the long term to implement it. It needs to be remembered that about 60% of the requests for treatment come through the criminal justice system, at least for males. For females, treatment demands come through social service-type agencies. Drug users are heavily concentrated in criminal justice populations: many arrested offenders tested positive for a range of drugs and were committing crimes under the influence of drugs (Bennett 1998). A street heroin addict probably commits over 80 serious property crimes per year, alongside numerous other offences. High-frequency drug users tend to be high-frequency offenders, yet periods in treatment produce dramatic reductions in criminality. The point here is that drug use and crime are inextricably bound up together, and in saying this nothing is implied that one leads to the other.

There are a few blueprints showing how it can be done. One mentioned earlier remains one of the best attempts at integration and is through the TASC programme which linked treatment to the judicial process (Nolan 1998: 81). I think TASC has much to offer. Briefly, TASC began in Delaware in August 1972 and those prisoners who volunteered for the programme were sent for local treatment where they were monitored and their progress was reported back to the courts. TASC is essentially a diversion programme, aimed at taking offenders out of prison to have treatment, but it can easily be extended to include a more comprehensive programme linking criminal justice to treatment. There are about 150 TASC sites in 40 states, making it the most respected organisation of its kind (*ibid*. p. 82).

The TASC programme organisers were very conscious of the philosophical differences between a traditional criminal justice perspective and a treatment one, recognising also the potential for conflict. They sought not to fuse the two operations together, but to act as a bridge between them. They saw the justice system's legal sanctions as reflecting community concerns for public safety and punishment, and the treatment community as recommending therapeutic interventions to change behaviour and reduce the suffering associated with substance abuse and the related problems (Nolan 1998, *ibid*.). Bridging the gap has not always been easy or successful, but it has been worthwhile and the services provided under TASC have produced a model which is worth introducing in Britain. That bridge is ever more urgently required.

There was no better example of the need for a TASC-type programme than that which occurred during a research project conducted in Leicestershire in the mid 1990s. There we found that offenders seeking treatment were almost always refused admission to the local statutory treatment agency if subject to a court order, or where there was a direct requirement from the courts to seek treatment. For those not under an order, or who were prepared to enter treatment voluntarily, they were often given appointments two or three weeks in advance. It was not clear whether this was part of the treatment providers' policy to test motivation, or to assess levels of determination, or whether it was because the agency had few vacancies. Either way, by the time the appointment came round the drug users invariably had appeared in court for other offences, or were unable to attend having been earlier remanded in custody. There was no drug testing. Inciardi and McBride see the solution to the shortage of treatment as 'easily solved by a financial restructuring of the war on drugs' (Inciardi and McBride 1991: 75). Would that it were so simple. While 'financial restructuring' must be part of any solution, the urgent need here is to introduce a TASC-like programme involving case management of drug using offenders and to give this priority. We cannot continue stumbling along, allowing individual agencies to determine policies and direction as if the rest of the world did not exist. I am not suggesting such changes are simple or straightforward, but I am suggesting serious consideration should be given to them.

An obvious group that would be tailor-made for TASC would be those heavy users who probably account for about three quarters of the total volume of drugs used in Britain, especially cocaine and heroin. They use a disproportionate amount and are persistent

offenders, having often served lengthy and frequent sentences. Their prognosis is poor and will remain so as long as their drug use continues. Reducing or removing their habit will have two important effects; it will reduce their criminality, which is persistent and serious, and it will reduce the overall demand for a drug. John Grieve is correct when he says we need to undermine the acquisitive base on which drug purchases are derived. The vast sums of money that fuel inter-dealer status and violence in a paranoid and treacherous environment are the product of thousands of burglaries by the same criminals who are arrested again and again (Grieve 1993: 8). This type of offender needs a treatment programme which takes account of the chronic nature of the problem, the high relapse rate, and the persistent offending that accompanies drug use. TASC could act as an umbrella, dealing with all the phases of referral from the criminal justice system, and directing the offender to the appropriate treatment programmes.

Successful case management involves bridging the ideological divide between criminal justice and treatment. As I say, a daunting task. There have been no grassroots movements in Britain aimed at doing that. There were no such preparations for the DTTO, which turned out to be a wonderful example of how not to do things. Nor have the Drug Action Teams appeared to move in that direction. The net result is that treatment services and criminal justice run on parallel lines.

To repeat and emphasise this point, look again at what Taxman calls 'threats that impede the implementation of treatment services' (Taxman 2000) i.e. they prevent getting the best out of the treatment services, or in some cases neutralise them altogether.

- A *lack of clear crime control goals for treatment services*. If the goals are not clear patients and staff will not know which direction to follow or how to do so.
- A *lack of clear assessment and eligibility requirements*. Again, the aims and objectives of the agency must be clear so that the most appropriate patients can be admitted.
- *Insufficient treatment duration to effect behavioural change*. The optimum time span for a treatment programme is about 60 days. Short-term programmes are rarely successful, but of course where governments wish to show they provide treatment facilities getting patients into treatment is more important than keeping them there.

- A *lack of supervision and sanctions/rewards to reinforce treatment goals*. The idea that drug users ought not to enter treatment under coercion, or be coerced in treatment, i.e. often before or after a court appearance, remains a dominant but misguided theme of many treatment agencies. Success is related to the length of time in treatment, the clarity of the goals and the supervision provided. It is not about self-motivation. The longer a person remains in treatment the more options become available, but this cannot occur without supervision and sanctions.
- A *lack of objective drug testing to monitor treatment progress*. The modern thinking behind successful programmes is based on a three-pronged approach, involving treatment, mandatory drug testing and supervision. All have to be linked, with the programme delivered in such a manner as to demonstrate to all, patients and treatment providers alike, that integration is complete. Each feature is important but of itself cannot produce satisfactory results. It is no good producing treatment facilities, or producing a drug testing programme, or having supervision, unless the treatment facilities are underscored by testing and supervision can back up the programme, the details of which must be agreed in advance, especially the quality of supervision. Inciardi talks of the value of treatment: if it is to be worthwhile it must be linked to supervision and testing – it is of little use on its own.
- *Insufficient case management services*. The TASC model could be used for all drug offenders who are referred for treatment, irrespective of the source of the referral.

Test these against any treatment programme involving criminal justice and see how they fare. Take arrest referral schemes, or take referrals to treatment agencies as a condition of probation. Arrest referral schemes permit the police to refer drug users to treatment programmes whilst on bail. As the law stands, the police cannot require treatment as a condition of bail as the Bail Act prohibits this, so referral is in part voluntary but of course a successful referral might persuade a court to be more lenient. Of course, changing the Bail Act to require attendance would not be difficult but would it be any more successful? Almost certainly not. As things stand at present most offenders attend only once, and even if required to attend more frequently would do little better. Arrest referral schemes fail to meet any of Taxman's criteria – perhaps, at a stretch, meeting that which is concerned with 'goals and assessment', but certainly not 'the length

of time in treatment', 'adequate case management', or 'supervision'. Similarly, where treatment is imposed as a condition of probation there are, and will continue to be, unsatisfactory results if procedures do not change: either the drug users fail to attend, or if they do they will give up quickly. Whether with arrest referral or probation there is little coordination, scant planning, and absolutely no attempt to link criminal justice goals to treatment or even the other way round. The exercise more resembles tokenism than treatment.

Or let us examine the DTTO. As I said earlier, this order has not worked and to underline that point I suggested this should also be tested against the 'impediments' listed above. Take for example supervision. Here the DTTO was simply added on to the probation services workload. Yet the probation service as currently constituted is not, in my opinion, the appropriate service to undertake such a task. Too often probation officers retain their social work value system, and are antithetical to the demands of coercive treatment where, as the American research shows, the longer an offender remains in a programme the better the chances of success (Anglin and Hser 1991). Some say a 90-day treatment period is likely to be the minimum, supported by clear unequivocal guidelines, others put it lower at 60. Fudging issues, accepting excuses for shortcomings, and ignoring violations do not help offenders in treatment. It may well be true that different rules could apply to non-offender patients, but for those within criminal justice a greater measure of certainty is required.

Nor are drug-testing facilities adequate. The current procedures leave too many opportunities to manipulate the system and allow offenders to avoid or escape the consequences of their illicit drug use. Drug testing under the DTTO is an amateurish affair, falling far short of what should be expected. The report on the DTTOs describes drug testing thus:

> The frequency of urine testing varies markedly between pilot areas. Very frequent testing may not be good use of money and can be counter productive in those who are reducing the amount of drugs they use. However testing does appear to be a valuable tool in reinforcing the motivation of those who are drug free … We think that testing needs to be integrated fully with treatment programmes, with testing regimes tailored to the objectives set for individual offenders. (Turnball *et al.* 2000: 85–6)

Indeed it does. It should start from the premise that drug testing must be certain. Elements contributing to the reliability and validity of drug testing are *inter alia*:

1 Direct observation of urine sample.
2 Specific detailed written procedures regarding all aspects of urine samples collection, sample analysis, and result reporting.
3 A documented chain of custody for each sample collected.
4 Quality control and quality assurance procedures for insuring the integrity of the process.
5 Procedures for verifying accuracy when drug test results are contested. (US Department of Justice 1997: 21–2)

Under the DTTO these minimum procedures are rarely met (nor, incidentally, are they remotely met in bail or probation hostels). The evaluation report describes staff attitudes to treatment which cast doubts about the possibility of staff seeing eye to eye with the courts, the latter being more enthusiastic about drug tests by regarding them as valid, giving them further confidence about their decisions to make a DTTO in the first place. The treatment staff in contrast said:

- Tests worked well in reinforcing good progress.
- Frequent testing was expensive and pointless for those who continued to use drugs.
- Tests were very destructive to the motivation of those who were reducing drug use considerably but were continuing to test positive.
- Tests were crude instruments which did not reflect different patterns of use. (Turnball *et al.* 2000: 37)

These comments illustrate a basic misunderstanding of the function of drug testing. The staff at the testing and treatment centres are of course correct when they say drug tests do not reflect different patterns of use, on the other hand they do show which drugs have been used, providing a pattern of sorts. They are also correct to say drug tests work well in reinforcing progress. Yet, as far as being 'expensive and pointless' the obvious rejoinder is that tests provide the major source of evidence as to the motivation to continue drug use. Also, when staff say tests were destructive of motivation it seems not to occur to them to insist that offenders try harder – after all no one ever suggested that getting off drugs would be easy. Successful programmes admit to no such compromises, that is why they are successful, and that of

course is why the DTTO fails. If the procedures are not appropriate then enforcement will not be appropriate, and the system will lose respect. It will become an irritant, not taken seriously, rather than the linchpin that provides verifiable data of offender's progress.

Drug-testing facilities are available, testing options are expanding, reliability has increased and costs are coming down. But, as John Carver says (2004), criminal justice and treatment communities do not make effective use of such advances (p. 144). Indeed, we muddle along at best but at worst do so in ways that are positively harmful. Carver lists the following as doing harm:

- Not testing many users with known drug histories.
- On some programmes tests only infrequent and then on regular scheduled days.
- Some programmes have so few controls it is easy to avoid detection.
- Even if an offender tests positive the most likely response is to do nothing.
- If the violation is known to the court, the hearing is likely to be a long time after the test.

Carver's conclusion is that if one set out to design a system to produce failure it is hard to imagine a better one (*ibid*. p. 144).

The tragedy of all this is treatment facilities *are* better in Britain than almost anywhere else. The range is wide and the quality of treatment provided is often more than satisfactory. The defects are ideological rather than practical. For example, an attempt was made under the DTTO to produce a clear line of accountability for treatment where inter-agency practices differed and where conflicts and disputes could be resolved. The final evaluation report (Turnball *et al.* 2000) noted that inter-agency working practices were 'perhaps the single most important factor to address in establishing programmes' (*ibid*. p. 82). The Report showed that rarely had the problems been resolved. It said

> It would be wrong to discount the difficulties encountered by the schemes [the three schemes in the pilot programme] as a function of personality clashes or deficits in skills. They are a consequence of work on a difficult joint enterprise involving organisations with big differences in working styles, traditions and values. We think they are likely to be widespread when DTTOs are rolled out nationally. (*ibid*. p. 82)

This comes as no surprise as little or no attention was paid to it in the first place. What it shows is that developing a team approach within criminal justice is difficult, time-consuming but entirely necessary, otherwise the programme ends up embroiled in inter-agency rivalry. Attempts to resolve some of the difficulties in the pilot programme involved interchangeability of staff, where community psychiatric nurses, probation officers and drug workers were all doing the same work. This was not given much approval by the evaluators, who said they were sceptical about aiming for interchangeability (*ibid*. p. 83) and that 'requiring criminal justice competence from CPNs (community psychiatric nurses) and medical skills from probation officers is an inefficient use of the skills of both groups' (p. 57). The muddle we get ourselves into arises because no attempt is made to seek out information from those who already have a tried and trusted track record. To return to an earlier point, consideration of TASC would have helped.

Finally, I want to emphasise the importance of data and of the police being data-led. This point was made in Chapter 7 and I want to repeat it here, if only to underline the importance of police operations using data whether as a management tool or as a means of evaluating programmes.

The second major area concerns education and demand reduction. What impact do these have to contribute to the solution? By 'education' I mean more than visits to schools, or courses on 'civics', but rather about getting across certain messages which counteract those in favour of drug taking. And there are quite a lot of these available. For example, too little is made of the point that everyone purchasing illicit drugs explicitly buys into and supports the most violent and cruel set of criminal organisations yet known. A letter to *The Times* (14 October 2006) supports this view, where the writer reports on Colombia and of the massive environmental damage resulting from the chemical processing of coca leaves as well as deforestation, and also violence inflicted on farmers by narco terrorists trying to get them to grow coca. The writer adds 'If this was better publicised here perhaps some of the smart set of cocaine users might be dissuaded'. Indeed they might.

Drug markets are violent places and purchasing their products tacitly, if not openly, gives *de facto* support to that level of violence. Presumably few people would buy products from legitimate organisations where employees were treated with such violent disdain, so what is different about the illegitimate? The usual answer would be that the violence occurs only because the product sold *is*

illegal, and by implication legal markets would be different. Namely, the illegal ones would somehow be expected to whither away.

If so, then such a position should be challenged. It fails to understand the nature of trafficking. Traffickers readily shift their activities to other drugs when it suits them – cigarettes will be smuggled rather than cocaine – depending of course on the economic conditions at the time. And they will be just as violent there as elsewhere, for it is not so much about illegality as about their methods of working, and in whatever setting they choose. Traffickers do not have a problem about supply, as there is no shortage of the product they wish to sell. Their problems are of distribution, avoiding detection, of maintaining discipline within their employee network, and of collecting money from sales. Their methods would not change were it likely that their product was legal. Suggesting that legality would produce a different ethos is to avoid looking at the reality.

It is also worth emphasising that drugs have a destructive effect on the social fabric of many of our inner cities. Drug markets are not pleasant places in which to live, for as the residents of Kings Cross made known their young children were exposed to discarded syringes and used condoms. Inner city areas are often inhabited by those living on the margins of social life, being separated culturally, socially and politically from the mainstream, where all too often their adaptation to ghetto life is drug use (Inciardi and McBride 1991: 75). Young teenagers able to earn £100 per night trading in drugs are likely to taunt others with their newfound wealth. This undermines the fabric of the community, as well as having a more immediate destructive effect on the family. Eventually, all local dealers meet their own downfall. This needs to be emphasised, whether it be as a result of out of control drug use or violence from other dealers and one or the other will almost certainly occur. Either way impoverishment will be the end product, whether financially or otherwise, leading to further damage to the community. That local drug markets might add to the wealth of a few absentee, high-ranking dealers merely adds to the sense of decay. It takes a long time to erase the damage. It is the ugliness they create, physically and spiritually which is so destructive.

The message also needs to be conveyed that drug markets at whatever level undermine the democratic institutions of any society. The aim of the high-level dealers is not to empower, but extract the maximum profit from local transactions and with local institutions under their control. Vulnerable institutions easily fall victim to the traffickers, as a number of small Caribbean countries have found to their cost, as too have a number of commercial activities used by

traffickers. Falling prey to the dealers can only lead to impoverishment, in the same way that it does for those who sell drugs on the streets. If these types of messages are conveyed that may assist with other demand reduction programmes. To repeat the point – demand reduction is the key to reducing the use of drugs and eventually making inroads into the problem.

We have done too little to challenge the antics of role models who take drugs, whether they be in the music business or part of the fashion industry. Too often we exhibit double standards. Drugs in rock and roll are acceptable but not in inner city ghettos, or drugs amongst the middle classes are less serious than within the working classes. Of course class hypocrisy is not confined to the drug problem, it shows itself elsewhere in our thinking about crime, but it does pervade the drug scene more than most. When the current head of the Metropolitan Police, Sir Ian Blair, said he was directing police resources at catching middle-class drug takers this was seen as a newsworthy item – that he had to say it is more to the point.

There are no easy solutions, but the dreary fact remains that defeating the drug problem is ultimately about the strength of our social institutions. It does not depend on quick fix solutions such as legalising certain drugs, or seeking legal changes which decriminalise, or offering the drugs of choice on demand. They will at best shift the direction of the problem and at worse exacerbate it. Nor should we rely on something turning up. Changes in fashion might help, with drugs one day becoming less fashionable than hitherto, and this may lead to a reduction in their use. But fashion is a precarious device, directionless in some ways and rarely predictable, whether in its content or strength. It can just as easily move in one direction as another, following as it does the movers and shakers of fashion, who are themselves as unpredictable as the fashion they create. Fashion will not solve the problem. Solutions can only come through policies aided by the strength of those social institutions designed to combat drug use. And by combat I do not mean a ‘war on drugs’ or such wildly destructive programmes and slogans, but the way institutions meet this challenge. Are the major institutions of our society sufficiently strong and attractive to appeal and compete with the world of drugs? When a young Black drug dealer says being a dealer is the best job he has ever had, or will ever have, the major institutions of society associated with the world of education, employment and labour have clearly failed him. Similarly, with drug use locked into those geographical areas of social disadvantage institutional failures are equally evident. If the education system fails to appeal, and the

employment system also fails, then we are in deep trouble. And all too often this is indeed the case.

It is also about shifting resources, about having a clear policy, using what we know and being data led. It is about developing a research strategy and taking advantage of what comes out of that. It is not about giving money to local projects in the hope they can come up with answers without spending time looking at what we know. Or promoting additional blue riband reports from worthy but well-meaning amateurs. We may not know much, but we know enough to move ahead. It is the will to do so that matters more than anything else.

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Drugs and Crime

THIRD EDITION

Philip Bean

A high proportion of crimes committed in Britain are drugs-related, with many offenders reporting drug use prior to the commission of their offence. However, the direct link between drug taking and crime is often less clear than is supposed if only because many of those offenders would have committed offences anyway, and these offences need to be separated from those that are directly caused by drugs. Attempts to address many of these and related issues have been bedevilled by misunderstanding and a lack of consensus on the nature of the relationship between drugs and crime.

This book is a major contribution to this debate, and provides an authoritative and much-needed overview of the range of issues associated with drugs-related crime. The author pays particular attention to policing drugs and drug markets and the way they operate, so that a central theme of the book is the importance of reducing supply at local, national and international levels. Accordingly there are chapters on the drugs–crime link, sentencing drug offenders, policing drug offenders including the use of informers, coercive treatment, trafficking and laundering, and on gender issues, including the treatment of women drug users.

This updated and expanded new edition builds upon the strengths of earlier editions of the book. It has been updated throughout, includes new information on police tactics such as 'stop and search' and 'test purchase', and has an entirely new chapter on the legalisation debate.

Philip Bean is one of the UK's leading authorities on drugs and crime, and has published widely in this field. He is Emeritus Professor of Criminology at Loughborough University, and a former director of the Midlands Centre for Criminology and Criminal Justice. He was also president of the British Criminological Society (1996–1999), and was until 2005 an Associate of the General Medical Council. His most recent book is *Madness and Crime*, published by Willan in 2007.

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