Drug strategy loses its way

As England's ten-year drug strategy comes up for renewal next year, we begin a series of articles examining ideas for its replacement. Here, Howard Parker argues that the changing alcohol and drug use patterns and problems of younger people are not being reflected in policy, planning or commissioning services because the Blair administration cannot see beyond casting treatment as crime reduction.

The building blocks of England's drug strategy were laid down in the late 1990s, when responding to problem heroin use was appropriate for enforcement relating to drug market and supply, and as a reason for significantly uplifting treatment provision.

With the subsequent spread of crack cocaine and merging of heroin and crack markets and the gradual creation of the heroin and crack user, the classic 'PDU', or problem drug user, became central to the drugs strategy and delivery discourse. The PDU became shorthand for the heroin and crack using prolific offender – to be 'gripped' and coerced into treatment in order to reduce drug related, volume crime.

Under the misleading strapline 'for any £1 spent on treatment £9 are saved by the public purse', the National Treatment Agency, steered by Number 10, set about driving an ambitious programme of uplift and modernisation of mainstream services. While this process has been underway the crime reduction agenda has gradually gained primacy and indeed 'hegemony' – that is the drugs-crime-treatment discourse has shaped almost everything.

The centrepiece is the Drugs Intervention Programme. Its role is to target PDUs who are also offenders and use a carrot and stick approach to coerce them into drugs treatment and try and maintain engagement as they journey through the criminal justice system and in and out of custody. Most recently the focus is on bigger sticks and compulsion with the mandatory drug testing of arrestees via 'test on arrest', which is being rolled out in high crime areas across the country. Arrestees who test positive for an opiate (usually heroin) and cocaine (cocaine or crack cocaine – the test can't distinguish) now have to see a drugs worker for a Required Assessment and a follow-up interview. Not to attend becomes an offence in itself, and most police services are diligently re-arresting non-compliers.

In short, the English drugs strategy around treatment has become disproportionately 'target' focused on the heroin-crack profile. This is not to ignore the wider and impressive modernisation of drugs treatment provision via the NTA. We have seen a doubling of treatment places and workforce numbers. Services are better commissioned and organised and in general terms more attentive to service user needs. The problem however is that all this is being shaped by the drugs-crime-treatment discourse. That public health and harm reduction initiatives focusing on heroin-crack injectors have been sidelined and thus have failed to prevent a massive increase in the spread of hepatitis and HIV among problem drug users, is one example of distorted priorities. Similarly, under-18s Tier 3 provision has not been proactively developed and is frighteningly uneven in scope and quality, mainly because it doesn't fit the crime reduction priority. In fairness, this issue is finally being officially recognised – not that this has prevented this year's substantial funding cut.

Most importantly, drug-using trends among under-30s have been changing for several years, but the significance of this has been drowned out by the ceaseless political noise of heroin-crack-crime. A rethink is required.

The ACCE Profile

Most areas of England are now at, or reaching the end of, their heroin cycle. The first heroin outbreaks of the 1980s and the second regional wave of the 1990s have been unexpectedly extended by crack cocaine. However there is now finally clear epidemiological evidence that the incidence – that is the number of new starters – is falling rapidly. This means fewer young heroin users and the established heroin-crack user population gradually getting older.

An important symbolic measure of this is a cultural view developing in younger drug users, which sees 'smackheads' and 'crackheads' as folk devils and as dirty scummy people. As discriminatory as this view is, its now widespread articulation is a highly protective factor. Far fewer vulnerable young people, who a decade ago would have turned to heroin, will now not even try this drug. They now use and misuse different substances and via a complex repertoire namely the Alcohol, Cannabis, Cocaine, Ecstasy repertoire.

The ACCE profile has been bedding in for several years. Today's teenagers who drink are drinking twice as many units a week as the children of the 1990s. Young women now drink as much as young men and 'binge' drinking has established itself in the young adult population.

Cannabis use is normalised and for those that take drugs (but not heroin) is the mainstay of their repertoire. With the wide variety of increasingly strong strains of cannabis, notably skunk, the very regular use of and self-medication with cannabis is producing a range of problems not previously seen in services. Cocaine use however is the biggest worry because there have been constant increases in consumption rates, even evidenced in the underpowered British Crime Survey. Only the price of cocaine is falling. Finally ecstasy, although no longer much associated with dance music, remains a readily available and cheap drug, widely used by those that take drugs. Drug-related deaths around ecstasy and cocaine are rising, whereas heroin deaths are falling.

The critical issue with the ACCE profile is not that one substance is used in moderation but that a minority of younger people are using all four drugs in purposeful combinations and to achieve specific effects including self-medication. Within this population is a further minority that are developing a wide range of problems with use and significant degrees of dependency. A new 'post-heroin' PDU population is being created, which looks certain to grow in size.

This poly substance profile, especially among vulnerable young people such as care leavers, is well known to under-18s' (Tier 2 and 3) substance misuse services in England because these teams are allowed to work with alcohol and drug presentations and referrals. The majority of these services around the country deal primarily with cannabis and alcohol-related problems and in most areas are seeing fewer young heroin users, while cocaine problems are climbing rapidly. Yet while alcohol is a critical part of problem substance use, these services are not allowed to record alcohol as the primary problem in the National Drug Treatment Monitoring System, which is used as the national monitor of drug use trends. Officially alcohol is not a drug. This is just one of many ways the drugs strategy apparatus is in denial and losing coherence and evidence-based planning ability.

However it is when we look at younger adult (over-18s) provision that we see the heroin-crack paradigm undermine recognition of, let alone responses to, changing substance misuse trends. England has totally separate alcohol and drug strategies and this bifurcation extends to commissioning and service provision. If your town actually has a functional alcohol service the chances are it will not be able to treat you if you are, say, a Jack Daniels drinking weekend cocaine user who's lost the plot and become violent towards his partner. Exactly the same scenario is highly likely to be repeated if you present to an adult drugs service.

There are exceptions, but few are well-geared to deal with the alcohol misuse elements of your poly use profile. This all stems from the primacy of the politicised drugs discourse, whereby the growth in alcohol misuse and responsive funding is denied and all resources are channelled to war on the heroin-crack user. Thus alcohol misuse, even if in combination with drug use, is usually left unattended through the Drugs Intervention Programme.

The same problem occurs within Probation Service provision, whereby community based Drug Rehabilitation Orders are being widely used by the courts but alcohol rehabilitation or treatment requirements have not been funded or set up. We need one poly substance treatment requirement to respond to the actual realities of substance profiles among younger offenders.

Ironically, it is mandatory drug testing which is inadvertently tripping over the ACCE profile. Secondary analyses of drug test results around the country are showing the younger the arrestee, the more likely they are to test positive for cocaine and negative for heroin. In short, the cocaine element of the ACCE profile is showing up. The problem of course is what has current treatment provision to offer? There may be methadone but there's no cocadone. The younger arrestee is required to meet a drugs worker, but will rarely engage.

The best match therapeutic intervention for stimulant dependency is Cognitive Behavioural Therapy (CBT), preceded by a process of motivating the subject to recognise the need for help and fairly intensive talk therapy. The basic principles of CBT require an empathetic relationship between client and worker in a safe and secure environment. While a custody suite Required Assessment certainly offers security, it is not likely to produce the other building blocks to engagement. Unsurprisingly, high rates of non-engagement via mandatory drug testing interventions are beginning to show.

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Moreover, where referrals to adult drug services are made these teams, having been monopolised by heroin-crack users, have not much developed skill around working with stimulant and cannabis users even if we can engage the ACCE profilers. Finally in terms of voluntary presentation by young adults with any or all the elements of ACCE, their disdain for smack-crack heads means they are unlikely to see their local community drug service as a place to visit believing it to be full of dirty junkies.

Strategic review

I undertook a formal review of Northern Ireland's alcohol and drug strategies in 2005. The Executive have accepted my report's recommendation to integrate the two strategies and to continue to develop provision and interventions whereby alcohol is set alongside other drugs like cannabis and cocaine. Northern Ireland's drugs consumption patterns are already dominated by ACCE and they now have the strategic and commissioning templates to respond effectively. This is the strategic rethink required in England, whereby alcohol and illicit drug misuse would be tackled holistically and drugs like cannabis taken seriously.

The focus on heroin and crack and the classic PDU needs maintaining in moderation, but provision for a different kind of PDU needs piloting and developing. An ACCE service will need to be underpinned by voluntarism, non-prescribing and empathetic engagement. This means that the NTA's performance indicators and narrow prescriptive targets will need revising. Primary alcohol referrals must score points, waiting times need to be zero but retention goals far more flexible; and 'numbers in treatment' goals will need to be replaced by engagement and outcome targets. Reducing poly substance use should be an acknowledged positive outcome.

The trick will be to maintain provision for heroin-crack users but develop a second type of service platform, initially for young adults as the ACCE profile emerges. The current politicised drugs discourse has already delayed a strategic review of the drugs strategy's salience in line with changing alcohol-drugs consumption trends. Recognition of the need to adapt is unlikely to emanate from Whitehall beyond isolated public health messages about alcohol or cannabis.

However, from this year, each Drug Action Team area is being asked to do a needs assessment based on local realities and unmet need. While they are, as ever, being pushed to focus of heroin-crack there is an opportunity to signal cannabis and cocaine issues – and with ring-fencing hopefully coming off drugs budgets, there is also a chance to define alcohol as a drug and challenge the tunnelled vision of central government to begin the necessary debate and redevelopment.

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