Chapter 5 – Drug policy in the UK: from the 19th century to the present day

5.1 Introduction

The need to address problems associated with drug use is not a new phenomenon. As discussed in **Chapter 6**, a key question is what the primary aim of drug policy and legislation should be. At one end of the spectrum, it could simply be to reduce or eliminate illegal drug use, while at the other end it would focus entirely on the health and social problems of the individual drug user, by considering drug dependence as a chronic medical disorder. These are two examples of possible foci: the question is discussed in detail in **Chapter 6**.

Current policy in Britain takes account of both viewpoints, as well as the wider social and economic factors associated with illicit drug use (see **Chapters 3** and **6**). This chapter examines the development of drug policy in Britain since the mid-19th century and the rationale behind current policy.

5.2 The beginnings of drug control in Britain

Opium eating and laudanum (an alcoholic solution of opiates) consumption were widespread in mid-19th century Britain. Opium, and its derivative morphine, were available as patent medicines, in tinctures and other commercial products that were readily accessible through chemists and herbalists. The use of these products declined after the 1868 Pharmacy Act restricted opium sales to the pharmacist's shop, with the Act requiring pharmacists to keep records of the purchasers. The later 1908 Pharmacy Act moved morphine, cocaine, opium and derivatives containing more than 1 per cent morphine into part one of the poisons schedule. At this point, control was on availability and sale and was largely based on self-regulation by pharmacists, with little Government intervention. There was a small population of morphine-using addicts and some opium and cannabis smoking among artistic, mystic and bohemian circles but the population of drug users at the beginning of the 20th century was relatively small. At the same time, British pharmacists and physicians had nearly 40 years' experience of dispensing opiates and attempting to control their use.[1,2]

5.3 Domestic policy developments and international drug control

Meeting Britain's international treaty obligations set the context for the development of British drug policy. Britain became committed to a drug control policy as a result of the international narcotics control system established in the early 20th century. A series of international meetings, largely prompted by American concern about Far Eastern opiate use, laid the bases of the system. Britain's involvement in the Indian opium trade with China through the 19th century was brought to an end by the Anglo-Chinese opium agreement. There was some domestic pressure for drug control, with public and press concern about cocaine smuggling to India and opium and morphine smuggling to the Far East, some of which involved British ships. This was of particular concern in the wartime emergency situation of 1915-1916 and was compounded by reports of cocaine use among soldiers, especially those on leave in London, which was seen as compromising army efficiency. In 1916, the Army Council issued an order prohibiting the gift or sale of cocaine and other drugs to soldiers, except on prescription. This was the first time that a doctor's prescription was required by law for the purchase of specified drugs. When cocaine dealers found ways of circumventing the order, pressure from the press, anti-opium interests, the police and the army resulted in the introduction of the Defence of the Realm Act regulation 40B (DORA 40B) in the same year. The regulation made it an offence for anyone except physicians, pharmacists and vets to be in possession of, to sell or give cocaine. The drug and its preparations could only be supplied on prescription. The Home Office had responsibility for policing DORA 40B and now took on the central role of initiating and shaping the restrictions of drug control policy.[2]

Before the First World War, Britain had been a signatory of the International Opium Convention at The Hague in 1912. This Convention was the first global attempt at drug control and aimed to reduce the use of morphine and cocaine by restricting the manufacture of, trade in, distribution and use of, these drugs to 'legitimate' scientific and medical purposes only. Although it did not specify limiting the use of opium to scientific and medical purposes (and this was, essentially, not covered until 1961 – see **Section 5.7**), signatories agreed to suppress the use of opium and distribution was expected to fall as a result of the Convention. In 1920, Britain was obliged to introduce the first Dangerous Drugs Act to meet the Hague Convention's requirements, while also incorporating the DORA 40B restrictions. The Dangerous Drugs Act laid the foundation of further legislation and control policy in Britain and consolidated the precedence of the Home Office over the Ministry of Health in the area of drug policy. The Act generated little debate at large, with recent sensational accounts of recreational drug use among bohemian circles prompting a political and press demand for a penal approach to drug control.[2] A penal emphasis in policy continued with the 1923 Dangerous Drugs and Poisons (Amendment) Act, which imposed stricter controls on doctors and pharmacists with respect to dangerous

drugs, introduced more severe penalties and higher fines and sentences, and expanded the search powers of the police.[2]

5.4 The Rolleston Committee

The 1920 Dangerous Drugs Act established that medical practitioners were allowed to prescribe morphine, cocaine and heroin but it was not clear from either the Hague Convention or the Act whether prescribing these drugs to addicts constituted legitimate medical work. The population of opiate users at this time was small, largely middle class, addicted to morphine and in the medical and allied professions, or had become dependent in the course of medical treatment. At the suggestion of the Home Office, the Ministry of Health convened an expert committee (Departmental Committee on Morphine and Heroin Addiction) chaired by Sir Humphrey Rolleston, then President of the Royal College of Physicians, to consider and advise on the circumstances in which it was medically advisable to prescribe heroin or morphine to addicts. The report produced by the committee (usually known as the Rolleston Report),[3] reaffirmed the doctor's freedom to prescribe regular supplies of opioid drugs to certain addicted patients in defined circumstances that the committee regarded as 'treatment' rather than the 'gratification of addiction'. While the possession of dangerous drugs without a prescription was still the subject of the criminal law, addiction to opioid drugs was recognised as the legitimate domain of medical practice (and hence prescribing). This balance of a medical approach within a penal framework became a hallmark of British drug control and has been called the 'British System' by commentators.

5.5 Increasing international drug control

The Hague Convention had laid down domestic control obligations for its signatories and not addressed the question of transnational controls. The League of Nations was established after the First World War and provided a centralised body for administration of international drug control. The second Geneva Convention of 1925 was signed under the auspices of the League of Nations and required parties to the treaty to provide annual statistics on drug stocks and consumption, the production of raw opium and coca, and the manufacture and distribution of heroin, morphine and cocaine. The Geneva Convention was also notable in bringing cannabis under international control, and restrictions on cannabis were implemented in Britain with the 1928 Dangerous Drugs Act.

5.6 Growth of drug use in Britain and the 1960s heroin crisis

Until the 1960s, prescribed heroin was the main medication used for treatment of those addicted to morphine and heroin; this population was predominantly aged over 30 years and middle class. This was a settled approach, as a major addiction problem was not apparent in the British drug scene. In the early 1960s, the first reports about the activities of young heroin users began to appear in British newspapers – a phenomenon that was new to Britain. The Home Office convened an interdepartmental committee under the chairmanship of Sir Russell Brain, largely prompted by concern about whether long-term prescribing was still appropriate more than 30 years after the Rolleston Report. The Brain Committee published its first report early in 1961,[4] and concluded that the drug problem remained small and no changes in approach were needed. Increasing media and professional evidence of a heroin epidemic in Britain involving younger heroin users led to a Second Interdepartmental Committee on Drug Addiction, again chaired by Brain. Drug addiction was formulated as a '*socially infectious condition*', for which it was appropriate to provide treatment. The committee concluded that the increase in heroin use had been fuelled by a small number of doctors who were overprescribing heroin and that individual doctors were unable to meet the demands of the new situation. As a result, the committee recommended that restrictions should apply to the prescribing of heroin and cocaine and that new drug treatment centres should be set up within the NHS hospital system.[5] These recommendations were enacted in the Dangerous Drugs Act 1967, which restricted the prescribing of heroin for treatment of addiction to doctors licensed by the Home Office. The doctors who obtained licences were mostly consultant psychiatrists in charge of drug treatment centres. This limitation of doctors' clinical autonomy received some criticism from the medical profession. As this restriction of clinical freedom did not extend to prescribing heroin for medical treatment other than addiction, and GPs were generally reluctant to treat addicts, the change was accepted by the medical profession.[6] The committee's recommendations also led to the introduction of a notification system for addiction (as with infectious diseases). The drug clinics took over the prescribing of heroin to patients who were previously prescribed by private doctors and NHS GPs. Prescription of heroin to addicts declined in the early 1970s, as doctors at the drug clinics were uncomfortable prescribing it. Methadone had recently been developed in the USA as a new treatment specifically for dependence on opioid drugs, and the clinic doctors considered oral methadone was a more suitable medication.

The 1960s also saw widespread use of other illicit drugs by young people, notably cannabis but also LSD and amphetamines. Concern over the use of amphetamines, or 'purple hearts' or 'pep pills' as they were commonly called, led to their control under the Drugs (Prevention of Misuse) Act 1964.[7] While amphetamine use among young people was the first to draw political reaction, cannabis-related convictions increased steeply as use of this drug became more popular in the mid-1960s, and the issue was

hard to ignore. A Home Office Advisory Committee (the 'Wootton Report') in 1968 recommended that the legal penalties for simple possession of cannabis should be reduced and casual users of cannabis should not receive custodial sentences.[8] Despite initial hostile Government reaction, the committee's proposals were implemented in subsequent legislation.

5.7 The UN Single Convention on Narcotic Drugs 1961 and the Misuse of Drugs Act 1971

Further international drug control protocols followed the Geneva Conventions of the 1920s and eventually all the existing international drug control treaties were consolidated in the UN 1961 Single Convention on Narcotic Drugs (see **Box 2**, **Section 1.2**).[9] The Single Convention has four schedules of controlled drugs, ranging from most restrictive to least restrictive. The Misuse of Drugs Act 1971 was introduced to meet the treaty obligations and has an analogous scheme of drug scheduling, with drugs considered the most harmful such as heroin and cocaine classified as Class A drugs (see **Table 1**, **Section 1.2**). The Act also established the Advisory Council on the Misuse of Drugs (ACMD) to keep the drug situation under review and give advice to the Government on measures '*which, in the opinion of the Council ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse*'.[10] Among its important functions is to recommend classification of new or existing drugs that may be misused. Further details of drugs covered by the Misuse of Drugs Act are given in **Section 1.2**.

5.8 Heroin use grows in the 1980s

The 1980s brought new pressures on the treatment system and Britain's drug control policy, with a new epidemic of heroin use. The numbers of addicts notified to the Home Office and the amount of heroin seized rose dramatically. There was widespread media coverage of this new wave of heroin use, and drug use became an important and sustained policy issue for the first time since the 1960s. The then Conservative Government sought to encourage a coordinated response from across the range of Government departments, by setting up an interdepartmental working group of ministers and officials, which resulted in the first Government strategy document *Tackling drug misuse*, issued in 1985.[11] During the same period, new ways of tackling drug treatment were developed following the recommendations of the *Treatment and rehabilitation* report from the ACMD in 1982.[12] The focus became the broader population of 'problem drug users', seen as a heterogeneous group with a range of problems beyond the use of a drug itself, encompassing social and economic as well as medical problems. The generalist doctor was seen as key to dealing with drug-related problems, and drug use was no longer seen as the sole province of the specialist clinic psychiatrist. The ACMD saw an increasing role for doctors outside the specialist treatment services, with the proviso that there were '*strict safeguards*'.[12] In response to the ACMD recommendations for safeguards, in 1984 the Department of Health and

Social Security issued all doctors with their publication *Guidelines of good clinical practice in the treatment of drug misuse*.[13] Revisions of these guidelines have been published subsequently, most recently in 2007.[14]

5.9 The AIDS epidemic and treatment policy

The late 1980s saw HIV and AIDS become the dominant public health concern. People who injected drugs were seen as a potential route for the HIV virus to rapidly diffuse into the wider community, through the sharing of contaminated injecting equipment. In response to the widespread concern about AIDS, HIV and those who inject drugs, the ACMD set up an AIDS and Drug Misuse Working Group. The resulting report, *AIDS and drug misuse. Part I* provided the template and rationale for a reorientation of drug treatment practice to meet the new challenge of drug use and HIV.[15] The report stated that '*The spread of HIV is a greater threat to individual and public health than drug misuse*'. The ACMD saw that the key aims of drug treatment were to attract seropositive injecting drug users into treatment, where they could be encouraged to stop using injecting equipment and move away from injecting toward oral use. Harm minimisation was the core principle of this policy and received support from the Government. Harm minimisation was characterised by adopting measures that sought to reduce the harm caused by continued drug use, through modification of using behaviours.[15] *AIDS and drug misuse. Part I* and the complementary report *AIDS and drug misuse. Part 2*,[16] continued the policy aim of involving GPs and general psychiatrists more actively in the direct provision of services to address the more general healthcare needs of drug users, while the specialist clinics maintained responsibility for the more complicated needs of the more difficult drug users. Needle exchange services rapidly became mainstream. Their early introduction, together with a range of other harm-reduction interventions, has been seen as critical in preventing the major spread of HIV among individuals who inject drugs that has been seen in other countries where such approaches were not adopted.[17]

Around this time, maintenance prescribing re-emerged in the form of oral methadone maintenance and became increasingly provided by GPs, either independently or in a 'shared care' scheme, as well as by specialist services.[18]

5.10 Crime and a redesign of British drug policy

Through the 1980s, there was a notable increase in use of recreational drugs among the young, not only cannabis but also the new 'dance drugs' such as ecstasy, and there was increasing public and political concern about the link between drug use and crime. The number of drugs offenders rose from 24,000 in 1986 to 95,000 in 1996, with the majority of these offences related to cannabis possession.[19] In 1995, the Government published *Tackling drugs together: a strategy for England 1995-1998*,[20] in which it sought to combine '*accessible treatment* [with] *vigorous law enforcement … and a new emphasis on education and prevention*' (see **Chapter 7**). The aim of the strategy was to

increase community safety from crime and to reduce the health risks and other damage related to drug use. This and subsequent Government drug strategies reconceptualised drug treatment as an intervention that might lead to a reduction of criminal behaviour. Criminals who use drugs were to be encouraged to enter treatment as a means of altering their behaviour. The strategy also indicated a move away from the harm-minimisation approach of the preceding years. The strategy stated that the principal objective of treatment was to assist drug users toward abstinence and maintenance of a drug-free state, while recognising that other approaches would continue to be taken to reduce the spread, by drug users, of HIV and other communicable diseases. There was to be an integrated approach coordinated by the Government but with the details of policy determined at a local level by new drug action teams. Statutory and voluntary sectors would work together and health and social care would be linked to the criminal justice system.

In 1996, the Department of Health (DH) set up a review of drug treatment services and their effectiveness, which concluded that '*treatment works*'.[21] This conclusion underlay the 10-year New Labour strategy *Tackling drugs to build a better Britain*,[22] which stressed the use of diversion into drug treatment from the criminal justice system. An example of this new approach was the introduction of community sentences for offenders, involving drug testing and treatment components called Drug Treatment and Testing Orders (DTTOs). Treatment services within prisons expanded. The main focus of the strategy was problematic drug users, which included those who injected drugs and those using opioid drugs and crack cocaine. Spending on drug treatment rose substantially. In 1994, around 67,000 people were counted as being in treatment, rising by 26.9 per cent to 85,000 in 1998-1999 and a further 129.9 per cent to 195,400 by 2006-2007, giving an overall rise from 1994 to 2006-2007 of 191.6 per cent.[23] The treatment and rehabilitation (see **Glossary**) budget for 1994 was £61 million, while the total spend on treatment in 2005-2006 was estimated to be £508 million.[23]

In criminality surveys conducted in England and Wales in 2000 and 2002, over one-third of male prisoners and over a quarter of men serving community sentences reported experiencing problematic drug use.[24] Men were more likely than women to say that they had problems staying off drugs in the last 12 months (43% versus 39%).[24] The budget for drug treatment interventions in the criminal justice system in England and Wales was over £330 million in 2006-2007 and spending on drug treatment in prisons increased from £7 million in 1997-1998 to £80 million in 2007-2008.[25]

The 2002 *Updated drug strategy* concentrated on the '*most dangerous drugs*', defined as Class A drugs, and again emphasised the objective of getting more of the estimated 250,000 problem drug users into treatment.[26] The Home Office was given overall responsibility for implementation of the drug strategy, although the DH and Department for Education and Skills (DfES) had key roles. The 2004 *Tackling drugs:*

changing lives strategy document again stressed Government policy to get as many offenders who were drug users into treatment as possible.[27] Another aim was to enhance the quality of treatment by providing support with housing, finance, skills training and job opportunities for drug users. The 2008 drugs strategy *Drugs: protecting families and communities*[28] maintained the focus on problematic drug users and the links between drugs and crime but laid a greater emphasis on the impact of problematic drug use on others in the user's circle, especially children and families.[29]

5.10.1 Recovery and policy

As part of the NHS, the National Treatment Agency (NTA) was set up in 2001 as a specialist health authority to monitor expenditure of the drug treatment budget and to expand the availability and quality of treatment. As described in the previous section, the number of people in drug treatment increased by 129.9 per cent from 85,000 to 195,400 between 1998-1999 and 2006-2007.[23] Then in 2009 the NTA shifted its focus from getting people into treatment to helping service users achieve and sustain long-term recovery (see **Glossary**), with services aiming to support recovery that is shaped by the individual drug users themselves. This focus on outcomes and an emphasis on recovery is mirrored in the most recent Government strategy, *Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to lead a drug free life*.[30] Policy continues to move beyond an individualistic focus, with less emphasis on drug–crime links and a greater consideration of the wider social and economic factors that drive problematic drug and alcohol use and that can help or hinder recovery.

A subsequent Government document, *Putting full recovery first*, provides more detail of the Government's aim of establishing a treatment system approach that puts more emphasis on people in drug treatment achieving recovery, rather than aiming to simply engage and retain them in treatment.[31] An Inter Ministerial Group on Drugs has been established to direct and monitor implementation of the drug strategy. The functions of the NTA will be transferred to a new body, Public Health England (PHE), from April 2013. PHE is being set up to provide leadership within a recovery sector that covers both drug and alcohol dependence. A payment by results model is to be developed to incentivise reaching outcomes that include being free of dependence and not involved in crime and being in employment. Local areas will be supported to move local commissioning structures toward recovery- and abstinence-based support.

It is worth noting that there are risks associated with moving to a payment by results system where the agencies, and presumably thus the professionals, are to be paid not for their services, but by whether the patient behaves, and lives his/her life, in the way that Government policy prescribes. Given the poor success rates for treatment of drug problems, particularly if the definition of success includes abstinence, this may make a bad situation worse. Apart from that, within a medical framework, this would be a

change in the aims of doctors: not to minimise sickness but to help the patient lead a good life, and to be paid not for services provided but by how the patient behaves. Under such circumstances, healthcare professionals may be reluctant to take on patients who have failed before, as they may be at higher risk of failing again.

The international policy framework means that all possession or marketing of illicit drugs remains a criminal activity.

An overview of current Government strategies in the UK is provided in **Appendix 6**.

Summary

- Purchase of psychoactive drugs such as opium and laudanum was unregulated in the UK until 1868, when the Pharmacy Act was passed, restricting opium sales to pharmacists' shops, with a requirement on pharmacists to keep a record of purchasers.
- In 1916, an Army Council order, and the Defence of the Realm Act later the same year, made it an offence for anyone except a physician, pharmacist or vet to possess, sell or give cocaine, and the drug and its preparations could only be supplied on prescription.
- The first Dangerous Drugs Act passed in 1920, and a further Act in 1923, passed to conform to the 1912 International Opium Convention at The Hague to which Britain was a signatory, imposed stricter controls on doctors and pharmacists in relation to dangerous drugs, in a climate with a penal emphasis on policy.
- It was not clear from these Acts or the Convention whether prescribing drugs to addicts constituted legal medical work. The Rolleston Report in 1926 affirmed the right of doctors to prescribe controlled drugs to addicts in defined circumstances and set the scene for a balanced medical approach within a penal framework.
- The second Geneva Convention in 1925 brought cannabis under international control, and restrictions were implemented in the 1928 Dangerous Drugs Act.
- As a result of increasing use of heroin, the 1967 Dangerous Drugs Act restricted prescribing of heroin to doctors licensed by the Home Office, and set up new drug treatment centres within the NHS hospital system. A notification system for addiction was also introduced.
- Introduction of other drugs to the illicit market, such as amphetamines and LSD, led to the Drugs (Prevention of Misuse) Act 1967, and recommendations that penalties for possession of cannabis should be reduced, with no custodial sentencing for casual use, were implemented.
- The 1961 United Nations Single Convention on Narcotic Drugs introduced four schedules of controlled drugs and was followed in the UK by the Misuse of Drugs Act 1971, with drugs categorised in classes according to perceived harm and therapeutic value. This Act also set up the Advisory Council on the Misuse of Drugs, to keep the drug situation under review and advise the Government.

- With increasing illicit drug use, Government strategies in the 1980s began to focus on the social and economic problems of drug users, in addition to their medical problems, and GPs became involved with the more general healthcare needs of drug users, leaving specialists to deal with more difficult drug users.
- The spread of HIV and AIDS generated 'harm-minimisation' policies in relation to drug use, by modification of using behaviours, from injecting to oral use where possible.
- The 1995 Drug Strategy moved away from this approach to one encouraging users to enter treatment, with the aim of moving users towards abstinence and achievement of a drug-free state and of reducing criminal behaviour.
- Later strategies (2002, 2004, 2008) continued to emphasise the need to move drug users into treatment and focused on the links between drugs and crime; they also aimed to move drug treatment away from the NHS into the community and voluntary sector.
- The 2008 strategy maintained a focus on drugs and crime but placed greater emphasis on the impact of problematic drug use on children and families of users.
- With the 2010 strategy, policy continues to move away from drug-crime links and towards a focus on wider social and economic factors that drive problematic drug use. The emphasis is on people in drug treatment achieving recovery, rather than aiming to simply engage and retain them in treatment.
- The international policy framework means that all possession or marketing of illicit drugs remains a criminal activity.