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The War on Drugs – A War on Drug Users

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ABSTRACT

The authors argue that since the 1980s UK drug policy has largely been ill considered, reactive and counter-productive. Rather than reducing drug taking and drug- related crime, such policies have exacerbated the problem and contributed towards an environment in which drug use and illegal drug activities are likely to flourish. One of the consequences of this `war on drugs' is that it manifests itself as a `war on drug users' with an emphasis not upon the development of appropriate rehabilitative models, but upon prevention, prohibition and punishment. Drawing on the authors' qualitative research on Merseyside, England involving 200 problem drug users, it will be argued that the war on drug users has subjected these people to a process of stigmatisation, marginalisation and social exclusion, and prevented many of them from recovery by hindering their reintegration into the wider social and economic community. Instead, growing numbers of problematic drug users remain locked into a cycle of chronic drug relapse.

> *'This government was elected on a promise of change. A promise to create a new and modern Britain for the 21st century. .. it could be much better if we could break once and for all the vicious cycle of drugs and crime which wrecks lives and threatens communities. .. We owe it to our children to come up with a truly imaginative solution and create the better Britain they deserve.'*
>
> (Tony Blair, Prime Minister, Cm 3945, The Stationery Office, 1998, p. 1)

1

Introduction

This paper will critically examine the principles underpinning UK drug policy over the past two decades and assess its effectiveness in terms of reducing the number of people using illegal drugs and in minimising the social consequences of drug misuse. The authors will argue that a drug policy centred upon a discourse of prohibition, punishment and abstinence is seriously misguided and ill informed. The UK Government's 10-year strategy is built upon the premise that `All drugs are harmful and enforcement against all illegal substances will continue' (The Stationery Office, 1998, p. 3). This approach fails to acknowledge the extent, nature and diversity of illegal drug taking across the UK and many recreational illegal drug users take issue with the government's assertion, rejecting enforcement laws (Parker et al., 1998). The consumption of legal and illegal drugs for pleasure should be recognised as a highly complex social issue, but instead it has been presented within a reductionist framework. Within certain boundaries the government sees the use of legal drugs (primarily alcohol and tobacco) as wholly acceptable, whereas, the use of illicit drugs in any circumstance is seen as dangerous and harmful, not only to the individual, but to society generally (Cunningham 1998). Illicit drug taking has been presented as an 'enemy' within' that can, and will be eradicated. With the appointment of a Drugs Tsar (the UK anti-drugs co-ordinator) and vast resources, the government is rallying the nation to wage war on illicit drugs. Some have rightly observed that the war on drugs could more accurately be described as a war on drug users (Ashton, 1992).

This has implications for many young people who regard recreational drug taking as a `normalised' activity within youth culture and lifestyle, albeit illegal (Parker et al., 1998). The most harmful consequence is the criminalisation of vast sections of society largely those under 25 years old (Ramsay & Partridge, 1999) the majority of whom are recreational drug users who primarily take ecstasy, cannabis and amphetamine. In 1998, for example, 115,232 people were found guilty, cautioned, fined or dealt with in the criminal justice system for unlawful possession of such drugs (Corkery, 2000, p. 40). Moreover, there is also a major concern about the impact the `war on drugs' is having upon long-term `problem' drug users, i.e. primarily heroin addicts (Hartnoll, 1994) who find themselves trapped in a process of stigmatisation,

marginalisation and social exclusion. Drawing upon three qualitative research studies involving 200 problem drug users across Merseyside the authors wish to illustrate how British drug policy has acted to legitimise and reinforce discrimination against problem drug users.

Drug Policy in the UK has been largely shaped by the Misuse of Drugs Act 1971, described as a law which has done `less good and more harm' than any other law on the statute book (Jenkins, 1999). Not insignificantly, when the Act was established in 1971 recreational and problematic illegal drug taking was neither mainstream, nor was it a particularly serious issue in the UK. When in the early 1980s illegal drug taking became endemic in large cities and urban areas (amongst unemployed working class youth) it shocked society. Heroin, the main drug of choice, had become a serious social problem affecting many large UK cities (Pearson, 1987). Not unrelated, it was during this period that de-industrialisation ravaged labour-intensive industries as factories and shipyards closed down. Whole communities were destabilised by mass long-term unemployment. In the 1980s, for the first time in the post-war period, a generation of school leavers who would otherwise have secured employment in apprenticeships, factories or semi-skilled positions, found themselves surplus to requirements. Work was not available and the long-standing concept of `a job for life' was being rapidly eroded. There was a growing realisation that some of these school leavers would never be able to find employment. Many unqualified and unskilled youth (along with their parents) became victims of the New Right free-market revolution. This discarded generation was excluded socially and economically from the benefits widely available to those in work (Hutton, 1996) and it was in this depressing environment that the youth of the 1980s attempted to make the transition to adulthood. Instead of addressing the impact of de-industrialisation on urban working-class communities, the New Right chose instead to blame the victim. At the time, a Conservative Member of Parliament infamously instructed the unemployed `to get on their bikes' and search for work. With little to lose, and little to gain, many of these discarded young people turned to heroin. By the end of the mid-1980 s heroin use on Merseyside had reached `epidemic' proportions (Newcombe & Parker, 1991). A painkiller with euphoric properties, heroin helped many young people block out the harsh social and economic realities of their lives (Buchanan &

Wyke, 1987; Dorn & South, 1987). However, heroin use brought many problems too.

Refusing to acknowledge the structural causes of the 1980s drug problem, UK Prime Minister Margaret Thatcher and US President Ronald Reagan united together to declare a new enemy `the drug addict'. The relationship with the USA was further cemented as the two countries united to `Wage War on Drugs' (Buchanan & Young, 1998a). The US war on drugs had been instigated some years earlier by President Nixon (South, 1997), and was now promoted by President Reagan who launched a new campaign to `Just Say No' to drugs. In the UK, Prime Minister Margaret Thatcher adopted an equally high profile campaign, based around the slogan `Heroin Screws You Up'. This portrayed young heroin addicts as unkempt social outcasts who threatened the cohesion of local communities and placed lives at risk. The government message was clear: heroin use must be fought on all fronts.

Crudely, drug users were dichotomised into two groups. One group, largely drawn from unemployed working-class youth who lived on council estates, were seen as social deviants heavily involved in drugs and crime and causing havoc amongst communities. The other group were presented as `respectable' youth who were `at risk' of being lured into drug addiction by evil drug pushers. By the late 1980s, however, the focus on prohibition and punishment had been seriously confronted by the arrival of HIV/AIDS, which emerged in cities across the UK (Robertson, 1987). The spread of HIV/AIDS was seen as a more serious threat to society than drugs (ACMD, 1988) and services were encouraged to embrace a shift in policy, primarily concerned to reduce the health risks of HIV/AIDS to the wider community (MacGregor, 1998). Widespread HIV infection amongst drug injectors in a number of major cities across Europe, including London and Edinburgh, forced a pragmatic shift in UK drugs policy towards a harm reduction approach designed to establish contact with the hidden drug-using population. With the threat of HIV/AIDS, services were encouraged to become more user friendly, provide free needles and syringes, condoms, accessible health education and flexible prescribing of methadone. It was a pragmatic strategy primarily concerned with protecting the non-drug-using society from the risk of HIV infection. The government's earlier demonisation of the drug-using

population, which had portrayed addicts as a deviant underclass undeserving of public support, ran counter to what was now being asked of health authorities. Many drug agencies therefore struggled and/or only reluctantly embraced this major shift in approach, while at the same time, the government itself remained unwilling to consider any softening or review of the 1971 Misuse of Drugs Act.

The reluctance to review drug legislation in the light of the important changes that were taking place in social attitude and behaviour around drug use, had two significant consequences. The Misuse of Drugs Act 1971 deterred many problem drug users from presenting themselves for treatment and seeking help for fear of legal sanctions. Secondly, it criminalised many thousands of otherwise law-abiding young people who were using drugs recreationally. This pattern of criminalisation is highlighted by the continued rise in convictions since the mid-1980 s illustrated in Figure 1. Of the 127,919 people dealt with in 1998, 97,245 concerned cannabis and 14,605 concerned the use of amphetamine. Whether cautioned or sentenced, such details remain on record. This could limit employment opportunities for many young people, especially if the government presses ahead with proposals to give employers access to criminal records.
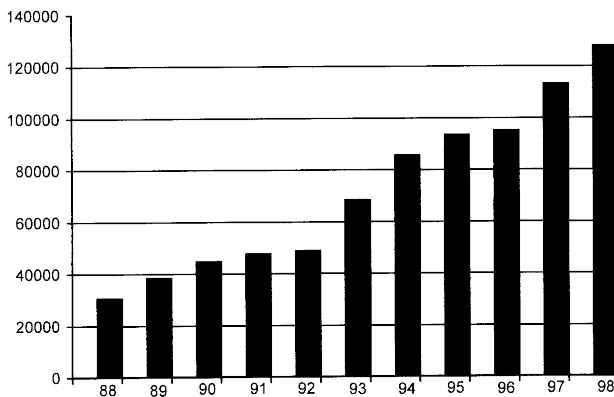

Figure 1. Number of people cautioned or found guilty or dealt with for drugs offences (Corkery, 2000, p. 40).

The 1990s witnessed a rapid diversification in patterns of drug taking with the proliferation of new recreational designer drugs. The users this time were `respectable' youth who were taking drugs, not to nullify life, but enhance existing experiences, usually while at dance clubs, parties or outdoor raves. Although the drugs and the drug users were different, the message on drugs remained the same all illegal drugs are dangerous and young people need to be protected even if it meant prosecuting them to achieve this. The campaign against ecstasy in the 1990s was similar to that for heroin in the 1980s. Through careful exploitation of individual tragedies, ecstasy was etched upon the political and public consciousness as an unpredictable killer drug (Murji, 1998). This portrayal created a cognitive dissonance between many thousands of regular ecstasy users and government policy.

The late 1990s saw the introduction of a range of measures that reoriented drug policy away from the concern about health issues and instead located it clearly within the domain of the Criminal Justice System. Key developments were: the introduction of mandatory drug testing in prisons (Criminal Justice and Public Order Act 1994); a minimum 7 years imprisonment for any third offence of Class `A' drug trafficking (Crime Sentences Act 1997), and Drug Treatment and Testing Orders that offer the choice between imprisonment or intrusive compulsory treatment monitored by regular urine tests and court reviews (Crime and Disorder Act 1998). Following a Home Office-funded study (Bennett, 1998), the government are now pressing ahead to introduce US-style measures to detect and deter drug users so that any person arrested may be subject to a compulsory urine analysis, which could prevent the person being granted bail (Criminal Justice and Court Services Bill). Such measures are crude and show little appreciation of the complexity of the issue. They blur the important distinctions between particular illegal drugs, such as cannabis and ecstasy at one extreme and heroin and cocaine at the other, while largely ignoring alcohol-related problems. Recreational users of `soft' drugs and problem users of `hard' drugs will both be criminalised and stigmatised as drug offenders, in spite of the entirely different nature of their drug use.
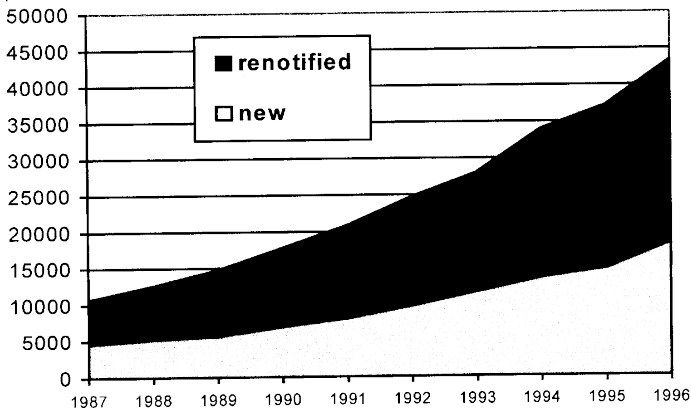
Figure 2. Notified and re-notified `addicts' notified to the Home Office, 1987-1996 (Corkery, 1997).

Two decades of prevention, prohibition and punishment have had little noticeable impact upon the growing use of illegal drugs; on the contrary drug use during this period has escalated. Despite attempts to deter drug taking amongst the younger generations, recreational drug taking has risen to the extent that many young people now regard the use of illicit drugs as a `normal' social activity. An extensive study amongst school children in North-West England revealed that by the age of 18 years, 64% had tried an illegal substance (Parker et al., 1998, p. 85). Furthermore, the 1998 British Crime Survey identified 16% of people aged between 16 and 29 years of age had tried an illegal drug during the past month (Ramsay & Partridge, 1999, p. 12). Indeed, numbers have steadily increased since the mid-1980s, with new outbreaks of heroin use emerging in the late 1990s (Parker et al., 1998). Figure 2 indicates the growing number of problem drug users, i.e. `addicts' notified (registered to the Home Office by the medical professions as `addicts' who are receiving medical treatment for a drug problem) or re-notified (each year an `addict' has to be re-notified) between 1987 and 1996.

These data represent only those drug users who have openly acknowledged their drug addiction to the medical profession, the vast majority being dependent upon opiates in order to access substitute prescribing. Moreover, the number of `existing' problem drug users who continue to be re-notified illustrates the difficulty of not only recovery, but also the

struggle for reintegration. Many of these problem drug users will have had periods of stability in their drug use and many will have tried to move away from a drug-dominated lifestyle. However, so demonised are this group they remain trapped in the same lifestyle and with limited options available many relapse and return to drug use. Research (Buchanan & Young, 1996), indicates that for many discarded youth of the early 1980s, this pattern of chronic relapse has continued for virtually their entire adult life.

On the basis of this research, it is evident that the anti-drug campaign s over the past 20 years have added to the isolation and marginalisation of the discarded working-class youth, many of whom began taking drugs in the 1980s. In addition to having to overcome their addiction, one of the biggest hurdles they have to face is breaking through the barrier of social exclusion. Discrimination has led many problem drug users to internalise and blame themselves for their position. This loss of confidence and self-esteem is a serious debilitating factor. They feel themselves to be labelled, discarded and isolated from mainstream society. It should come as no surprise then to find that the demand and attraction for illegal drugs is significantly higher in poorer areas (Social Exclusion Unit, 1999, p. 26). In her study of drug trafficking, Penny Green argues that geo-political issues must ultimately be considered, and states that any analysis of the effectiveness of UK drug policy against a whole series of indicators leads to the inevitable conclusion that the war on drugs is seriously failing;

By a whole range of indicators the evidence is incontrovertible prohibition driven crime control strategies enormously amplify and in the majority of circumstances actually create the major social problems commonly associated with drug abuse (the spread of HIV; the existence of the black [illegal] market; deaths resulting from overdoses and adulterous drugs, drug related property offences, the growth of organised crime and so on). (Green, 1998, p. 134)

Social Exclusion, Discrimination and the Experience of Problem Drug Users on Merseyside

For the purpose of this article problem drug users are defined as people who are dependent socially, psychologically and/or physically upon a substance or substances, to the extent that

they experience problems and/or present problems to others. Most problem drug users are poly users, have been dependent for many years, and will have made numerous unsuccessful attempts to give up, or regain control of their drug use. In this section the authors examine in more detail the experiences of such people living on Merseyside, England, many of whom have experienced social and economic disadvantage. While many question and doubt the motivation of drug users to change, our findings from qualitative research (Buchanan & Young, 1996, 1998b, Goldson et al., 1995) with 200 problem drug users indicates that it is not so much motivation that is lacking, but rather opportunities exacerbated by discrimination. The three studies conducted between 1995 and 1998 involved semi-structured interviews with problem drug users in the Bootle and Liverpool areas of Merseyside. The studies were concerned with listening to what problem drug users had to say about the barriers they faced and what assistance they needed to be able to recover and reintegrate back into the wider community. The majority of problem drug users interviewed were over 26 years old and had been taking illegal drugs for between 7 and 13 years. Fifty-two per cent had no qualifications. Many were teenagers in the mid-1980 s who were unable to get jobs and resorted to drugs. One in seven had never been able to secure a job, while over half had been unemployed for the past 5 years. Only two people were currently in employment. This perhaps reflects the severe shortage of employment opportunities for unskilled and semi-skilled workers on Merseyside caused by the deindustrialisation of the past two decades.

Virtually all the sample identified heroin as their main drug of dependency, though it was commonly combined with a wide range of other illicit drugs. Fifty-five per cent defined their current drug use as `stable' to the extent that they were able to function `normally', while a further 18% said they were at present drug- free, though their capacity to be able to sustain this position was uncertain. The number of drug users from black and minority ethnic groups was small at just under 5%, while the ratio of males to female s was 2:1, slightly higher than most drug services.

When this group were asked how they felt when in the presence of people who did not use illegal drugs the answers were quite revealing. Many problem drug users felt rejected and

stigmatised by the non-drug-using population. The impact of this discrimination appears to have been deep and intrusive: 'They [non drug users] look down on me as scum of the earth and as someone not to be associated with'. Many recognised the low status they were ascribed as a `smackhead' and were acutely aware of the negative stereotypical roles attributed to them: `They see me as a drug addict, a smackhead and they think I'd rob them'. Such was the degree of isolation (perhaps initially partly self-imposed because of its illegal nature), but which was now so severe and long lasting, that many now felt uneasy or even unable to cope in the company of non-drug users, `I feel the odd one out, I've nothing in common with them. I start to get paranoid'. Aware and afraid of harsh judgmental attitudes some felt they had little choice except to avoid contact, `I used to avoid them like the plague. I used to be scared of what they might think', while others believed they were constantly being observed and watched, `I feel nervous in case I slip up, I know they would look at me in disgust'. The war on drugs has encouraged strong public disapproval of drug taking and indeed drug users. These comments illustrate how this has contributed to the level of isolation and detachment experienced by problem drug users. This hostile climate leaves drug users isolated, uneasy and often unable to integrate: `I never really mixed with people who have never taken drugs'. It would seem that separate `worlds' have been created, and there is little overlap or inter-connection between the two.

Quality of Relationships *Average Rating*			
0 = very poor 25 = poor 50 = okay 75 = good 100 = very good	6 months Prior	On Entry	On Completion *(3 months later)*
Partners (n=28)	44	68	74
Parents (n=50)	53	70	76
Children (n=36)	67	67	89
Friends* (n=variable)	51 (n=40)	63 (n=43)	76 (n=48)

*=A number of students said they had no friends and therefore couldn't answer the question

Figure 3. Improving the quality of relationships.

During interviews with a group of recovering problem drug users (Buchanan & Young, 1998b) who had attended a student-

centred Structured Day Programme (Transit, Liverpool), the drug users were asked to rate the quality of their relationships and these were monitored over a period of time. These data (Figure 3) illustrate the social isolation that was most acute prior to attendance at the programme. Apart from the relationships with their own children, relation- ships with parents, partner and friends were all rated as barely `okay'. The 36 interviewees who had children were possibly less likely to admit to failing relationships with their children due to the ongoing threat of being an unfit parent and losing the children. The programme they attended was specifically designed for the needs of problem drug users and had a positive impact upon all relationships. The most significant improvement, achieved while attending the course, was the relationship between problem drug users and their children. When asked how would you rate your relationship with your child, the comments by one woman (in chronological order) reveal the progress:

> `I was very irritable. I needed to be hospitalised, sectioned. I'd have sold my daughter for crack. I even phoned the police to take her away.' (1st interview)

> `Very close. Her teacher phoned me to tell me that no child had come on so much in a month.' (2nd interview)

> `Fine. I've got more patience with her. I set a timetable with her, it's like coming to a job.' (3rd interview)

Once a problem drug user becomes stable or drug-free, they need quickly to establish new routines and relationships that are not centred upon illicit drug taking. Without this reorientation, reintegration will be difficult and relapse is likely. However, integration of recovering drug users into mainstream com- munity life is not helped by government rhetoric that presents drug users as a serious threat to families and communities. This reinforces isolation and discrimination towards people who develop illicit drug problems, and tends to ghettoise them within drug sub-cultures with few exit routes into mainstream society, as one person explained. `I had drug associates and only one friend really'. Many problem drug users had few relationships that they would describe as friendships, instead, they referred to having acquaintances with drug associates these were largely functional relationships necessary to survive the day. This harsh and dehumanising experience undermines their

ability to form relationships with the non-drug users, and tends to reinforce social isolation and subsequent dislocation. In the `normal' world, from which they have been excluded, many feel vulnerable and lack confidence, and a drug-centred lifestyle is all that is on offer.

Marginalised groups who are subject to individual and institutional discrimination can internalise the ascribed identity and come to believe that the discrimination is somehow warranted and justified. This is particularly debilitating and for problem drug users it reinforces low self-esteem and poor self-confidence. Ironically it can lead to ongoing drug taking in order to mask the sense of inadequacy: `I'd use drugs to give me confidence'. Though many drug users recognise this is not a satisfactory strategy, `One of the reasons I use is that I get confidence but it's a false confidence'.

Denied opportunities and having experienced poverty and deprivation for most or all of their life, many problematic drug users have become part of a well- developed alternative informal economy involving petty crime, usually shoplifting (Bennett, 1998) and minor drug dealing. The `war on drugs' avoids this structural analysis and instead pathologises individuals. It fails to recognise that major structural changes in the past two decades have left large sections of UK society with little or no stake-holding in society. Many of these people have become problem drug users and commit crime to fund their habit. However, many are reluctant criminals, `I was using street drugs and I had to find money to support my habit'. Despite committing crime some still wished to distance themselves from a criminal identity, `I'm not a thief, I'm not a robber, it's because of the drugs and my situation'. However, with access to appropriate treatment many had managed to give up criminal activity, `Now that I'm on a [methadone]- script I'm not offending, it was only ever to support my habit'. While some people committed crime before becoming dependent upon drugs, others committed crime out of necessity, and were keen to stop as soon as it was possible, `I'm not using so I don't need to find money'.

On the basis of the authors' research findings, problem drug users appear to be seeking but rarely finding the appropriate assistance they need. We would argue that a much greater emphasis and resources must be given to treatment,

rehabilitation and social reintegration. Instead, it is estimated 85% of the UK drug budget is spent upon prevention, prohibition and punishment (UNDCP, 1997, p. 319). The Drug Tsars' First Annual Report and National Plan appears to recognise this crucial imbalance and will be building new resources to support the Drug Treatment and Testing Orders. The expansion of the arrest referral scheme is also welcomed, but it is questionable whether the criminal justice system is the most appropriate setting within which to arrange and manage new treatment programmes.

Although some problem drug users do not want to change, the authors' research indicated that many problem drug users are tired and frustrated, but trapped within a monotonous pattern of life wanting help to change, `I've been wanting to change for 5 years'. But motivation alone is not sufficient; drug users need opportunity and assistance: `I want to be drug-free, get a job and live normal life'. Without support and sensitive access to education, training, employment, leisure and housing, problem drug users will struggle to break out of the drug sub-culture: `It is difficult, you feel divorced from the mainstream, I want to get back into it'. The divide between the excluded and the rest of society can cause frustration `I'm sick of it. I see people with their own houses, family and friends. I'd like friends who don't use'. While others feel trapped and have adjusted their expectations accordingly: `No prospects for someone like me, I gave up years ago thinking I could get a job, I might as well reach for the moon'.

In contrast to the stereotype of being lazy or work-shy, many problem drug users lead a surprisingly busy existence, working hard to secure their daily supply of drugs as one drug user stated, `I was just going out hunting money and getting a fix'. Though the futility of such an existence was recognised, `I was living life in a bubble, wasting my life drugged up'. Paradoxically, listening to drug users it seems the need for illegal drugs can provide a similar pattern to normal working life: routine, purpose, focus, structure, stress, rewards and most important of all it occupies the hours of each day. The day begins with a clear focus, as one drug user stated: `Drugs take over your life, you can't get on as normal. You wake up and have to take something to feel normal.' Figure 4 describes the eight-step daily cycle typical of many problem drug users found in the authors' research:
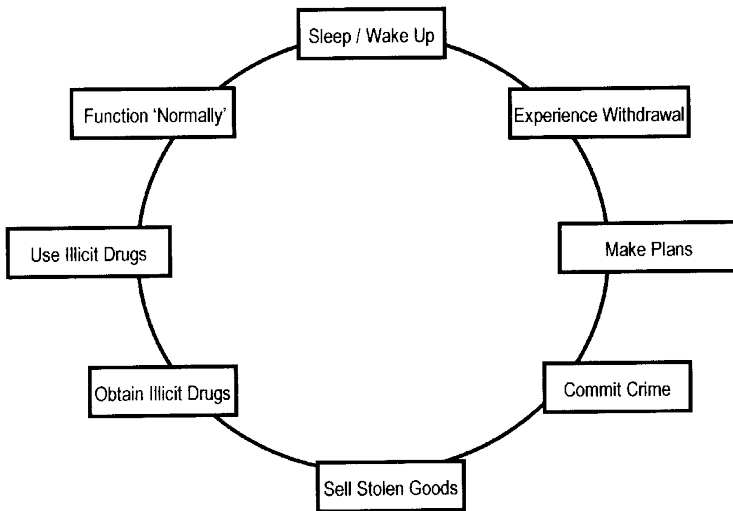
Figure 4. Daily cycle: problematic drug use.

1. The person wakes up anxious; concerned about generating sufficient funds, for example; typically around £50 worth of heroin would be needed to get them `sorted'.

2. Without access to drugs they will begin to experience withdrawal symptoms of sickness, stomach cramps, aches, pains and sweating, referred to as `turkeying'.

3. The person `plans' for the day in order to generate sufficient funds to be in a position to purchase a daily supply of drugs.

4. The person goes out `grafting' (committing crime). Any goods stolen will need to be worth considerably more than the cost of the drugs they need to purchase.

5. The stolen goods are sold at a fraction of their true value, often to people living in impoverished communities.

6. With cash in hand they seek a place to purchase drugs, referred to as going to `score'.

7. Once they have acquired a supply of drugs they can enjoy the pleasures of their hard work.

14

8. At this point having taken drugs the person can function `normally' and will feel more able to cope.

9. Provided they have been able to obtain a sufficient amount of drugs, the cycle is complete and they are able to get some sleep (though often intermittent) before the same process begins again the following day.

Moreover, this pattern has become influential in the development of an alternative informal economy that provides access to goods for economically deprived communities, who would otherwise be unable to enjoy the material benefits available to wider society. It is therefore not surprising to discover a correlation between the discarded working-class population in Merseyside in the 1990s, and the struggle of a discarded population living in the New York `slums' in the 1960s identified in Prebble and Casey's study:

> The career of the heroin user serves a dual purpose for the slum inhabitant; it enables him [or her] to escape, not from purposeful activity, but from the monotony of an existence severely limited by social constraints, and at the same time it provides a way for him [or her] to gain revenge on society for the injustices and deprivation he [/she] has experienced. (Prebble & Casey, 1969, p. 22)

The social and economic disadvantage endured by many unskilled youth on Merseyside, like those in New York three decades earlier, has forced many into a career of drug use. This is not to avoid employment or purposeful activity, because that is an option that has largely been denied, instead the drug-centred lifestyle is an alternative to a monotonous empty and largely meaningless existence. It is difficult to accept Prebble & Casey's (1969) interpretation of this behaviour being `revenge on society'. However, when people who are excluded and economically unwanted face the daunting prospect of growing up in a hostile individualistic society that promotes free enterprise and innovation, the emergence of a drug sub-culture could be interpreted as an unconscious but direct alternative to long-term unemployment. Once in this lifestyle their limited chances of employment are even more diminished. They become increasingly socially isolated and it is then difficult to find avenues back into mainstream society. Figure 5 outlines

the phases and difficulties that drug users experience in their attempts to reintegrate back into the wider non-drug-using community. Importantly, it indicates the role and importance of developing a full range of services to help complete the stages to full recovery. Drug agencies tend to be concentrated on assisting problem drug users to achieve control and/or become drug-free (Department of Health, 1996). Few agencies, however, have been established to assist problem drug users in the difficult process of social reintegration.

The move up the steps from `chaotic' to `control' may take several years with relapse occurring frequently at any stage in the process. At the bottom problem drug users begin in a chaotic phase with little or no insight into their situation, they cannot see, will not see, or do not see that they have a drug problem. In the ambivalent phase they develop some awareness and insight, and at times may fleetingly consider they have a drug problem that needs dealing with, but at the same time they are aware of the benefits and pleasure s that drug taking brings. The action phase is the period when the decision has been made and the person is genuinely working, and at times struggling, to regain control of their life. At the control phase, recovering drug users have achieved a level of stability and are usually either drug-free or maintained on a legal substitute, though it is possible some may have achieved controlled illegal use. This is a critical period when recovering drug users need considerable support and encouragement as they attempt to move on to the reorientation phase. In this phase well-established habits need to be replaced by new forms of behaviour and thinking. A new focus for each day is required. Whatever benefits a drug-centred lifestyle provided (and these may be many) need to be replaced. The final phase before full integration into wider society is the reintegration phase in which the person reintegrates within new friendship groups, leisure activities, education establishments and employment. Having achieved this stage relapse becomes more unlikely.
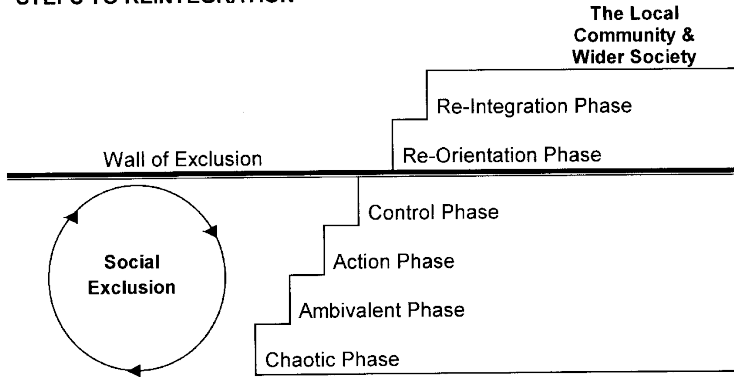
STEPS TO REINTEGRATION

Figure 5. Steps to reintegration.

However, the Steps to Reintegration (figure 5) identifies a Wall of Exclusion in which it appears problem drug users are often denied opportunities and prevented from gaining access to wider society. The authors argue that a barrier has been constructed to separate and isolate problem drug users. This discriminatory action is legitimised and indirectly supported by a drug strategy that portrays all problem drug users as dangerous addicts and criminals, people not to be trusted or associated with. This has prevented many recovering problem drug users getting beyond the `wall of exclusion'. This often-unrecognised exclusion appears to be a major contributing factor in drug relapse. The process becomes even more debilitating when problem drug users embrace and internalise the identity as undeserving, second-rate citizens. The research indicates that many problem drug users on Merseyside feel socially stranded, largely forgotten, with little hope of alternatives. Once this drug-using identity is ascribed and the process of stigmatisation, marginalisation and exclusion initiated, it is very difficult to get beyond the Wall of Exclusion. Peter McDermott, a writer and researcher on drug matters who has first-hand experience, states: `I can person- ally assure you that no matter how stable you are, or how useful your activism is, once you are 'outed' you will experience serious discrimination that can be very difficult to overcome' (1997, p. 10).

Conclusion

17

Divisive and exclusive policies dominated British political ideology towards the end of the 20th century and many citizens were denied the opportunity to participate fully within society. The fragmentation of social cohesion and community is one of the most disturbing outcomes of these major structural changes. Large sections of working-class society became economically and socially stranded by deindustrialisation and New Right politics. In the 1980s, when many young people from discarded working-class communities left school with the realisation that ahead of them was the prospect of life-long unemployment, boredom and poverty, it was no coincidence that heroin addiction escalated beyond recognition, and reached epidemic proportions. Many of those who resorted to heroin in the 1980s are today's long-term problem drug users who struggle to access services and find appropriate treatment. Long waiting lists are common and flexible prescribing, which includes pre-scribing oral or injectable methadone and/or heroin maintenance, is hard to find in the UK.

Recently introduced populist drug policies that seek to uncover drug users by urine testing and then `offer' compulsory abstinence-orientated treatment programmes have further isolated problem drug users from mainstream society. When elected in 1997, New Labour had an ideal opportunity to rethink and develop a more radical and rational approach to the national (or indeed international) drug problem. Instead, a politically safer option was chosen, one that attempts to convince the nation that the war on drugs can be won. However, with half the population under the age of 30 having tried an illegal drug (Ramsay & Partridge, 1999, p. viii) government policy appears increasingly out of touch with younger sections of society. The limitations and indeed negative consequences of a drug policy pouring vast resources into maintaining prohibition is widely recognised (Flynn, 1998; Police Foundation, 2000; Smith, 1995). The recent Independent Inquiry on the Misuse of Drugs rightly argued that drug legislation must be brought into line with `public opinion and its most loyal ally, common sense' (Police Foundation, 2000, p. 10).

The war on drugs rhetoric is creating a fracture in society as thousands of otherwise `law abiding' citizens are criminalised for recreationally using `soft' drugs, while problem drug users, who tend to be dependent on `hard' drugs such as cocaine and

heroin, are stigmatised and kept isolated within drug sub-cultures. The present populist UK drug policy primarily concerned with prevention, prohibition and punishment will inevitably reinforce this position and lead to more dangerous and hostile environments. A bold and radical rethink of UK drug policy is needed. This should include an overhaul of the Misuse of Drugs Act 1971, a rational and non-emotive examination of recreational drug use (legal and illegal), serious consideration to decriminalise the possession of any substance for personal use, and the development of strategies that tackle inequality, disadvantage and discrimination to enable social reintegration for problem drug users. The inquiry (Police Foundation, 2000) into the Misuse of Drugs Act 1971 could have been the catalyst for such change, but the government appears reluctant to engage in an open and constructive dialogue, and unwilling to develop a rational drug policy fitting for 21st century Britain. The consequences are not insignificant.

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