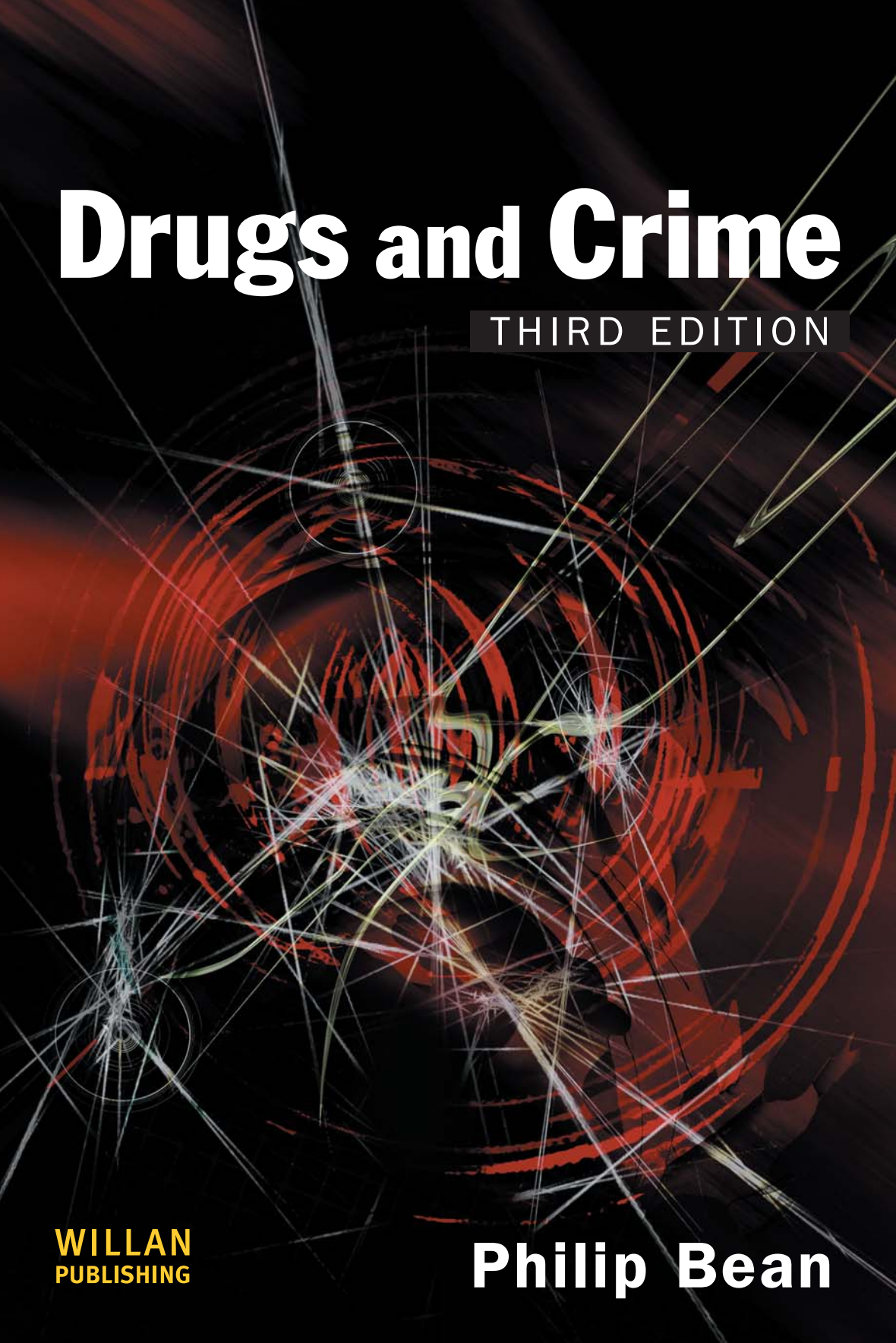
Drugs and Crime

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.