Controlling the Use of Illicit Drugs: Enforcement through Criminal Sanctions and the Legalisation Debate

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This paper examines some of the arguments for and against changes in the enforcement policy and law relating to cannabis and certain other drugs which are currently controlled under the Misuse of Drugs Act 1971. It sets out estimates of the levels of use of these drugs and the penalties which may currently be imposed on defendants found guilty of possessing, supplying, producing or importing them.

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Summary

In October 1994 the Government issued a Green Paper *Tackling Drugs Together* [Cm 2678] setting out proposals for a strategy to deal with the problem of drug misuse. A white Paper of the same name was published in May 1995. [Cm 2846] The papers reiterate a commitment to reduce the supply of illegal drugs and the demand for them through a wide range of actions, programmes and initiatives at international, national and local levels. The strategy's Statement of Purpose is,

"To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:

increase the safety of communities from drug-related crime;

reduce the acceptability and availability of drugs to young people; and

reduce the health risks and other damage related to drug misuse."

Both the Green Paper and the White Paper stress the desirability of total abstinence from drug-taking but acknowledge that where those people who do take drugs are concerned, efforts should be directed at minimising the harm which their actions may cause to themselves, their families and the wider community. This emphasis on harm reduction is a new element in the Government's strategy on drugs which has met with general approval.

In an annex to the Green Paper the Government discussed the legalisation debate, which it acknowledged "can be conducted in good faith by responsible people who can respect each others' views" [Cm 2678 p.111].

The Government stated that it remained strongly opposed to the legalisation of cannabis or any other controlled drug and set out its reasons for taking this view [Cm 2678 p.111-112] This paper examines the arguments for and against the various potential forms of relaxation of drug controls and sets out the available evidence on public opinion concerning the current law. It also summarises the current sentencing provisions available to the courts in dealing with people convicted of those offences. Finally there is an analysis of the available evidence on current levels of drug usage.

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I Legalisation of Currently Illicit Drugs

The expression "legalisation" embraces a number of different possibilities for loosening controls on cannabis and other currently illicit drugs. The most commonly cited options are "decriminalisation", "licensing" and outright "legalisation".

"Decriminalisation" tends to be used in connection with the debate on the legalisation of cannabis, for example, to describe a system under which the possession of small quantities of cannabis for personal use would cease to be a criminal act. Through an extension of this principle, the cultivation of small amounts for personal use and the gift of small amounts to another person might also be permitted. Other activities, such as possession of larger amounts or cultivation and supply for profit would remain illegal and it would also probably be necessary to restrict personal use in certain circumstances, such as where a person was driving a motor vehicle. The purpose of decriminalisation would be to remove the stigma of criminality from cannabis use by the individual while continuing to penalise the commercial exploitation of the drug.

"Licensing" would be used to regulate the use or consumption of a controlled substance or the behaviour of users or consumers and could also be used to raise money through taxation. In the specific context of cannabis a licensing or regulatory system would aim to permit moderate use by adults without increasing availability enormously, to discourage excessive consumption and to reduce the attraction and power of the market in illicit drugs by providing a legal source of supply. Supporters of a licensing system for other addictive drugs such as heroin would add that improvements in the purity of drugs under a regulatory system and the measured does which would be available might reduce the number of deaths of addicts attributable to contaminated or unusually concentrated supplies of these drugs. They would also argue that although licensing might be seen as a compromise, experience such as that of the United States during the prohibition era between 1919 and 1933 shows that if the demand for something is strong enough its supply cannot effectively be stamped out.

"Legalisation" is taken to mean that the drug concerned would cease to be a controlled substance and could be purchased, possessed and used without the risk of criminal sanctions. It would not necessarily follow that all forms of control would immediately be removed as restrictions might still be needed to bring the drug concerned into the tax system or to protect young people.

Of these three options the one most popular with critics of current drug control policy, particularly where cannabis is concerned, is decriminalisation. Decriminalisation of cannabis has been adopted most notably in Holland and in some of the states in the United States of America. Some other member states of the European Union have also moved or are reported to be moving in this direction. It could be argued that a certain amount of de facto

decriminalisation, particularly of cannabis, has already taken place in the UK. In 1993, 52% of drugs offenders were cautioned by the police, while only 5% were cautioned in 1983. Policy changes account for much of this increase as most police forces in England and Wales now caution first-time offenders found in possession of small quantities of cannabis and some other drugs for personal use. Detailed statistics of measures taken against drugs offenders are set out in chapter VI of this paper.

Provisions in the Criminal Justice (Scotland) Bill currently before Parliament which would make all statutory offences triable in the district court and therefore punishable by a fiscal fine, which would not amount to a conviction or be recorded as such, led to press comment that the possession of cannabis, which is a statutory offence, was being decriminalised in Scotland. The White Paper *Firm and Fair - Improving the Delivery of Justice in Scotland*[1] noted, however, that the change would not mean that all those accused of a statutory offence would be offered a fiscal fine and that the decision on the suitable disposal of a case would be taken by the procurator-fiscal, based on the known facts of the case and guidance issued by the Lord Advocate.

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[1] Cm 2600 para. 8.9

II Arguments for and against the relaxation of controls on drugs

The case for relaxing controls on drugs is based on a mixture of libertarian and utilitarian arguments, health considerations and arguments about the potential effectiveness of a more permissive system. Some of these arguments are closely linked. They have here, however, been grouped under four separate headings for ease of reference.

A. Individual freedom and the wider duty of the state

The libertarian argument for the relaxation of controls on drugs would be that the state is only justified in forcefully intervening to curb the behaviour of an individual who has reached the age of majority where this is done to prevent the person from harming others. Opponents of this argument would contend that the state is properly the protector and arbiter of morality and well-being and that drugs are a threat to society and an indicator of social and moral decline. They would be likely to argue that whatever society's current ills, any relaxation of controls on drugs would be defeatist and likely to lead to further degeneracy.

The philosophical underunnings of the arguments for and against drug control are set out succinctly in the 1968 Report by the Advisory Committee on Drug Dependence (the Wootton Report) on *Cannabis* as follows:[2]

> 13. The great majority of the restrictions currently imposed upon an individual's freedom in this country are defended on the ground that they are necessary for the safety or well-being of others. Although there may be differences of opinion as to how far such restrictions may legitimately be carried, at least it is clear that the law which requires a land-owner to obtain the approval of the local authority before he can erect a building upon his own property is not designed in the interests of his personal convenience; nor does anyone suppose that the law which fixes the maximum concentration of alcohol in the blood with which it is permissible to drive a motor vehicle is primarily intended to protect the drunken driver from himself.
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> 14. Much more controversial, however, is the question whether, and if so, how far, it is justifiable for the law to restrict a man's freedom in what is presumed of be his own interest. On that issue there is considerable support today for J. S. Mill's dictum that "the only purpose for which power can rightly be exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant". It was, indeed, on this very ground that the Wolfenden Committee put forward a recommendation, which Parliament subsequently accepted, that homosexual acts committed in private between

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[2] p.3-5

two consenting adults should no longer be criminal; and it can be argued that by similar reasoning the use or sale of drugs in general, and of cannabis in particular, ought not to be the subject of criminal proceedings. Adult men and women, it is said, ought to be free to make their own decisions, in accordance with their personal tastes, and their own moral judgments, as to what substances they think it proper to consume. Added weight is, moreover, given to this argument by the multiplicity of restrictions on individual liberty which in any complex modern society are incontestably necessary for the common good. The greater the number and variety of unavoidable limitations on personal freedom, the more pressing, it may be said, is the urgency of preserving freedom of choice in what are matters of purely individual concern.

15. While we appreciate the force of this argument, it has to be recognized that no hard and fast line can be drawn between actions that are purely self-regarding, and those that involve wider social consequences. If, generally speaking, every one is entitled to decide for himself what he will eat, drink or smoke, the fact remains that those who indulge in gross intemperance of almost any kind will nearly always become a burden to their families, the public authorities or both. Indeed, examples of actions which never in any circumstances involve social repercussions are by no means easy to find. Nor can it be said that any consistent principle dictates the occasions on which the law at present intervenes to protect the individual from himself. Suicidal attempts at immediate and total self destruction are not criminal; yet he who shortens his expectation of life by misusing heroin is liable to prosecution. Again, anyone over the age of 16 is entitled to ride a motor bicycle, although the statistics of self-destruction thereby' bear eloquent testimony to the lethal character of these machines.

16. Every proposal to restrict the freedom of the individual in his own supposed interests must, therefore, be decided on merits, in the light of the probable severity of any damage that he may inflict upon himself, and of the risk that in damaging himself he may also involuntarily be the cause of injury to others.

17. In addition, account must be taken of public attitudes. It is clear that interest in mood-altering drugs has much increased in the past few years. Explanations of this phenomenon can only be speculative. To some extent it could not unreasonably be ascribed to growing disenchantment with the highly competitive and threatening nature of contemporary society, or to the destruction of the natural environment. Again, it is notable that some of those who use drugs such as cannabis or L.S.D. appear to be searching for spiritual experience. They speak of "new levels of consciousness" and of "the heightening of sensual, visual and musical experience" in terms reminiscent of those employed by mystics. The students of the epidemiology of crowd behaviour will, moreover,

B. Perceptions of the harm resulting from the current law and of the potential harm which might result from the relaxation of that law

People who would not necessarily hold that the state had only a limited role in the enforcement of morality might nonetheless argue that changes should be made because large numbers of law enforcement officers and huge sums of money are tied up nationally and internationally in operations against drugs to no apparent effect while, particularly where 'hard drugs' are concerned, crimes committed by addicts trying to service habits which are costly largely because of their illegality, continue to rise. The personal cost to users is high as they may acquire criminal records or serve prison sentences, which may also cause hardship and suffering to their families. Enforcement of drug laws may also cause tension between the police and otherwise law-abiding citizens. Users seeking to obtain drugs will also have to come into contact with criminal networks. Huge profits from the trade are made by organised crime which brings with it violence and corruption in public and private life.

Opponents of this argument could argue that individuals must take responsibility for their actions and the wider consequences of those actions. They might say that it would be inappropriate for the state to take steps which might have serious consequences for the wider public simply because a minority of people find themselves unable to comply with laws which a majority comply with and consider acceptable. Arguments about the harm caused by the current law would not necessarily further the case for decriminalisation, as this option would not damage the existing market in illicit drugs. Users would still have to obtain their drugs from criminal networks, but decriminalisation might result in more people being introduced to drugs by removing any reluctance they might currently have which was attributable to the illegal status of those substances. It might therefore be argued that in spite of their limitations the current laws may prevent even larger numbers of people becoming involved in drugs, in that some people may be deterred by the criminal sanctions imposed on drug users.

C. Health Considerations

Critics of the present system of controls on drugs would stress the dangers to the health of drug users caused by impure or adulterated supplies and varying strengths of drugs available on the illicit market, and note that most drug fatalities are caused not by the drugs themselves but by overdoses or the consequences of impure supplies of drugs or the insanitary methods by which they are consumed. They would say that all of these problems could be tackled if clean, regulated supplies of drugs were legally available. They would also stress the importance of informing and educating the public and particularly young people, both to discourage them from using drugs at all and to advise them about how to reduce the risks to themselves if they do decide to use them. They would stress that alcohol and tobacco are freely available despite the harm which they cause and note that a number of controlled drugs have legitimate medical uses, as is clear from the fact that some of them are available on

prescription.

Opponents of moves to relax controls on drugs might say that strictly speaking the fact that alcohol and tobacco cause harm is an argument for further restricting their availability, not an argument for relaxing controls on other drugs, such as cannabis. They might consider it inappropriate for the state to permit the availability in non-medical contexts of an even wider variety of substances which alter perception or consciousness. In addition, they might argue that once the controls on these drugs had been lifted it would be very difficult to reverse the position and cut consumption if it were later decided that the move to relax controls had been mistaken.

D. Effects of a relaxation of controls

Supporters of the licensing or full legalisation of drugs currently subject to controls argue that there would be considerable financial benefits for the government, in that some of the huge profits currently made from the trade in illicit drugs by traffickers and organised crime would be transferred to the state through taxation. The illegal market would be eliminated and there would be savings in the costs to the criminal justice system in dealing with that market and the crime, violence and corruption associated with it. They point out what they see as an inconsistency in the arguments of those advocates of a free market who suggest that the criminal law can be used to any significant effect in combatting the illicit market in drugs. They would add that a legal market would ensure that supplies made available to users were produced under proper manufacturing conditions and subject to quality control.

Opponents of licensing or legalisation might consider that the state's existing permissiveness towards and profits from the sale of alcohol and tobacco are questionable and that it would be wholly morally objectionable for the government to become involved in the supply of an even wider range of intoxicants for non-medical use. It is unlikely that the manufacture or production of legalised drugs would become a state monopoly. It might be argued that it would be unwise to speculate on the likelihood of criminal gangs and networks ceasing to be involved in the supply of drugs, particularly if they could undercut the highly-taxed drugs supplied by the state with their own adulterated or unadulterated drugs. In answer to this particular argument it could be said that the legal supply of alcohol and tobacco in this country has not brought with it an equivalent illegal trade in adulterated products, although there is concern about illegal trading resulting from price differences within the European Union.

Opponents of changes in the law might also argue that advocates of the relaxation of drug controls across the board do not give consideration to practical questions concerning controls on the manufacture and distribution of legalised drugs and who is to be permitted to have access. They might express concern about access to legalised drugs by young people. It might also be argued that advocates of wholesale legalisation do not distinguish sufficiently between different types of drugs and have little to say about whether a state which adopted

a policy of licensing, or legalising drugs in general would then license or legalise any new intoxicating substance which was developed or which appeared on the illicit market.
An important debating point on the possible consequences of a relaxation of controls is, of course, the effect which this might be expected to have on levels of consumption. The Institute for Drug Dependency (ISDD)'s briefing *Legalisation: For and Against* summarises arguments for and against the proposition that greater availability would not lead to greater consumption as follows:

> *More availability doesn't equal more use - cannabis use did not escalate in the US states which decriminalised the drug in the '70s. Nor does more availability mean more addiction. During the Vietnam war many US soldiers used heroin regularly, most stopped when they returned. Heroin was easy to obtain, but the main reason soldiers used it was because they were in a war situation. Once they got home, they didn't use it even though they could have done so.*
> That's wishful thinking. More availability does mean more use and that means more problems. What the Vietnam experience shows is that when drugs are freely available, more people will use them, and more will become addicted. You only have to look at the numbers who smoke and drink as opposed to those who use illegal drugs to know this must be true. Then look at the massive problems we already have from tobacco and alcohol. There is good evidence that the more alcohol drinkers there are, the more become problem drinkers.

A number of commentators have observed that the price of any legalised drug would be likely to be an important factor influencing levels of consumption. In the Green Paper the Government agreed with this view and referred to research on the price of alcohol and tobacco in support of this argument [Cm 2678 p.11].

The Netherlands have adopted a policy concerning drugs which endeavours to draw a clear distinction between cannabis, which is tolerated as far as use and small-scale dealing is concerned, and drugs which are considered to present "unacceptable risks", such as heroin and other "hard" drugs. In a paper published in 1989 in the *British Journal of Addiction* a senior official in the Dutch government made the following comments about the results of the de facto decriminalisation of cannabis in the Netherlands:[3]

> The policy of *de-facto* decrimalization of cannabis does not produce more drug use and has proven to be very successful. The prevalence of cannabis use in the Netherlands is low. In the age bracket between 10 and 18 years, 4.2% have ever used cannabis (life time prevalence). Among them 1.9% are still using occasionally. The number of daily cannabis users appeared to be one in a thousand (nationwide school survey; N=25,000; 1984).
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> As is well-known the prevalence of drug use is always highest in metropolitan areas. Therefore the Dutch carried out a household survey in Amsterdam, in December 1987 (N=4370) among respondents of 12 years and older'. The average life time prevalence of cannabis use was 22.8%. The so-called last month-prevalence of cannabis use appeared

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[3] "Dutch management of drug problems" - British Journal of Addiction (1989) 84, 213

to be 5.5%. The highest last-month-prevalence was found in the age bracket of 23 and 24 years: 14.5%.

A study published in 1994 by the Council of Europe on *Drug misuse trends in thirteen European cities* reported that the level of cannabis use had remained relatively stable over the 1980's.[4] It was reported in the *Guardian* on January 24th 1995 that proposals were being put forward in the Netherlands for the decriminalisation and possible government regulation of the supply and production of cannabis, both of which are currently subject to criminal sanctions. There are complaints from some of those involved in law enforcement in the Netherlands that taking action against those people who supplied cannabis to coffee shops were small-scale dealing and use were tolerated "served only to push up prices, increase crime levels and boost the influence of organised crime".

There has been much press comment on the trade in "hard" drugs in the Netherlands. These drugs have not, of course, been decriminalised in the Netherlands and their use, supply, production and manufacture is still subject to criminal sanctions there.

The possible effects of decriminalisation and legalisation on drug consumption are discussed in some detail in, amongst other places, the 1979 ISDD study group report on Cannabis: Options for Control,[5] Ronald Bayer and Gerald Oppenheimer's book Confronting Drug Policy[6] and the Institute of Economic Affairs paper *Winning the War on Drugs: To Legalise or Not?*.[7]

E. Health Considerations concerning cannabis

The Advisory Council on the Misuse of Drugs made the following remarks about the health arguments relating to cannabis in its 1982 *Report of the Expert Group on the Effects of Cannabis Use*:[8]

18. In considering, as a Group, the conclusions that can be drawn from these individual papers, there are a number of more general points which we thought it right to take into account. First, the research work which we have examined was based on tests conducted in controlled, often laboratory conditions, using cannabis products with a predetermined content of tetrahydrocannabinol (THC), the main physiologically active component in cannabis. Analyses of cannabis seized by the law enforcement authorities have, however, shown wide variations in the THC content, ranging from 0.03% for herbal cannabis to as high as 18% for cannabis resin, and up to nearly 50% for liquid cannabis. These variations are accounted for in part by geographical origin, in part by the degree of maturity of the seized

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4 p.10
5 p.24-27 and p.92-97
6 (1993) p.86-89 and p.348-353
7 1994 p.56-57 and p.85-87
8 p.3-4

material, and also by other factors which have not as yet been fully identified. We think it right, however, to draw attention to this wide variation in the potency of illicit cannabis available in this country, (a variation which also extends to the other constituents of cannabis) and to the fact that the results of the many research projects which we have examined cannot be regarded as providing conclusive evidence on the effects of cannabis as used "at street level".

19. Second, it will have been noticed that many of the research projects which were examined by our members have been conducted on animals. While the results of these projects can provide in many instances a pointer to the effect that the use of cannabis can have on the human body again they cannot provide conclusive evidence. Recent advances in detection and measurement of cannabinoids in body fluids should assist such study as well as in epidemiological or toxicological work.

Third, we noticed the absence of research on the epidemiological characteristics of cannabis, an area in which we think there is a need for detailed and careful study.

20. In the light, therefore, of the studies examined in the papers included in this report, we consider that:

1 there is insufficient evidence to enable us to reach any incontestable conclusions as to the effects on the human body of the use of cannabis;

2. but that much of the research undertaken so far has failed to demonstrate positive and significant harmful effects in man attributable solely to the use of cannabis;

3. nevertheless in a number of areas there is evidence to suggest that deleterious effects may result in certain circumstances;

4. there is a continuing need for further research, particularly on the epidemiological characteristics of cannabis use and on the effects of its long-term use by humans;

5. there is evidence to suggest that the therapeutic use of cannabis or of substances derived from it for the treatment of certain medical conditions may, after further research, prove to be beneficial.

The ISDD's *Drug Abuse Briefing* contains the following summary of views on the effects of long-term use of cannabis:[9]

There is no conclusive evidence that long-term cannabis use causes lasting damage to physical or mental health. Experiments suggest that it may be damaging in a number of respects, but studies of cannabis users have failed to confirm these possibilities. This may be because the kinds of study needed to detect slow-to-develop and infrequent outcomes (studies of large groups of users over a long period of time) have not been done.

In particular, it is probable that (as with tobacco smoke) frequent inhalation of cannabis smoke over a period of years helps cause bronchitis and other respiratory disorders, and perhaps also lung cancer.

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[9] 5th edition 1994 p.30

People who use cannabis are more likely to use other drugs. Likewise people who smoke tobacco or drink are more likely to try cannabis. In neither case is there any evidence that using one drug actually causes people to use another. Cannabis does not produce physical dependence, though mild withdrawal symptoms have been produced in experiments. Regular users can come to feel a psychological need for the drug or may rely on it as a 'social lubricant',

A heavy user chronically intoxicated on cannabis may appear apathetic, lack energy, and perform poorly at their work or education. However, such a condition seems rare, and no different from what might be expected of someone chronically intoxicated on alcohol or other sedative-type drugs. There is no evidence of a special cannabis 'amotivational syndrome'.

The effects of cannabis may cause special risks for people with existing or underlying mental illness, or with lung, respiratory or heart disorders. Prolonged heavy use occasionally causes a temporary Psychiatric disorder, including mental confusion and delusions, which clears up within a few days, once the drug is stopped.

Regular, frequent cannabis use during pregnancy may help cause premature birth with its attendant complications. However, results are conflicting, and cannabis use is likely to be just one of a number of factors affecting foetal development. Very heavy (eg. daily) cannabis users may give birth to babies who temporarily suffer tremor and distress, and are easily startled, There is no evidence that any adverse effects persist beyond the first year of life.

Bucknell and Ghodse note in their book on *Misuse of Drugs*[10] that the long-term effects of chronic use of cannabis are a cause for concern, saying that it has been suggested that heavy long-term use may lead to an "amotivational syndrome" with loss of ambition, apathy and social deterioration. They add, however, that there is no definite evidence either for this theory or to confirm that cannabis causes brain damage.

The Government discussed and rejected the arguments for the legalisation of cannabis and other drugs in the October 1994 Green Paper. In referring to possible health risks associated with cannabis it noted:[11]

D.8 Specific arguments are sometimes put forward in relation to cannabis for which, . id, there is little evidence of grave risks to health through moderate use. But, while the Government recognises that not all cannabis users become drug addicts, its use is part of the spectrum of drug misuse and carries real hazards associated with short-term memory problems, anxiety and sometimes depression. There is also increasing evidence that some forms of cannabis are available with a high THC (tetrahydro cannabinol) content which probably have a much greater toxic effect on the user. Evidence from research on long-term use has shown that cannabis may cause damage to body organs such as the liver, lungs and testes. Other long-term effects described in research include interference in male and female hormone levels, gestation time, fertility in women and reduced immune function. Long-term use can also be associated with a toxic psychosis which may become prolonged in some cases.

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[10] Second Edition p.60-61

[11] Tackling Drugs Together Cm 2678 p.112

III The United Kingdom's International Obligations

The United Kingdom is currently bound by a number of international conventions, agreements and treaties outlawing certain drugs including cannabis and various aspects of the trade in those drugs. A unilateral decision to decriminalise or legalise any of the drugs which are covered by these agreements would therefore be likely to put the UK in breach of its international obligations. It is not unprecedented for countries which are parties to these conventions to opt out of some of their provisions, but doing so might be considered politically difficult.

The ISDD's briefing paper *Legalisation For and Against* refers to the sale of cannabis in cafes in Holland, the use of administrative rather than criminal sanctions to deal with possession of drugs in Italy, the use of fines for possession in Spain, the brief experiment involving permitted use of a park in Zurich for injecting by addicts in Switzerland and the permitted prescribing of heroin and cocaine to addicts by certain doctors in the UK as evidence of a variety of approaches by countries which are nonetheless concerned with implementing international obligations in respect of controlled drugs.

A report by the European Parliament's Committee on Civil Liberties and Internal Affairs on Drugs Policy, published in January 1994, called for a review of the international conventions prohibiting certain drugs. The report noted that:[12]

> Any attempt to relax the prohibition of drugs is also complicated by the fact that current national law and international conventions (CounCil of Europe, United Nations) lay down a blanket prohibition of drugs. moreover, a question that should not be underestimated is whether the implementation of legalization measures in one country would not risk attracting addicts from other countries.
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> That is all the more reason to discuss at the supra-national level (EC, Council of Europe, united Nations) the advantages and applicability of formulas for replacing the anti-drug policy conducted so far. Initially a comprehensive study could be carried out and an international conference held on the subject, possibly in cooperation with the Council of Europe and the united Nations.

[12] EP DOC A3-0018/94 p.14

IV Public Opinion

In 1993 the Home Office published the results of a survey on *Drug Usage and Drugs Prevention - the views and habits of the general public.* As far as the public's views on drug control policies and legalisation were concerned, the survey found that:[13]

In **summary,** responses to an item in our questionnaire dealing with the issue of legalisation suggest that around 30% of the general population and around 50% of individuals in groups at risk of drug usage may be in favour or some limited form of legalisation or decriminalisation. Whilst in the case of the general population such figures suggest that this option remains a minority preference, the numbers favouring legalisation are still surprisingly high given that neither legalisation nor the problems faced by supply side control are issues which have as yet been addressed in the public domain. Multivariate analyses suggested further that demographic profiles and personal experience of drug usage were not the sole motivators behind any support for legalisation.

The report made the following observations about those respondents who had been in favour of legalisation and those who had been opposed to it:[14]

So what types of people *were* in favour of legalisation? As noted above, the under 35 age group were more likely to favour legalisation than their older counterparts. Male respondents were also slightly more likely to favour legalisation than female respondents. Similarly, respondents from ethnic minorities were more likely to favour legalisation than white respondents. The gender and. ethnic profile was common to both main and booster samples. The age bias, not surprisingly, was present only in the main sample. In contrast to many other attitudinal issues,. support for legalisation showed no clear effect for socioeconomic status in either main or booster sample, with any apparent trend being largely location dependent.

The profile of those respondents wishing to keep all drugs *illegal* was for the most part the mirror image of this demographic distribution, as one might expect. One exception to this being that no clear pattern emerged for the effect of ethnicity. Taking the data as a whole it appeared that whilst white respondents tended to spread their responses across all three options (legalisation, decriminalisation and keeping all drugs illegal), respondents from ethnic minorities tended rather to polarise their responses around the legal/illegal dimension.

Looking at the demographic profile of those *favouring decriminalisation,* a broad socioeconomic split did emerge, with respondents from groups AB and Cl being more likely to be in favour of decriminalisation than respondents from the C2 or DE groups. The split between males and females was also more extreme than that noted for legalisation, with again a higher percentage of males than females in favour of decriminalisation in both main and booster samples. The ethnic profile was as indicated above.

If we separate those respondents in favour of some form of legalisation or decriminalisation from those respondents in favour of maintaining present

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[13] p.181
[14] p.180

legal controls, the most noticeable distinction is, rather predictably, that between drug users and non-drug users with the former group being significantly more likely to favour both legalisation and decriminalisation than the latter. Although this is a predictable pattern to emerge, there are a number of interesting points to be made alongside this broad observation. Firstly, drug users were more likely to favour decriminalisation than the more extreme option of legalisation. Secondly, the distinction between drug users and non-users was not restricted to that between respondents presently using drugs and those not using drugs. Those who had in the past used drugs but who had chosen to stop doing so were still more likely to be in favour of some form of legalisation than non-drug users. A final point to note 'is that users of opiates were more likely to favour *both* legalisation and decriminalisation than users of either non-opiates or cannabis.

The above points are important in that they stand in contrast to a *number of common* assumptions regarding legalisation. In the first place, drug users would not seem, on the whole, to favour all-out legalisation. The fact that users of the more heavily controlled drugs *are* more likely to favour extreme forms of legalisation is not unexpected, since they are the group most likely to face severe penalties as the law stands at present. However, this point in itself undermines any suggestion that cannabis or other 'soft' drug users are the main proponents of legalisation within the drug using community. In line with this latter point, it would seem also that those who do have some experience of using drugs, but who may have a more balanced or long-term perspective than *present* users by virtue of the fact that they have stopped using drugs, still feel disposed towards legalisation, or at least decriminalisation. Taken as a whole these features of the data present a more balanced picture of the type of support given by the drug using community to legalisation than that which is often presented by, for example, the media.

In its concluding summary of this chapter the report noted that:[15]

The data we outlined in earlier sections of this report suggested that the public regard drug usage and drugs control as being in a largely unidirectional causal relationship. Some form of positive intervention in drug usage is preferred, a variety of quite distinct methods of control are approved of, and all are seen as likely to be at least partially effective in significantly reducing the misuse of drugs.

The real picture, as outlined in the present chapter, suggests that the nature of the drug usage/drugs prevention relationship is rather *more* convoluted. Control methods may reduce drug misuse to some extent, but they are equally likely to show a more symbiotic relationship with both dealing and usage and may even be completely *oblique* to the issue. Given which, the high fiscal cost associated with putting control into practice could be difficult to justify. On the other hand, a reduction in, or complete withdrawal of, control on drug usage may conflict with firmly held moral or philosophical views on the nature of drug usage. A substantial minority of our respondents appeared to be in favour of some restricted form of legalisation'. but the general attitude towards drug usage nevertheless placed drug users in the category of victims or criminals rather than legitimate consumers. This leaves the very pertinent dilemma that, whilst control measures have a high fiscal cost, any removal of control may have an equivalently high political cost.

To avoid both pitfalls, it might be possible to *redirect* rather than reduce or remove drugs control, for example, by shifting the emphasis from less effective to more effective methods, or from supply reduction to the reduction of demand. Although providing a potential political and financial solution to the drugs issue, this option is also problematic. It entails an ability to monitor and compare the outcome of methods which are not only qualitatively distinct in terms of their operation, but which also presuppose a range of different end

[15] p.183

points in the ascription of 'success'. In addition to such immediate problems we are also left with the more long term' difficulty of establishing what the deeper causal structure of the 'drugs problem' actually is. Clearly, there is no easy or short term solution to the problem of drug usage - however this is defined.

A Gallup poll of February 1994 showed the following levels of support for the legal position on "soft" and "hard" drugs:[16]

☐ *What should be the legal position on 'hard' drugs such as heroin and cocaine other than on medical prescription? Should it be a criminal offence to:*

	Today	May 1973	Aug 1967
- sell them to other people?			
Should	96	93	92
Should not	3	5	2
Don't know	1	2	6
- take them?			
Should	80	78	81
Should not	15	17	10
Don't know	4	5	9
- have somebody in your home who takes them?			
Should	69	66	72
Should not	26	24	18
Don't know	5	10	10
- have them in your possession?			
Should	86	80	82
Should not	11	14	10
Don't know	3	6	8

☐ *What should be the legal position on 'soft' drugs such as cannabis and marijuana other than on medical prescription? Should it be a criminal offence to:*

	Today	May 1973	Aug 1967
- sell them to other people?			
Should	74	86	88
Should not	23	10	4
Don't know	3	4	8
- take them?			
Should	61	71	77
Should not	34	22	12
Don't know	4	7	11
- have somebody in your home who takes them?			
Should	56	61	67
Should not	39	29	21
Don't know	5	10	11
- have them in your possession?			
Should	64	71	76
Should not	33	20	12
Don't know	3	9	12

[16] Gallup Political & Economic Index Report 402 : Fieldwork for Drugs questions 19-25.1.94 n=1051

V Sentencing for Drugs Offences

The mode of prosecution and maximum sentences available for some of the more common drugs offences are set ou in a table at the end of this chapter.

The sentence imposed on an offender in a particular case is entirely a matter for the judge or magistrates concerned, although both judges and magistrates must, of course, keep within such maximum sentences as may be set out in the statute for the particular offence concerned. Maximum penalties are designed to deal with the worst possible circumstances fitting within the offence concerned. They have had little effect on the important question of what should be the appropriate penalty in the majority of cases which come before the courts. Instead a "tariff" has been established by the Court of Appeal guiding judges on the range of penalties imposed for offences for which the statutory maximum penalties are high. This tariff is not to be found in any official publication, although D. A. Thomas's loose-leaf compendium *Current Sentencing Practice* can be regarded as virtually authoritative.

The formal channels of influence over sentencing decisions such as the Judicial Studies Board, which organises training seminars for judges, and the Court of Appeal, have made moves in recent years to encourage greater consistency in sentencing. The Court of Appeal has from time to time issued decisions which are specifically referred to as "guidelines" for future use. Guidelines on sentencing for drugs offences were issued in December 1982 by the then Lord Chief Justice Lord Lane in *R v. Aramah (1982) 4 Cr App.R. (S) 407.* Thomas's *Current Sentencing Practice* sets out the guidelines in relation to Class 'A' drugs, as amended by subsequent cases, as follows:

> Lord Lane C.J.: Class "A" Drugs and particularly Heroin and Morphine: It is common knowledge that these are the most dangerous of all the addictive drugs for a number of reasons: first of all, they are easy to handle. Small parcels can be made up into huge numbers of doses. Secondly, the profits are so enormous that they attract the worst type of criminal. Many of such criminals may think, and indeed do think, that it is less dangerous and more profitable to traffic in heroin or morphine than it is to rob a bank. It does not require much imagination to realise the consequential evils of corruption and bribery which the huge profits are likely to produce. This factor is also important when considering the advisability of granting bail. Sums which to the ordinary person, and indeed the ordinary defendant, might seem enormous are often trivial for the trafficker in drugs.
>
> The two main sources of supply are South East Asia and South West Asia. These two sources are in competition, one with the other, and with the stakes so high, this may be a fruitful source of violence and internecine strife. Fourthly, the heroin taker, once addicted (and it takes very little experimentation with the drug to produce addiction), has to obtain supplies of the drug to satisfy the terrible craving. It may take anything up to hundreds of pounds a week to buy enough heroin to satisfy the craving, depending upon the degree of addiction of the person involved. The only way, it is obvious, in which sums of this order can be obtained is by resorting to crime. This in its turn may be trafficking in the drug itself and disseminating accordingly its use still further.

Fifthly, and lastly, and we have purposely left it for the last, because it is the most horrifying aspect, comes the degradation and suffering and not infrequently the death which the drug brings to the addict. It is not difficult to understand why in some parts of the world traffickers in heroin in any substantial quantity are sentenced to death and executed.
Consequently anything which the Courts of this country can do by way of deterrent sentences on those found guilty of crimes involving these Class "A" drugs should be done.

Importation of heroin, morphine and so on: Large scale importation, that is where the weight of the drugs at 100 per cent purity is of the order of 500 grammes or more, sentences of 10 years and upwards are appropriate. Where the weight at 100 per cent purity is of the order of five kilogrammes or more, sentences of 14 years and upwards are appropriate. It will seldom be that an importer of any appreciable amount of the drug will deserve less than four years.

This, however, is one area in which it is particularly important that offenders should be encouraged to give information to the police, and a confession of guilt, coupled with considerable assistance to the police can properly be marked by a substantial reduction in what would otherwise be the proper sentence.

Supplying heroin, morphine, etc.: It goes without saying that the sentence will largely depend on the degree of involvement, the amount of trafficking and the value of the drug being handled. It is seldom that a sentence of less than five years will be justified and the nearer the source of supply the defendant is shown to be, the heavier will be the sentence. There may well be cases where sentences similar to those appropriate to large scale importers may be necessary. It is however unhappily all too seldom that those big fish amongst the suppliers get caught.

Possession of heroin, morphine etc. (simple possession): It is at this level that the circumstances of the individual offender become of much greater importance. Indeed the possible variety of considerations is so wide, including often those of a medical nature, that we feel it impossible to lay down any practical guidelines. On the other hand the maximum penalty for simple possession of Class "A" drugs is seven years' imprisonment and/or a fine, and there will be very many cases where deprivation of liberty is both proper and expedient.

In *R v. Martinez (1984) 6 Cr App R. (S) 364* Lord Lane added that:

Lord Lane C.J.: First of all it should be made clear that there is no distinction to be drawn between the various types of Class A drug. The fact that in the decision to which I have referred, namely Aramah, particular mention was made of heroin was because at that time, in terms of availability, heroin presented the greatest threat to the community. The same considerations as applied to heroin apply equally to other Class A drugs. Any idea that those who import or deal in cocaine or LSD, as it is known, should be treated more leniently is entirely wrong.

The guidelines from *R v. Aramah* on cases involving Class 'B' drugs such as cannabis are as follows:

> Lord Lane C.J.: Class "B" Drugs, particularly Cannabis: We select this from amongst the class "B" drugs as being the drug most likely to be exercising the minds of the Courts.
> *Importation of cannabis:* Importation of very small amounts for personal use can be dealt with as if it were simple possession, with which we will deal later. Otherwise importation of amounts up to about 20 kilogrammes of herbal cannabis, or the equivalent in cannabis resin or cannabis oil, will, save in the most exceptional cases, attract sentences of between 18 months and three years, with the lowest ranges reserved for pleas of guilty in cases where there has been small profit to the offender. The good character of the courier (as he usually is) is of less importance than the good character of the defendant in other cases. The reason for this is, it is well known that the large scale operator looks for couriers of good character and for people of a sort which is likely to exercise the sympathy of the Court if they are detected and arrested. Consequently one will frequently find students and sick and elderly people are used as couriers for two reasons: first of all they are vulnerable to suggestion and vulnerable to the offer of quick profit, and secondly, it is felt that the Courts may be moved to misplaced sympathy in their case. There are few, if, any, occasions when anything other than an immediate custodial sentence is proper in this type of importation.
>
> Medium quantities over 20 kilogrammes will attract sentences of three to six years' imprisonment, depending upon the amount involved, and all the other circumstances of the case.
>
> Large scale or wholesale importation of massive quantities will justify sentences in the region of 10 years' imprisonment for those playing other than a subordinate role.
>
> *Supply of cannabis:* Here again the supply of massive quantities will justify sentences in the region of 10 years for those playing anything more than a subordinate role. Otherwise the bracket should be between one to four years' imprisonment, depending upon the scale of the operation. Supplying a number of small sellers-wholesaling if you like-comes at the top of the bracket. At the lower end will be the retailer of a small amount to a consumer. Where there is no commercial motive (for example, where cannabis is supplied at a party), the offence may well be serious enough to justify a custodial sentence.
>
> *Possession of cannabis:* When only small amounts are involved being for personal use, the offence can often be met by a fine. If the history shows however a persisting flouting of the law, imprisonment may become necessary.

Most offences involving possession of small quantities of drugs for personal use will be dealt with by magistrates courts, if indeed they proceed as far as the courts rather than being dealt with through the use of a caution administered by the police. The Magistrates Association

has produced *Sentencing Guidelines* for magistrates which suggest a community penalty as the "entry point" for offenders convicted of possession of Class A drugs, and a fine as the "entry point" for offenders convicted of possession of Class B drugs or of cultivating cannabis. The guidelines note that offences involving the production, supply, or possession with intent to supply of Class A drugs should not normally be dealt with in magistrates courts, but should instead be committed to the Crown Court for trial and that the same is true of possession with intent to supply Class 'B' drugs, unless the supply is small-scale, in which case a custodial sentence should be imposed.

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VI Prevalence of drug-taking

Over 7,000 people aged between 12 and 59 living in private households in England and Wales which took part in the 1992 British Crime Survey were asked to complete a booklet of questions about their knowledge and use of 13 drugs or controlled substances. They were asked to indicate if they had heard of the drugs, whether they had ever taken any of them, if they had been offered any "in the last twelve months", whether they had taken any "in the last twelve months" and which methods of taking drugs they had tried.

Surveys of self-reported drug use cannot provide a precise estimate of the number of people in the population who have taken controlled drugs. Some may be reluctant to admit to illegal behaviour even when assured of anonymity and the confidentiality of their replies. They might refuse to answer questions, or exaggerate[17] or conceal their drug use, or be less willing to admit to taking the drugs which carry the most social disapproval, or to taking any drug recently. Some drug takers, especially those with the most problems, may not be living in private households, or, if they do, may not be willing to be interviewed.

The British Crime Survey asked "which, if any, (of the list of drugs) have you been offered in the last twelve months". The results are shown in table 1. This question is generally considered to be an indication of the extent to which people are exposed to drugs of misuse. Sometimes the responses can be difficult to interpret since respondents may themselves interpret the question in different ways.

However the question was interpreted, amongst the respondents aged 12-59 cannabis (9%) was by far the drug most commonly mentioned, followed by Ecstasy (4%), amphetamines (4%) and LSD (3%). The 16-29 year-olds were most likely to say they had been offered cannabis (23%), Ecstasy (12%), amphetamines (10%) or LSD (9%).

Males (16%) were more likely to have been offered any of the drugs than females (9%) though for the 16-29 age group the percentages were 36% and 24% respectively for males and females. For males aged 16-19, some 50% said they had been offered drugs in the past year, compared with 41% of females.

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[17] One of the "drugs" on the list was "semeron", which is a fictitious drug, designed to test how exaggerated the claims of drug taking were. Only 4% said they had heard of semeron, and less than 0.2% said they had ever taken semeron.

Table 2 sets out the results of the question "which, if any, (of the drugs listed) have you taken in the past twelve months". Of all the respondents aged 12-59, 6% said that they had taken any of the drugs in 1991, compared with 14% for 16-29 year-olds. Males were more likely to have said that they had taken a drug in the past year compared with women. Cannabis was the drug most likely to have been used in 1991.

Table 3 sets out the results of the broader question "which, if any, (of the drugs listed) have you ever taken". Slightly less than a fifth (17%) of all respondents said they had ever taken one or more of the drugs listed with males (20%) more likely than females (13%) to say so. For persons aged 16-29, one third of males and almost one quarter of females said they had ever taken a drug.

Cannabis again was the drug that most people said they had taken. Of all respondents, 14% said that they had at some point taken cannabis, whilst for persons aged 16-29, almost one quarter (24%) said they had taken cannabis.

Table 4 shows that in all age groups around twice as many respondents living in inner city areas said they had taken a drug compared with those living in rural areas, with those living in "other urban" areas in an intermediate position. For those aged 16-29 living in inner city areas, 35% said they had at some point taken one or more of the listed drugs, compared with 28% for other urban areas and 18% for rural areas. However, respondents may not have been living in these types of areas at the time they took the drugs, so the results must be treated with a little caution.

Addicts notified to the Home Office

Doctors are required to notify patients whom they consider to be addicted to one or other of fourteen listed drugs to which regulations apply, including cocaine, heroin and morphine. The number of addicts who are notified to the Home Office is probably only a small proportion of the number of regular misusers of opiates and cocaine. Some will have not sought medical treatment or will be waiting for treatment and will not therefore have been notified. In addition, it may also be that, for a variety of reasons, doctors do not notify all the addicts that they see. Despite the limitations on these figures as a guide to the true *number* of addicts, the statistics do give an indication of the *trend* in the number dependent on notifiable drugs.

Table 5 shows that in 1993 just under 28,000 addicts were notified to the Home Office, including new addicts and renotified addicts. New addicts in each of the past five years have accounted for around 40% of all addicts notified, with the proportion rising steadily. Some of the rise in notifications may reflect increased efforts to attract more addicts to seek medical treatment in view of the threat of AIDS and the continuing development of drug treatment services.

Heroin was by far the most common drug of addiction (68% of all notifications in 1993) whilst cocaine notifications showed the largest increase (up 26% on 1992). Methadone, which is used in the treatment of heroin addiction, increased by 22% in 1993. The average age of all addicts notified to the Home Office was 29 years.

Seizures of controlled drugs and known offenders

It is important to recognise that changes in drug seizures and offenders shown in tables 6 and 7 do not necessarily imply similar changes in the prevalence of the misuse of controlled drugs. Drug misuse is a largely clandestine activity and the numbers of seizures and offenders dealt with are affected both by changes in the amount, direction and effectiveness of the enforcement effort and by changes in recording procedures.

Table 6 shows that the *number* of seizures involving controlled drugs reported to the Home Office rose in 1993 by 19% to just under 86,000. This represents a rise of 228% since 1983. The police authorities were responsible for 91% of all seizures in 1993, with the remainder dealt with by HM Customs and Excise.

Cannabis was again the most common drug, involved in 81% of seizures in 1993. The number of cannabis seizures has risen by 206% since 1983. Cocaine seizures rose by 336% since 1983 and in 1993 accounted for just over 3% of all seizures.

Of course, looking at the number of seizures does not say much about how significant each seizure is compared with others. Table 6 also gives some figures for the *quantity* of drugs seized for selected drugs. Again, in terms of weight, cannabis is the most common drug, with 53.5 tonnes seized in 1993, up 160% since 1983. Cocaine seizures illustrate the point made above, in that though the *number* of seizures actually rose between 1992 and 1993, the *quantity* seized fell dramatically, from 2.2 tonnes to 0.7 tonnes.

Table 7 sets out the number of known drugs offenders - the number of persons found guilty by the courts, cautioned by the police or dealt with by compounding for drugs offences. There has been a growing problem with the recording of persons dealt with by the police for drugs offences. Comparisons with separate data on court proceedings and cautions for England and Wales suggested that upwards of 8,000 people were omitted from the "old basis" figures in 1991 and 1992. To rectify this, several changes were made to the reporting procedures for both seizures and offenders in England and Wales from the beginning of 1993. The existing procedures for collection of data from Scotland and Northern Ireland continued unchanged.

The number of known drugs offenders in 1993, at just over 68,000, was about 11% more than in 1992. In 1993 47% of these offenders were found guilty by the courts, and 52% were cautioned by the police. Cautioning accounted for 45% of the total in 1992, and just 5% in 1983. However, much of this rise can be explained by policy changes, for example it is policy that in most police forces in England and Wales, first-time offenders found in possession of small amounts of cannabis and some other drugs for personal use should receive a caution.

Males accounted for 91% of offenders in 1993. Offenders aged under 21 represented over 37% of offenders in 1993, with the average age of drug offenders at 24 years.

As in previous years unlawful possession was the most common offence in 1993 - just over 88% of drug offenders were found guilty or cautioned for this offence (alone or with other offences). The vast majority of these offenders were found in possession of cannabis.

Table 1

Percentage of respondents who had been offered a drug in the last twelve months

England and Wales

Age group	12-13	14-15	16-19	20-24	25-29	30-39	40-59	All 12-59	All 16-29
Amphetamines	2	7	17	10	5	1	*	4	10
Cannabis	3	11	31	25	16	6	1	9	23
Cocaine	1	3	5	4	3	1	*	2	4
Crack	*	2	3	1	1	*	*	1	2
Ecstasy	1	7	20	13	7	1	*	4	12
Heroin	1	2	2	*	1	*	*	1	1
LSD	1	8	18	8	4	1	*	3	9
Magic Mushrooms	1	5	15	6	2	*	*	2	7
Methadone	1	1	1	*	*	*	0	0.2	0.4
Any drug	10	22	46	31	19	8	2	13	30
Males	*10*	*18*	*50*	*36*	*26*	*12*	*3*	*16*	*36*
Females	*10*	*26*	*41*	*26*	*13*	*4*	*1*	*9*	*24*

Notes: * less than 0.5%

Source: Home Office Research & Planning Unit Paper 89 "Self-Reported Drug Misuse in England and Wales: findings from the 1992 British Crime Survey"

Table 2

Percentage of respondents who said they had taken a drug in 1991

England and Wales

Age group	12-13	14-15	16-19	20-24	25-29	30-34	35-39	40-44	45-59	All 12-59	All 16-29
Amphetamines	*	1	8	4	1	1	*	*	0	1	4
Cannabis	1	6	18	14	7	4	2	2	*	5	12
Cocaine	0	0	1	1	*	*	*	0	0	0.3	1
Crack	0	0	1	0	*	0	*	0	0	0.1	0.2
Ecstasy	*	1	8	2	1	*	*	*	0	1	3
Heroin	0	0	0	0	*	0	*	0	0	0.1	0
LSD	0	1	6	3	1	0	*	0	0	1	3
Magic Mushrooms	*	*	5	2	1	*	*	0	0	1	2
Methadone	0	*	0	0	*	0	*	0	0	0.1	0.1
Any drug	2	9	22	15	8	5	3	2	1	6	14
Males	*3*	*9*	*28*	*19*	*10*	*7*	*4*	*4*	*1*	*8*	*18*
Females	*1*	*9*	*15*	*12*	*5*	*2*	*2*	*1*	*	*4*	*10*

Notes: * less than 0.5%

Source: Home Office Research & Planning Unit Paper 89 "Self-Reported Drug Misuse in England and Wales: findings from the 1992 British Crime Survey"

Table 3

Percentage of respondents who said they had ever taken a drug

England and Wales

Age group	12-13	14-15	16-19	20-24	25-29	30-34	35-39	40-44	45-59	All 12-59	All 16-29
Amphetamines	*	1	11	8	8	5	5	4	1	4	9
Cannabis	1	9	23	24	24	19	16	12	2	14	24
Cocaine	*	*	2	2	4	3	2	1	1	2	3
Crack	0	0	1	*	1	0	*	1	0	0.3	0.6
Ecstasy	*	1	9	3	2	*	1	1	*	2	4
Heroin	0	*	*	*	1	*	1	1	0	0.4	0.4
LSD	*	2	8	7	4	2	4	2	*	3	6
Magic Mushrooms	1	1	6	5	6	4	2	2	*	3	6
Methadone	*	*	*	1	1	1	*	1	0	0.4	0.6
Any drug	3	14	31	28	27	23	19	14	3	17	28
Males	*4*	*13*	*34*	*33*	*31*	*31*	*24*	*17*	*4*	*20*	*33*
Females	*3*	*14*	*26*	*24*	*22*	*15*	*15*	*11*	*3*	*13*	*23*

Notes: * less than 0.5%

Source: Home Office Research & Planning Unit Paper 89 "Self-Reported Drug Misuse in England and Wales: findings from the 1992 British Crime Survey"

Table 4

Inner city residence and drug taking

Percentages ever taking particular drugs by age group **England and Wales**

	Inner city	Urban	Rural
Aged 12-15			
Cannabis	8	5	2
Amphetamines	1	1	0
LSD	1	1	0
Magic Mushrooms	1	*	1
Ecstasy	2	1	0
Cocaine	1	*	0
Crack	0	0	0
Any drug	11	8	6
Aged 16-29			
Cannabis	31	23	13
Amphetamines	11	9	3
LSD	8	6	2
Magic Mushrooms	8	6	5
Ecstasy	5	4	1
Cocaine	4	3	1
Crack	*	1	1
Any drug	35	28	18
Aged 30-59			
Cannabis	17	9	6
Amphetamines	5	2	2
LSD	3	1	1
Magic Mushrooms	3	2	1
Ecstasy	1	*	0
Cocaine	3	1	1
Crack	1	*	0
Any drug	19	11	8

Notes: * less than 0.5%

Source: Home Office Research & Planning Unit Paper 89

"Self-Reported Drug Misuse in England and Wales: findings from the 1992 British Crime Survey"

Table 5

Drug addicts notified to the Home Office

United Kingdom

	1989	1990	1991	1992	1993
By type of drug (a)					
Heroin	12,484	14,497	15,086	16,964	18,919
Methadone	2,951	4,992	7,997	10,011	12,229
Dipipanone	349	387	350	320	283
Cocaine	888	1,085	1,525	1,951	2,463
Morphine	760	839	406	321	255
Pethidine	85	91	83	82	80
Dextromoramide	260	283	269	219	155
Levorphanol	1	2	-	1	1
Hydrocodone	-	-	-	-	-
Oxycodone	2	2	2	-	-
Phenazocine	5	7	3	1	3
Piritramide	-	-	-	-	-
Hydromorphone	-	2	-	-	-
Opium	25	23	25	21	43
All addicts	14,785	17,755	20,820	24,703	27,976
By age of addict					
Under 21	1,443	1,695	1,755	2,225	2,683
21 and under 25	3,380	4,072	4,569	5,271	5,961
25 and under 30	4,332	5,411	6,441	7,668	8,391
30 and under 35	2,754	3,208	3,820	4,484	5,293
35 and under 50	2,581	3,067	3,839	4,682	5,116
50 and over	143	143	192	234	260
Not recorded	152	159	204	139	272
Total all ages	14,785	17,755	20,820	24,703	27,976
Average age	28.9	28.8	29.2	29.4	29.2

Notes: (a) As an addict can be reported as addicted to more than one drug, figures do not sum to total

Source: Home Office Statistical Bulletin 10/94 "Statistics of Drug Addicts Notified to the Home Office, 1993"

Table 6

Seizures of controlled drugs

United Kingdom

	1983	1989	1990	1991	1992	1993
Number of seizures (a)						
Total	26,216	52,131	60,859	69,805	72,065	85,876
by the police	22,750	44,749	53,454	62,410	64,435	78,444
by HM Customs & Excise	3,466	7,382	7,405	7,395	7,630	7,432
in England	22,529	44,931	52,243	58,903	60,275	71,232
in Wales	1,218	1,980	2,234	2,800	3,089	4,338
in Scotland	2,343	4,940	6,183	7,810	8,209	9,732
in Northern Ireland	126	280	199	292	492	574
of which						
Cannabis	22,668	44,920	52,856	59,420	57,663	69,349
Amphetamines	2,333	3,322	4,629	6,821	10,570	11,632
Heroin	1,940	2,728	2,593	2,640	2,968	3,679
Cocaine	684	2,045	1,805	1,984	2,365	2,983
LSD	518	967	1,859	1,636	2,474	2,513
MDMA (b)	..	768	399	1,735	2,399	2,341
Quantities seized (c)						
Cannabis (kilogrammes)	20,594	59,369	30,889	32,204	51,103	53,506
Amphetamines (kilogrammes)	35	108	304	421	569	966
Heroin (kilogrammes)	236	351	603	493	547	655
Cocaine (kilogrammes)	80	499	611	1,078	2,248	709
LSD (thousand doses)	..	147	295	170	544	453
MDMA (thousand doses)	..	39	44	365	554	301

Notes: (a) As a seizure can involve more than one drug, figures for individual drugs cannot be added together to produce totals

(b) Often known as "Ecstasy"

(c) Seizures of unspecified weights are not included

Source: Home Office Statistical Bulletin 29/94 "Statistics of Drugs Seizures and Offenders Dealt With, 1993"

Table 7

Persons found guilty, cautioned or dealt with by compounding for drugs offences

United Kingdom	1983	1989	1990	1991	1992 old basis	1992 new basis	1993
By action taken (a)							
Found guilty by the courts	22,158	24,972	26,713	25,808	23,466	(32,846)	31,790
Cautioned by police	1,183	12,380	17,025	20,742	24,746	27,877	35,522
Settled by compounding (b)	101	1,063	1,184	1,066	716	(716)	732
Total	23,442	38,415	44,922	47,616	48,927	(61,439)	68,044
By age and sex of offender							
Under 17	588	1,312	2,431	2,777	2,754		4,234
17 and under 21	6,068	10,478	13,754	15,756	16,432		21,164
21 and under 25	6,232	10,564	11,856	11,967	12,378		17,296
25 and under 30	5,175	8,109	8,735	9,049	9,145		12,926
30 and over	5,379	7,952	8,146	8,067	8,216		12,424
Male	20,894	34,482	40,563	43,357	44,425		61,702
Female	2,548	3,933	4,359	4,259	4,499		6,342
All ages/sexes	23,442	38,415	44,922	47,616	48,927		68,044
Average age	25.2	25.4	24.7	24.4	24.3		24.1
By type of offence (c)							
All drugs offences	23,442	38,415	44,922	47,616	48,927		68,044
of which							
Unlawful production	1,179	584	629	664	1,022		2,964
of which: cannabis	*1,165*	*567*	*613*	*645*	*1,002*		*2,751*
Unlawful supply	1,053	1,740	2,151	2,133	2,189		3,269
Possession with intent to supply	1,041	2,355	2,751	2,782	3,203		4,825
Unlawful possession	20,286	33,207	39,350	42,575	43,492		60,082
of which: cannabis	*17,706*	*30,030*	*36,086*	*38,457*	*37,444*		*50,366*
Unlawful import or export	1,554	2,577	2,478	2,136	2,034		1,944

Notes: (a) Figures in parentheses indicate estimated data

(b) HM Customs and Excise cases dealt with by the payment of a penalty in lieu of prosecution

(c) As the same person may be found guilty, cautioned or dealt with by compounding for more than one drugs offence, figures may not add to totals

Source: Home Office Statistical Bulletin 29/94 "Statistics of Drugs Seizures and Offenders Dealt With, 1993"

APPENDIX

Drugs - their legal status, uses and effects

The tables set out on the following pages are reproduced by kind permission of the Institute for the Study of Drug Dependence from their *Drug Abuse Briefing* (Fifth Edition 1994). They are intended as a guide to the contents of that briefing, rather than for independent use. Drugs are grouped according to their most characteristic pharmacological effects at doses usual in therapeutic or recreational use. More information can be obtained from the ISDD at Waterbridge House, 32-36 Lomam Street, London SE1 OEE (0171-928-1211).

DRUG GROUP	PRINCIPAL DRUGS		LEGAL STATUS	RECOMMENDED MEDICAL USES	METHODS OF ADMINISTRATION	PREVALENCE & AVAILABILITY	EFFECTS
	Scientific names	Trade, 'slang' & other names					
ALCOHOLIC BEVERAGES	ethyl alcohol or ethanol	'BOOZE' etc Beers Wines Spirits Liqueurs	Can be bought by adults (18+) and drunk outside a pub/bar by children (5+). Need licence to sell.	None.	Swallowed as a beverage.	Available through over 170,000 licensed premises. Over 9 in 10 adults drink to some extent.	Depress the nervous system relieve tension and anxiety, promote relaxation, impair th efficiency of mental and physical functioning, and decrease self-control. In higher doses there can be 'drunken' behaviour, drowsiness, stupor, sleep/ unconsciousness. With the exception of minor tranquillis ers, these effects may be associated with positive feelings of pleasure. Tolerance develops with frequently repeated doses. Ir high doses there can be strong physical dependence to alcohol or hypnosedatives less strong to minor tranquillisers, not at all to solvents or gases. Depressant effects may be dangerously augmented if more than one depressant drug is taken at a time, or if depressant drugs are taken with opiate-type drugs.
BARBITURATES	quinalbarbitone amylobarbitone (combination of above) pentobarbitone butobarbitone	'DOWNERS' 'BARBS' & various slang terms derived from trade names or colour of pill/capsule. Seconal Amytal Tuinal Nembutal Soneryl	Prescription Only Medicines. Controlled drugs.	Promote sleep in severe, intractable insomnia.	Swallowed as pills, capsules or elixirs. Injected.	Barbiturate pills and capsules produced for medical use rarely available on the illicit market.	
BENZODIAZEPINES	MINOR TRANQUILLISERS diazepam chlordiazepoxide lorazepam oxazepam nitrazepam flurazepam triazolam temazepam	'TRANX' Valium Librium Ativan Serenid Mogadon Dalmane Halcion Normison, 'Tems', 'Eggs', 'Jellies'	Prescription Only Medicines. Controlled drugs but legal to possess without a prescrip-tion.	Relieve anxiety. Promote sleep in insomnia.	Swallowed as pills or capsules.	Most commonly prescribed drugs in Britain. Also available on the illicit market.	
SOLVENTS AND GASES	toluene acetone butane fluorocarbons trichloroethylene trichloroethane	Glue Glue Lighter fuel Aerosols Cleaning fluid Cleaning fluid	In UK illegal to sell knowingly for inhalation. In Scotland misusers may be taken into care.	None.	Vapours or gases inhaled through nose/mouth.	Widely available in shops, homes and places of work. Some 5-10% of secondary school pupils may have tried them.	

DRUG GROUP	PRINCIPAL DRUGS		LEGAL STATUS	RECOMMENDED MEDICAL USES	METHODS OF ADMINISTRATION	PREVALENCE & AVAILABILITY	EFFECTS
	Scientific names	Trade, 'slang' & other names					
AMPHETAMINES and amphetamine-like drugs	AMPHETAMINES amphetamine sulphate dexamphetamine	'UPPERS', 'SPEED' 'sulphate', 'sulph', 'whizz' Dexedrine	Prescription Only Medicines. Controlled drugs.	Treatment of narcolepsy and hyperkinesia.	Amphetamine sulphate powder sniffed up the nose and injected. Some pills and capsules by mouth.	Illicitly manufactured amphetamine sulphate commonly available on the illicit market, plus some pills and capsules produced for medical use. After cannabis, probably the most widely misused controlled drug.	Except for steroids and nitrites, drugs that stimulate the nervous system increase alertness, diminish fatigue, delay sleep, increase ability to maintain vigilance or perform physical tasks over a long period, and elevate mood. Excepting tobacco, high doses can cause nervousness, anxiety and (with the exception of tobacco and caffeine) temporary paranoid psychosis. Withdrawal effects include hunger and fatigue. Although unpleasant, these effects are practically never of the kind that might require medical assistance.
	AMPHETAMINE-LIKE DRUGS methylphenidate diethylpropion phentermine pemoline	 Ritalin Apisate, Tenuate Duromine, Ionamin Volital		Short-term treatment of obesity.			
COCAINE	cocaine hydrochloride	'coke', 'snow'	Prescription Only Medicines. Controlled drugs.	Rarely prescribed. Local anaesthetic.	Cocaine hydrochloride powder sniffed, sometimes injected. Cocaine freebase smoked.	Illicitly manufactured imported hydrochloride powder available on the illicit market, but expensive, so not usually used frequently.	
	cocaine freebase	'crack', 'freebase', 'base', 'rock', 'wash'					
CAFFEINE	caffeine	Coffee Tea Cocoa Soft drinks Chocolate Analgesic pills	Unrestricted.	None.	Swallowed as a beverage, in confectionery, or in pills.	Freely available in beverages and foodstuffs taken regularly by the great majority of people in Britain.	
TOBACCO	TOBACCO nicotiana tabacum nicotiana rustica nicotiana persica	Tobacco Cigarettes Snuff	Illegal to sell to children under 16. Otherwise unrestricted.	None.	Smoked. Snuff is sniffed up the nose.	Widely available in shops. 38% of UK adults smoke.	
ANABOLIC STEROIDS	anabolic steroids	Nadrolone Stanozolol Dianabol Durabolin Deca-durabolin	Prescription Only Medicines.	Persistent anaemia. Protein build-up.	Swallowed as pills or injected.	Available in gymnasia, health clubs etc.	Potential for increasing aggression and sex drive in men and women; possible liver and heart damage; non-reversible virilising effects on women (body hair; deep voice); growth stunting in adolescents; psychological dependence.
ALKYL NITRITES	amyl nitrite	'POPPERS'	Pharmacy medicine.	None.	Vapours inhaled through nose/mouth.	Available in sex shops, clubs, bars etc.	With nitrites 'rushing' sensation as blood vessels dilate; enhanced sexual pleasure; possible headaches, vomiting and dermatitis. Excessive use of nitrites could bring on methaemoglobinemia (severe vomiting, shock and unconsciousness) which has caused fatalities. Tolerance develops, but no reports of withdrawal or dependence.
	butyl nitrite isobutyl nitrite	'rush' 'locker room'	Unrestricted.	None.			
HALLUCINOGENIC AMPHETAMINES	methylenedioxyamphetamine MDA MDMA MDEA	'ecstasy', 'E', plus many names derived from shape and colour of drugs	Controlled drugs; not available for medical use.	None.	Swallowed as tablets or capsules.	Illicitly manufactured and generally available on the illicit market.	With ecstasy feelings of empathy with others at low doses; more amphetamine-like restlessness and anxiety at higher doses.

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