

The Truth About Drugs

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TREATMENT WORKS

If preventing production is hard and interception almost impossible, and if stopping teenagers and young adults from trying illegal drugs is only partly successful then it becomes of the utmost importance to ensure that those who become addicted are helped as quickly as possible to break the habit.

The biggest barrier to treatment is the person who needs it. You cannot help someone who is happy to stay as things are. Often it takes a personal crisis of some kind to bring a person to the point of recognising the need for help and being motivated enough to take it. It might be a wife threatening to leave home or losing a job or major debts or a life-threatening illness caused by addiction. Drug testing may assist that process by helping to identify those with dependency and encouraging them to see the habit as something that is unhelpful to their future.

Treatment gets results

Treatment not only rehabilitates a user back into normal life, but is also a key strategy in demand reduction, since, as we have seen, a relatively small number of heavy users are responsible for a significant proportion of the total spending on drugs purchases. Yet treatment can be hard to find - effective treatment offered in a way that the person needing it feels able to accept.

Let us look first at the US situation. Almost four million Americans need help with addiction. However only a million a year get help with big regional variations. A key aim is to focus on chronic drug users, helping identify them and offering treatment. For example, two thirds of US cocaine consumption is by 20% of users - who are being targeted aggressively with rehab programs. Drug testing is part of this identification process.

Treatment locations are:

- 54% clinics
- 16% community health centres
- 10% general hospitals
- 7% free-standing residential

Outpatients covers 87% of clients of which 75% are expected to be drug-free and 12% are being given methadone. There has been a steady decline in residential care as a proportion, from 16% to 13% from 1980 to 1992.

The lack of treatment is appalling. It is particularly shocking in the light of some very encouraging results. A recent US survey found that substance abuse treatment:

- Cut drug use by half
- Reduced criminal activity by up to 80%
- Increased employment
- Decreased homelessness
- Improved physical and mental health
- Reduced medical costs
- Reduced risky sexual behaviour
- Reduced drug injecting / needle sharing

Treatment has proven and lasting benefits. Significant reductions in drug and alcohol use are found a full year after the end of treatment (average 50% of former level).

In a large national study, use of a primary drug (the one which led to their treatment) fell from 73% of the whole group to 38% a year after treatment ended.

- Cocaine use fell from 40% to 18%

- Heroin use fell from 24% to 13%
- Crack use fell from 50% to 25%.

These are great achievements, hard facts, and behind each statistic is a life totally changed and others greatly improved. This impacts not only those addicted, but also those who love them and the communities in which they live. It shatters the cruel myth that heroin and crack addiction are one way tickets to oblivion and personal destruction. Breaking free is hard. It is a huge, almost insurmountable personal challenge, yet every year significant numbers manage to do so, with and without help. But the right kind of intensive long term help makes a successful outcome far more likely.

Some cynics may choose to believe that release from addiction is only temporary but this is untrue. Over the years I have worked alongside a number of people personally who have been addicted to heroin or other drugs who have been completely set free, and have walked clear of all addiction for many years, now holding down long-term jobs with stability and responsibilities. I would defy anyone to guess at their past on meeting them.

These spectacular success figures face us with a direct challenge to come up with the resources for everyone who needs help to benefit. No longer does society have any excuse to marginalise the problem, deriding a "bunch of junkies" for every possible evil, and casting them out of circulation or putting them in prison. Here in front of our eyes is clear evidence that addiction can be a phase through which someone can grow to a place of wholeness and maturity.

We cannot and must not abandon those directly affected, nor their families, their children, neighbours and friends. As we have seen, addiction can become a curse on a whole community, and it requires a compassionate, caring response from us all. This may seem at odds from what has been said in the previous chapter about testing but we must keep in mind that the primary purpose of testing is to identify those with a problem, for the protection of others and so that help can be given.

And if compassion does not sway the argument enough for some, then let the economic reality speak for itself. The cost/benefit ratio for treatment programmes shows a one to seven ratio:

ten dollars in treatment saves seventy dollars in other costs. One California study found:

- \$209 million spent
- 150,000 drug addicts treated
- \$1.5 billion saved - mainly in reduced crime.
- Hospital use fell by 33%
- Illegal drug use by 33%
- Criminal activity fell by 66%

These effects were greatest where the treatment was longest.

So how do different methods compare? Another study found that all treatment options cut abuse, whether methadone replacement therapy, residential or community based programs, and non-methadone clinic support.

- Reports of "beating someone up" fell from 50% to 11%
- Arrests fell from 48% to 17%

- Substance abuse hospital visits fell 50%
- Mental health admissions fell by 25%.

So then, what about the effectiveness of prevention programmes in Britain? Less data is available because far less has been spent on research (which in itself is an indicator of previous government policy). However, a recent British study that showed that shoplifting fell by between 40% and 85% in heroin users following treatment. There is no reason to think that any of the other US findings will be different in other countries regarding the effectiveness of long term treatment programmes in getting people back to a drug-free, non-dependent life.

US figures showed:

- Selling of drugs fell 78%
- Shoplifting fell 82%
- Violence against another person fell 78%
- Arrest rates for any offence fell 62%
- Numbers supporting themselves through illegal activity fell by 48%. Welfare support costs also fell.
- Employment increased from 51% to 60% (19% increase)

- Welfare recipients fell from 40% to 35% (11% decrease)
- Those reporting they were homeless fell from 19% to 11% (43% decrease)

Health costs were reduced:

- Alcohol or drug-related medical visits fell 53%
- Mental health problems fell 35%
- Those needing mental health hospital care fell 28%

What more evidence do we need? The fact is that any medical intervention programme or community action project would be delighted with this scale of achievement. Outcomes are often notoriously hard to measure - for example levels of independence of elderly chronic sick men and women in the community following extra provision of home care. Most health care workers would be content with a 15% improvement in such a situation, but here we are seeing improvement greatly in excess of this - of 50% or more in some measures. The outcomes are both clear and convincing, often based on objective data rather than self-reported levels of drug-taking. Arrest figures and admission rates to hospital for example are both verifiable.

Treatment has a far wider impact than on the person with dependency. Children settle down at school as a parent returns to his normal self, truancy and petty crime falls - both often expressions of distress at home. Marriages recover. Friendships and relationships with neighbours are restored. Other risks are reduced. For example, a major concern has been that the sexual partners of drug users may be exposed to HIV if they are carriers. Rehabilitation is also a very effective way of reducing sexual risk-taking among drug users. In the US study:

- Numbers of people trading sex for money or drugs fell 56%

- Numbers having sex with an intravenous drug injector was reduced 51%
- Those having vaginal sex without a condom fell 35%

Costs of treatment

So then, we have seen that treatment works and that the cost / benefit ratio can be as good as one to seven. But how are those figures broken down? And how do the costs compare of keeping people in hospital, at home or in residential care?

Treatment costs varied from \$1,800 to \$6,800 per person, compared to the cost of keeping someone in prison of more than \$20,000 a year.

- Methadone clinics cost \$13 a day per person for average of 300 days - total cost \$3,900
- Non-methadone clinics cost \$15 a day per person for average of 120 days - total costs \$1,800
- Long term residential care costs \$49 a day for average of 140 days - total costs \$6,800
- Short term residential care costs \$130 a day for average of 30 days - total costs \$4,000.
- Treatment in prison - additional costs \$24 a day for an average of 75 days - total costs \$1,800

So there are very significant differences in costs per person treated. It would be easy to assume in the light of current research that one should go for the lowest cost option if all outcomes are effective. The trouble is that even in the US there is insufficient evidence yet to be able to

compare different options with confidence and there is even less in other countries such as Britain.

There are three patterns of residential rehabilitation:

- Therapeutic communities
- "12 step" Minnesota model houses, largely in the non-state sector
- General houses including those with a Christian philosophy

There are also a variety of community approaches. The problem is that many different addiction patterns and social groups tend to get muddled together, when they require separate solutions. Indeed, every person is unique. As we have seen, there the stereotypical heroin or cocaine user may be hard to find. Many people are using a wide variety of different drugs, or have done in the past. Their personalities and support structures are different. For example, one man may recognise, with others, that remaining at home in his own locality will be an impossibly difficult temptation, when he sees drug-taking friends in the pub and on the street corner. He may come to the conclusion that nothing will work as well as going into a long-stay, residential, therapeutic community several hundred miles away.

On the other hand, another person may be in a situation with a very supportive partner and several children who do not want to be separated from him or her for six months or more, nor do they want to live next door to a residential unit. Every person is unique which is why a comprehensive range of options is needed. One of those options has to be treatment in prison (see later).

Culture is also important. A support group mainly consisting of former heroin users may not have much to offer one or two others that have problems with binge alcohol drinking. The philosophy of the residential unit may also vary - for example some may be strongly Christian and others aggressively secular. People have their own preferences, which must be respected if the therapy is to have the greatest chance of success.

The antabuse program for alcoholics is a good example of how alcohol and illegal drug abuse

often need very different approaches. Antabuse (disulphiram) is a drug with no therapeutic action inside someone who is fit and well. However it prevents the normal destruction of alcohol in the body causing very unpleasant reactions such as flushing, low blood pressure (faintness), sweating, nausea and weakness. Antabuse lasts up to four days so is a useful psychological barrier for someone who knows they might be tempted to do something on impulse that they might later regret. However the reactions can be extremely severe.

Christian organisations have always been at the forefront of rehabilitation. Indeed the Christian community has been responsible for building hospitals and care centres in more than a hundred nations over the last century and a half, following a tradition expressed in countries like Britain and America. The philosophy of Christian care historically has been unconditional love to all regardless of how they come to need help, and the offering of spiritual support as an optional part of a comprehensive package of care, designed around each individual according to their own preferences.

Large numbers of rehab projects in Britain, America and other nations have a religious basis, and attribute their success to the fact that many who pass through the door leave with a new spiritual certainty or faith. Indeed so many have religious roots that a secular drugs association has been created in America to help provide wider choices for those who want a completely secular approach. An excellent example of secular residential rehab is Phoenix House, a network of residential projects, such as the one based in Glasgow. Links Project in Edinburgh provides a similar service.

One prominent US religious group is the Prison Fellowship Ministries, founded by Charles Colson. Christian organisations also have a long track record in prison visiting, primarily through chaplaincies and the work of religious orders, influenced by the command of Jesus to visit the imprisoned as well as the sick. They also have been successful in helping motivate those who have lost hope to find new ways of living. There is far more to prison rehab than withdrawing the drug. Aftercare, counselling, literacy skills and job training are vital. Support needs to be well organised before, during and after release.

All too often in Britain a drug user is pitched out onto the street on leaving gaol, with unresolved problems from the past and an active addiction. The first problem can be housing, where there are large rent debts and the local authority is unhelpful. The next problem is persuading an employer to take

Almost all residential abstinence programs for drug users follow a very traditional pattern, whether religious or secular. The ideal is to take the user away, out of his usual environment, far from friends and all known networks of supply, preferably to a residential unit in the middle of nowhere.

Once there the user is rapidly weaned off all drugs (usually with the exception of tobacco which is the most difficult addiction for many to break), and then integrated into a supportive community of former drug users under staff supervision. Those with alcohol addiction are treated in a similar way. Once again tobacco addiction often remains. Numbers staying off cigarettes are often the same regardless of whether they have been thorough an alcohol rehab program or not.

Community duties help give the person a sense of worth and bring in the normal disciplines of non-addicted day to day living. Group sessions help explore some of the reasons why the addiction developed in the first place, and begin to tackle underlying behaviour patterns which put the person at risk of relapse once the treatment period is over.

People stay variable lengths of time and are usually free to opt out of the programme at any stage. They may also be thrown out if they insist on breaking rules, bringing drugs into the site for example.

Rebuilding a whole way of life takes time. There are no short cuts. We are talking about a far greater transformation than merely weaning a body off physical dependency. If the person has been addicted for some time, she will have created for herself a world where every action, every conscious thought is influenced and shaped by the need to satisfy a craving that keeps on returning.

When a person leaves rehab she will need to find new friends. A drink in a familiar pub could be all that is necessary to lead back into drug use, when surrounded by people who themselves are quite keen for the person to indulge again. Some will encourage it because it makes them feel better about their own addiction. Others will make money out of it.

Then there is a job to consider for someone who may have been virtually unemployable for years, and a home to find.

Track record

Residential communities have remarkable track records although obviously they are expensive individual solutions. But then addiction is expensive for society in terms of social costs and crime. It is scandalous that many people in Britain who want to give up addictive drugs are unable to find suitable residential units. There are not enough places. It is also a shameful reflection of bad priorities that residential facilities for treating chronic alcohol abuse are even fewer.

Society seems to have the view that someone addicted to heroin needs intense, long term professional help while someone with alcoholism can somehow manage on his own at home with just a weekly support group. Who are they kidding? This discrimination against those with alcohol-related problems is no help when trying to help families with an addicted member put their lives back together again.

Community based

An alternative to residential rehab is community support. While it is true that someone can withdraw from drugs or alcohol safely in a community setting, it requires close supervision which can also turn out to be costly, and the relapse rate is likely to be higher. For these reasons community care is not necessarily cheaper.

Community teams in Britain usually consist of a social worker, a community psychiatric nurse and administrative staff, working with a consultant psychiatrist, often with a link to a local family doctor. GPs are increasingly involved in seeing drug users and this trend is likely to increase.

Team roles can include assessment and counselling, detoxification and prescribing, advocacy, child protection, complementary therapy, writing of court reports and liaison with the criminal justice system, with clinics, probation officers and referrals to other services. Most teams emphasise harm reduction with abstinence as the ideal eventual goal.

Community living carries a daily risk that the person will wander out down the road and come back intoxicated or with fresh supplies. This is a particularly high risk if the community support is based in the area where the drug user has lived in the recent past. However community settings are an excellent half-way house between the formal disciplines of residential care and the totally exposed full integration back to normal life.

Long climb up to full rehab

In summary then, full rehab is a long climb back up, it takes time and energy, and relapses are common. It is not unusual for a user to need two or three attempts at residential rehab before kicking free for the long term. Despite this, success rates are excellent and the impact is very

significant from every person who is fully recovered.

The truth about drugs in prison

"Ah yes, what have we here?" said the prison officer to me, lifting an upturned flowerpot in the greenhouse area of Holloway women's prison in London. "This is where they pass it on." "She tried another couple of pots." "So then, none today. We tried stamping it out but there was a lot of trouble so now we turn a blind eye."

Later we visited a number of women in cells, unlocked to allow them to wander in and out of the corridors for several hours a day. Many had young babies. Some had been convicted for offences relating to prostitution, others also had HIV and drug addiction was common. "Sex is how they pay for the drugs when they get out. It's the only way they can find to survive."

But it isn't just women in Holloway who are likely to be using drugs in prison. As we have seen, most convicted prisoners have abused substances shortly before arrest. A great number are addicted on arrival - and their addiction led to the crimes for which they were convicted. But others begin a drug habit once inside, or relapse.

Prisons are a school house for drug-taking

Needles are hard to come by and sharing can be the normal pattern. One might imagine therefore that an elementary step in protection would be to issue clean needles - particularly following the disturbing reports recently that fourteen prisoners were using a single needle in one British prison. Such stories could be repeated in the prison service almost every day.

However, issuing needles is a major risk. One of the biggest nightmares for a warden is the thought of being threatened by a prisoner holding a needle and syringe, contaminated with HIV infected blood. As an offensive weapon, whether as a dagger or thrown, it is terrifying. Such a weapon is more than enough to persuade a jailor to hand over keys. That is why prisons have never supplied needles - even on an exchange basis. But injecting continues just the same - ten or twenty prisoners sharing the same needle on a daily basis. One lad in Perth prison (Scotland) was so desperate for a needle that he sharpened the plastic shaft of a biro and used it to inject into veins in his neck. Then he shared it.

Desperate situations call for desperate measures. Just as we have seen over the issue of drug testing, normal sensitivities have to be cast aside. Hence the extraordinary statement by a British Minister in Spring 1998 that the government was seriously considering (even) issuing

needles to prisoners.

What makes such a proposal even harder to live with is that the very people who want the needles are by definition far more likely to be those whose blood may be carrying hazardous viruses. In fact the risk of HIV transmission from a carrier who is symptom-free from a single needle stick injury is now recognised to be less than one in two hundred. We know this from the very large number of such accidents among health care workers world-wide over the last decade who have been carefully followed up. Nevertheless, it would be a very brave man or woman who would tackle a drug user with such a weapon, particularly. The risk to them could be far greater if the needle and syringe are heavily contaminated or full of fresh blood and the aim is to inject rather than merely to stab.

This single issue of needles in prison illustrates the complexity of prison-based addiction, a problem which would be greatly eased by separating out those who agree to be drug-free from wings containing hardened drug users with no desire to change. Once again, there is no doubt whatever that drug testing could have a huge impact on the pattern of abuse, if consistently applied with a well-defined set of sanctions such as loss of early release possibilities. However, if sanctions are applied too severely, there are no rewards left that a prisoner feels are worth the effort. The greatest rewards are of course the promise of a shorter sentence.

The problem of drugs supply in prisons is just a mirror of the rest of society. One might suppose that prison should be the one place on earth where drugs should by definition be easiest to control. No one comes in or goes out except on a semi-permanent basis, and those who arrived are searched. There is limited contact with visitors and the staff one might assume are trustworthy.

Compare this highly controlled environment to the open gates of a local school. Prisoners have little or no money to trade with - in theory. Contrast that to the free flow of cash to pupils from parents or small-scale theft to users and then to dealers just outside the school gate. The drive to find fresh supplies inside a prison can become a compulsive obsession.

Keep the prison happy

It is a well known fact that the harsher the prison regime, the more disgruntled and angry the inmates become, and the greater the risk of disturbances. Drug supplies keep some prisoners quiet, but keep others in a simmering furnace of increasing dependency and loss of self-control.

Just stopping prisoners from using drugs -even if you succeed - does nothing to help them after release. #

- 75% of those released on parole with previous heroin or cocaine addiction return to their old patterns of use within 90 days.
- 66% are re-arrested within 18 months.
- 75% of those who receive treatment in prison and good support after discharge are 75% drug-free after 18 months
- 70% are arrest-free.

These figures are compelling and are the reason for the huge growth in US prison drug rehabilitation programs. In a growing number of prisons the inmates can choose to be moved to a "drug-free" wing where they enjoy privileges and access to extra support, therapy and care. If they break the rules and test positive they risk being transferred back.

They also risk other sanctions such as "closed visits" where all physical contact with friends and family is barred. As these programs are being rolled out nationally it seems that with the right approach and a skilled team and a decent budget, a very significant proportion of convicts are willing to take part in such a program. Of course, there is always a danger with any incentive based system.. If the rewards become big enough, people will take risks to take part, even perhaps taking heroin for the first time in gaol just to qualify for rehab privileges.

In Britain there have already been cases where drug injectors have deliberately shared needles with others they knew had HIV in order to get themselves a positive HIV test, which would qualify them for immediate priority housing and other benefits.

Now the British government has plans to create a drug-free wing in every prison, costing £9 million a year. The new deal will also cost an additional £40 million for drug testing and compulsory treatment schemes.

The AIDS factor

AIDS caused complete rethink about the goals of prevention. For a start, what is the point of someone struggling to beat a heroin addiction when they are likely to die soon anyway? That was the new theory.

Giving free needles and syringes to addicts seemed outrageous to some in Britain and still remains highly controversial in the US. People worried that it would appear to officially encourage injecting, and that it may prolong the injecting career of the user. However, if people are going to inject anyway, then there is a public health need to prevent spread of illnesses, which will inevitably also affect a wider community through sexual relations and child-bearing. A key worry is that for some, the sight of injecting equipment arouses a desire, and there is clear evidence that needle exchanges have been targeted by people looking for equipment.

Needle exchanges have to operate as

- Friendly and non-judgmental
- Anonymous
- Free from police watchers as people come and go

Their only purpose is to change behaviour. Therefore attracting and retaining a large number of active users is vital. Needle exchanges can also be a vital avenue for other health information and support - for example on sexual health, contraception.

There are over 300 specific needle-exchange projects in the UK and needle-exchange is a part of many other programmes. In addition, over 2,000 pharmacies participate in needle exchange

schemes. These schemes have been very successful in containing HIV among drug users, remaining 1% outside London and 7% in London by 1995, compared to other European Nations. HIV rates in Edinburgh of 55% by 1985 had fallen to 19% by 1994.

In conclusion, there is no doubt that well run treatment programmes cure people of addiction long term and that spending on these programs should be an urgent priority area with very little cost in total society terms because of the enormous benefits from dealing with addiction.

Having seen the size of the drugs problem, counted the cost, looked at different drugs, and examined prevention and treatment questions we now need to turn to the most vexing question of all: if it is true that drug using now has such a hold on society at very level, should we not stop turning users into criminals? Should we not at the very least seriously consider decriminalising Marijuana and perhaps Ecstasy, seeing as both are far less harmful than tobacco?

The Truth About Drugs - free book by Patrick Dixon, published by Hodder in 1998

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