Ref: N70

Drugs

dilemmas, choices and the law

Use of illegal drugs is increasingly common, yet there has been little serious discussion of the underlying causes, or whether existing prevention policies are effective.

This summary brings together findings from two inquiries that received support from the Joseph Rowntree Foundation and which were designed to consider how UK drugs policy should move forward.

A working party of the Royal College of Psychiatrists and the Royal College of Physicians examined key issues in preventing drug misuse, while an independent inquiry established by The Police Foundation into the Misuse of Drugs Act, 1971 made proposals for law reform.

Trends

- **Cannabis is the most widely-used illegal drug**, which one in four 16- to 59-year-olds say they have tried. Around 10 per cent have used amphetamine and 4 per cent ecstasy.
- Accurate figures are not available, but it is clear that **thousands of deaths occur each year as a result of illegal drug use**. Most relate to heroin and misuse of the synthetic opiate, methadone.
- **Many more deaths each year are attributable to tobacco and alcohol than to controlled drugs**. Almost three out of ten adults smoke tobacco, which is responsible for 120,000 premature deaths in Britain a year.
- **In 1997-98, 75 per cent of the £1.4 billion committed to tackling drug misuse was spent on law enforcement**. Treatment and rehabilitation programmes claimed 13 per cent, and 12 per cent went on education and prevention.
- **The number of drug offenders dealt with by the criminal justice system each year rose from 12,532 in 1974 to 113,154 in 1997**. Most cases concerned possession offences involving cannabis - 55 per cent of which were dealt with by a caution.

Summary of key issues from the Royal Colleges' Working Party report

- **Ambitious Government targets for reducing heroin and cocaine use are unlikely to be reached without a stronger commitment to invest in prevention.**
- **The proven cost-effectiveness of methadone programmes for heroin addicts makes the case for increased spending on treatment programmes.**
- **Systematic investment is needed to increase improvement rates achieved by UK treatment programmes.**
- **Despite clear evidence of the health dangers, little research has been carried out into amphetamine dependency or treatment.**
- **Although more research is needed into its long-term effects, cannabis is almost certainly less damaging to health than tobacco or alcohol. The Working Party decided that cannabis-use to relieve disabling medical conditions like multiple sclerosis should not be prosecuted.**
- **Despite legal, ethical and cost issues, routine drug-testing of staff by their employers could eventually have a major impact on drug-use.**

Summary of reforms proposed by the Police Foundation Independent Inquiry into the Misuse of Drugs Act, 1971

- **No drug covered by the Misuse of Drugs Act should be legalised, but the law should establish a more accurate 'hierarchy of harm' with penalties reflecting the relative dangers of the drug and activity, as originally intended.**
- **Heroin and cocaine should remain as Class A drugs, reflecting their addictive potential, but Ecstasy and LSD should move down to Class B. Cannabis should move from Class B to Class C.**
- **Prison should no longer be available as a penalty for possession of Class B or Class C drugs for personal use. The normal sanction for possession or cultivation of cannabis should be an out-of-court disposal.**
- **Police should retain the power to arrest suspects for possession of Class A and Class B drugs, but not Class C.**
- **Laws against trafficking in controlled drugs should be strengthened, including a new offence of dealing.**

Introduction

Drugs are a contentious issue on which public attitudes are polarised. Many people view them as alarming and as bringing sometimes catastrophic consequences. Others, particularly those under the age of 30, regard the drugs that they and friends have tried as no more dangerous than alcohol, and as producing psychological effects at least as enjoyable. Neither group can understand why the other can be so misguided.

What is certain is that profound changes have taken place during the past 50 years in attitudes to 'drugs' and their prevalence. Although patterns of drug-use have varied over time and in different localities, the use of drugs is more common and the negative social consequences have become more obvious. Drugs can be obtained not just in big cities, but in every market town. Schoolchildren experiment with them from an increasingly early age, while many young people take Ecstasy and other stimulants almost as a matter of course at weekends. Tens of thousands of others have become dependent on heroin and many resort to crime to pay for it.

Despite these changes, successive governments have maintained there is no alternative to the control policies they are pursuing. There has rarely been any serious discussion of the underlying causes of increased drug-taking, or of alternative strategies that might be more effective in preventing it or reducing its harmful consequences.

Trends in drug-use

Although opiate addiction and other 'drug problems' were recognised a hundred years ago, political concern in the UK dates from the 1950s when their recreational use began to spread among young people. The association between cannabis and protest movements in the 1960s attracted further attention, as did the arrival of LSD. Some problems, like barbiturate misuse, have largely disappeared. Others, like amphetamine misuse, have persisted. The 1980s and 1990s saw a heroin epidemic involving inhalation ('chasing the dragon') that affected teenagers as well as young adults. Increasing quantities of cocaine also entered the country, used both as powder and in its smokeable form ('crack'). From the late 1980s, deaths among young Ecstasy-users shifted media interest to the emergence of a 'dance drug' culture. At the start of the twenty-first century rising seizures of heroin and its widening use in major cities and elsewhere have become a renewed focus of concern.

Drug misuse is today viewed as a serious social problem for different, but connected reasons:

- The physical health of users can be damaged by toxic effects of a drug, dependence, or the way it is used (such as infection with a dirty needle).
- Psychiatric illness is often found among heavy users, although it may be difficult to establish which came first.
- The heavy cost of maintaining a heroin or cocaine habit often propels users into a life of crime.
- Although no drug consistently produces violence, some users become violent under a drug's influence. The drug trade itself involves gang warfare and violence.

Thousands of deaths occur each year in Britain as a result of illegal drug-use. Most relate to the use of heroin, methadone and other opiates. Although accurate figures are not available, recorded deaths associated with drug dependence, non-dependent abuse or poisoning rose from 1,800 to 2,100 between 1979 and 1997.

The complex causes of drug-use

Drug-users range from occasional cannabis smokers and weekend users of dance drugs to heavily dependent users of cocaine or heroin. Drug-use is found among young people from all social classes, yet risky behaviour, such as injecting or smoking heroin, is more often linked with neighbourhoods experiencing multiple disadvantage. Drugs may also be easier to obtain and harder to control in areas where there are fewer legitimate ways to make money.

While drug choices are shaped by social and economic circumstances, biological endowment and psychological development are also important. Genetic factors do not 'cause' drug-use or dependence, but they increase the risks for certain individuals, if drugs are available.

Other risks relate to family relationships. Abuse, neglect and homelessness all increase the chances that children will experience problems with drugs later on. The chances are also increased where parents and other family members use drugs. These and other risk factors for heavy drug-use are far more significant when they cluster together in children's and young people's lives.

The main drugs

Most, but not all, of the most widely used psychoactive substances are addictive. They can be summarised according to their individual medical and psychological effects. However, many users do not limit themselves to one drug and will often try other substances – so-called 'polydrug' use.

Alcohol stimulates sociability, but impairs judgement and reflexes. The risk of addiction increases with regular consumption of large quantities. Alcoholics risk premature death through cirrhosis of the liver, accidents and suicide. Alcohol is the most commonly used drug in Britain with only 7 per cent of men and 13 per cent of women describing themselves as non-drinkers.

Amphetamine is a stimulant misused for a 'buzz' of extra alertness and energy. But it also impairs judgement and concentration. Depression and anxiety characteristically follow binges. Psychotic reactions resembling acute paranoid schizophrenia may follow heavy use. Ten per cent of 16- to 59-year-olds, rising to 20 per cent of 16- to 29-year-olds, have tried it.

Benzodiazepines are tranquillisers including diazepam (Valium), nitrazepam (Mogadon) and temazepam. They are often used in polydrug 'cocktails'. Overdoses can cause prolonged sleep, coma and impaired breathing, especially when combined with alcohol or heroin. Three per cent of adults report having used tranquillisers not prescribed for them.

Cannabis is mostly used as leaves, resin or cannabis oil. It commonly produces a feeling of intense relaxation. But a single 'joint' can slow reactions for 24 hours, affecting ability to drive or concentrate. Heavy use can produce temporary acute psychosis. It can also exacerbate schizophrenia symptoms. Positive uses to relieve symptoms in chronic illnesses are being actively researched. It is the most widely used illegal drug, with 25 per cent of 16- to 59-year-olds and 40 per cent of 15- to 16-year-olds saying they have tried it.

Cocaine is a powerful stimulant usually inhaled as powder or smoked as vapour from crystals ('crack'). An intense 'high' tends to be followed by a 'crash'. Addictive cravings can endure for months after the last dose. Paranoid feelings and psychosis may also occur. Long-term use can lead to premature heart attacks. Around three per cent of 16- to 59-year-olds report using cocaine, and one per cent using 'crack'.

Ecstasy (MDMA) has effects like amphetamine, but also causes feelings of well-being and sociability. Deaths have occurred at parties, 'raves' and clubs among users who keep dancing without replacing fluid. However, ecstasy also has an anti-diuretic effect, and deaths have also resulted from users drinking excess water, producing swelling of the brain. The true extent of related mental illness is unknown, but users may be at greater risk of depressive illnesses in later life through damage to nerve endings in the brain. Four per cent of the overall population aged 16 to 59, but 10 per cent of 16- to 29-year-olds, have tried the drug.

Heroin is an opiate producing immediate euphoria and pain relief when injected intravenously. It can also be snorted as powder or inhaled as vapour. It is highly addictive, requiring increasing amounts to achieve the same 'high'. Sudden withdrawal leads to nausea, muscle pains, diarrhoea and goose flesh ('cold turkey'). Heroin overdoses cause about 200 deaths a year in Britain. Methadone, a synthetic opiate, is used to treat heroin addiction, but is itself responsible for around 400 deaths a year through overdoses. About one per cent of adults report having used heroin and one per cent report using non-prescribed methadone.

LSD is a hallucinogen whose effects include distortions in shapes and colours. These are often enjoyable, but may appear menacing ('bad trip'). Users are occasionally violent because of paranoid delusions. Hallucinations have led to accidental injuries and some deaths. About five per cent of 16- to 59-year-olds have tried LSD.

Solvents are most often abused by schoolchildren to gain an immediate 'high'. Most deaths occur from sniffing butane gas, but glue-sniffing can also lead to loss of consciousness and asphyxiation from vomiting. Long-term abuse can damage the brain, liver, kidneys and bone marrow. Six per cent of 16- to 29-year-olds have tried solvents and two per cent of 16- to 59-year-olds.

Tobacco is primarily a stimulant with pharmacological actions akin to cocaine and amphetamine. It is as addictive as heroin and causes cancers, chronic lung disease and heart attacks leading to 120,000 premature deaths a year in Britain. Babies of mothers who smoke are more likely to have a low birthweight. Some 28 per cent of adults smoke, including 29 per cent of 16- to 19-year-olds.

Prevention strategies

Strategies intended to reduce the damage caused by drug misuse range from regulation and law enforcement to education programmes - and also include treatment and rehabilitation for dependent users. There are substantial differences in the level of public money and other resources currently allocated to these activities.

Figure 1 shows that out of the total of £1.4 billion spent tackling drug misuse in the UK during 1997-98, some 75 per cent was committed to enforcement activity by police, customs, probation and the courts. Education and prevention claimed 12 per cent and 13 per cent went on treatment and rehabilitation programmes.

Preventive programmes aim to reduce:

- initial use of a drug (primary prevention);
- adverse effects of occasional use (secondary prevention);
- harm caused by those who have become dependent on drugs to themselves and to other people (tertiary prevention).

Some prevention strategies, like publicity programmes and legal controls, are targeted at the general population. Others, especially secondary and tertiary programmes aimed at 'harm reduction', are selectively targeted at those deemed most at risk. Improved targeting is essential since an intervention for young people who have started experimenting could be wholly unsuitable for those of a similar age who have never tried drugs.

Research into the effectiveness of primary and secondary drug prevention has mostly been conducted in North America. This suggests that simply providing children and young people with information about drugs has little or no effect on subsequent use of alcohol, tobacco or drugs. The US National Institute of Drug Abuse has recommended that preventive programmes should:

- aim to reduce known risk factors and enhance protective factors;
- target all forms of drug misuse, including alcohol and tobacco;
- be family-focused, including a component for parents;
- be long term across a school career;
- be age-specific and culturally sensitive;
- address local problems and seek to strengthen community norms against drug-use.

Promising approaches include programmes that promote reasoning and social skills, helping young people to recognise and resist the pressures to use drugs. These, together with comprehensive approaches that take account of family and community influences, need to be replicated in the UK. British health education programmes aimed at drug misuse have not been adequately evaluated in the past and their cost-effectiveness is in doubt.

Treatment programmes

There are more than 500 drug treatment agencies in England and Wales, over half of which are in the voluntary sector. They include needle-exchange schemes intended to reduce the transmission of blood-borne diseases such as HIV and hepatitis.

Attempting to reduce the social, psychological and physical harm that dependent drug-users may cause to themselves (and others) requires co-operation between many agencies, statutory as well as voluntary. For example, the growing number of community drug teams working in England and Wales bring together psychiatric nurses, social workers and doctors. GPs have traditionally been reluctant to treat drug-users, regarding them as a specialist problem. But 'shared care' schemes, involving specialist GP liaison workers, are gaining ground.

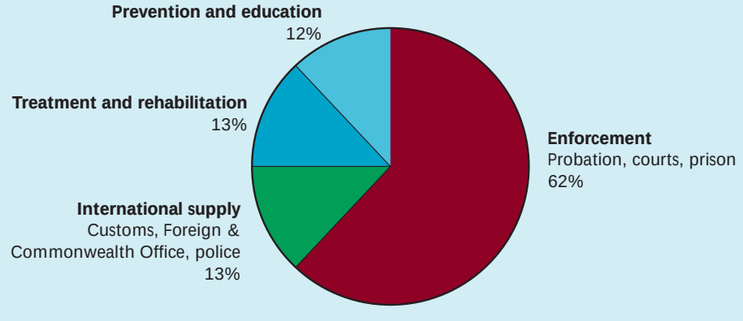
Treatment normally includes counselling and other support services as well as pharmacological intervention. Detoxification from heroin is, in most cases, achieved by prescribing diminishing oral doses of methadone. There is evidence that the rates of initial success and subsequent abstinence are higher for users treated by specialist in-patient services. Methadone is also generally used in maintenance treatments for heroin-users, although buprenorphine and other drugs have proved effective in controlled trials. In spite of the scope for abuse, one in ten opiate prescriptions in 1995 was for injectable methadone, rather than its oral form.

Treatment programmes for dependence on amphetamine, cocaine and other stimulants are, by comparison, poorly developed. Some agencies prescribe oral dexamphetamine on a reducing or maintenance basis, but the treatment remains controversial. Alternatives are to support users through withdrawal symptoms using anti-depressants. Despite extensive American research, no treatment for cocaine dependence has proved conclusively effective in achieving sustained abstinence.

In Britain, there has been a long-term failure to evaluate treatment programmes adequately. However, the National Treatment Outcome Research Study has suggested that the main specialist treatments of heroin dependence (mainly by methadone substitution) are cost-effective, saving the community £3 for every £1 invested. American treatment programmes have reported higher savings – a ratio of seven to one.

Figure 1

Estimated total expenditure on drug misuse in the UK 1997-98



Source: Adapted from *Comprehensive Spending Review, UK Government,* quoted *in Tackling drugs to build a better Britain - The Government's 10-year strategy for tackling drug misuse - Guidance Notes, April 1998.* Published in *Drugs: Dilemmas and choices,* The Royal College of Psychiatrists, 2000.

The Misuse of Drugs Act (MDA) and other legislation

National and international legislation against the misuse of drugs reflects cultural traditions and economic interests. Alcohol and tobacco, although dangerous drugs, are accepted and marketed, whereas opiates, cocaine and cannabis are banned and their international trade prohibited.

The Misuse of Drugs Act, 1971 was designed to meet UK obligations under United Nations conventions on drug-trafficking, as well as to control the drug 'scene' of 30 years ago. It divides the drugs it controls into three categories that determine the maximum penalties for possession, trafficking and other offences:

Class A includes heroin, methadone, cocaine, LSD, cannabinols and – since 1977 – Ecstasy. The maximum penalty on Crown Court indictment for possession is seven years' prison and/or an unlimited fine. On summary conviction in a magistrates' court, the maximum penalty is six months' prison and/or a £2,500 fine. Drug-dealing and trafficking carry a maximum life sentence.

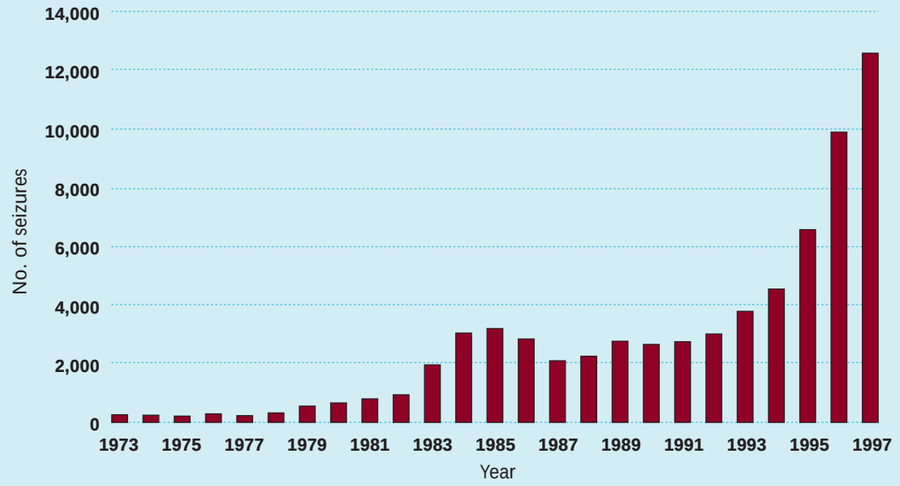
Class B includes amphetamines and cannabis. Possession carries a maximum five years' prison and/or unlimited fine on indictment, and three months' prison and/or a £2,500 fine on summary conviction. The maximum penalty for possession with intent to supply and other trafficking is 14 years' prison and/or an unlimited fine. In a magistrates' court it is six months' prison and/or a £2,500 fine.

Class C includes benzodiazepines and buprenorphine, a synthetic opiate. The maximum Crown Court penalty for possession is two years' prison and/or an unlimited fine and, in a magistrates' court, three months' prison and/or a £1,000 fine. Possession with intent to supply carries a maximum five years' prison on indictment and three months' prison on summary conviction.

Offences involving Classes A, B and C are 'arrestable' in law. It means police have powers to insist that suspects accompany them to the police station and to search their premises without a warrant. Other offences under the Act include assisting in the commission of a drugs offence outside the UK, allowing premises to be used for the supply or use of a controlled drug, and cultivation of cannabis. The Customs and Excise Management Act, 1979 prohibits the import or export of controlled drugs except for approved medicinal or scientific uses. The 1994 Drug Trafficking Act creates further offences in connection with money 'laundering' and gives courts the power to order confiscation of assets obtained through drug-trafficking.

Figure 2

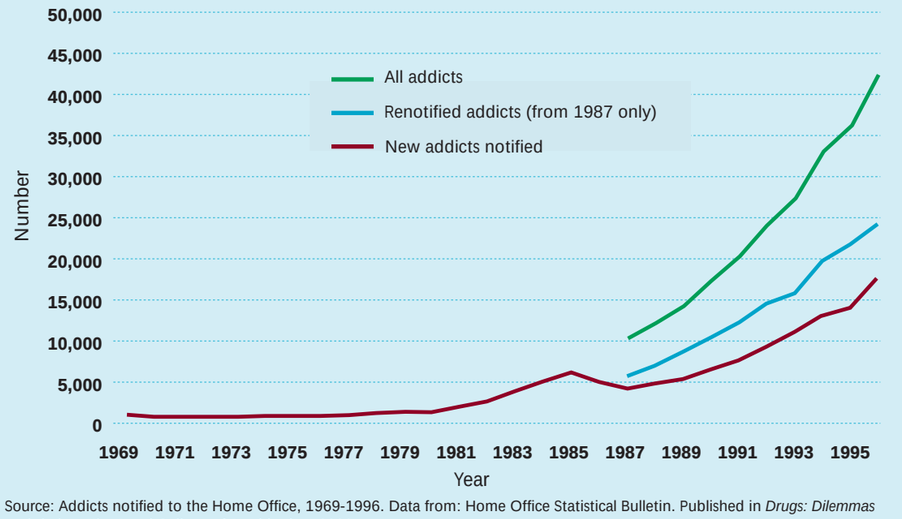
UK seizures of heroin 1973-1997 (not including Northern Ireland)



Source: Data from Home Office Statistical Bulletin and personal communication (John Corkey, 1999). Published in *Drugs: Dilemmas and choices,* The Royal College of Psychiatrists, 2000.

Figure 3

Addicts notified to the Home Office, 1969-1996



Source: Addicts notified to the Home Office, 1969-1996. Data from: Home Office Statistical Bulletin. Published in *Drugs: Dilemmas and choices,* The Royal College of Psychiatrists, 2000.

Enforcement

Possession offences dominate the operation of the law against drugs, accounting for 90 per cent of MDA cases. More than three out of four cases in 1997 involved cannabis, followed by amphetamine (12 per cent), heroin (8 per cent), Ecstasy and Ecstasy-type drugs (5 per cent) and cocaine (3 per cent). Nine out of ten offenders are male with an average age of 25.

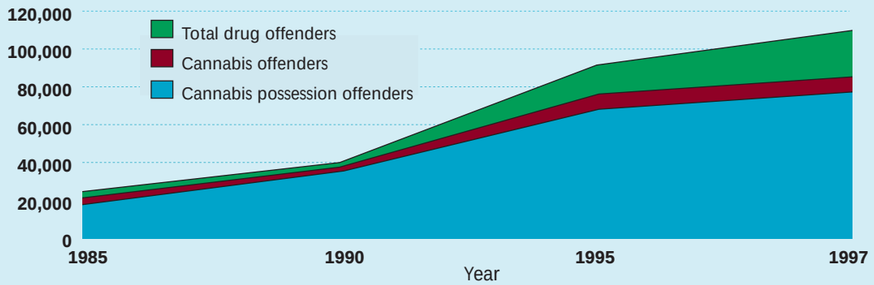
The number of drug offenders dealt with by the law each year has risen from 12,532 in 1974 to 113,154 in 1997. There has also been a big increase in the number of offenders who admit possession and receive a formal police caution, rather than go to court. For example, 58 per cent of those dealt with for cannabis possession in 1997 were cautioned.

Those accused of trafficking and other serious drug offences are more likely to be prosecuted, and receive prison sentences if convicted. Even so, the majority of sentences passed by the courts for drug offences in 1997 were fines or community sentences rather than immediate custody.

Confiscation of drug-related assets is an important means of ensuring that traffickers do not profit from their crimes and that the proceeds of organised crime cannot be reinvested. Nevertheless, there is evidence that the present system is poorly administered. The average amount of a confiscation order from convicted traffickers in 1997 was £3,834, barely half the figure for the previous year.

Figure 4

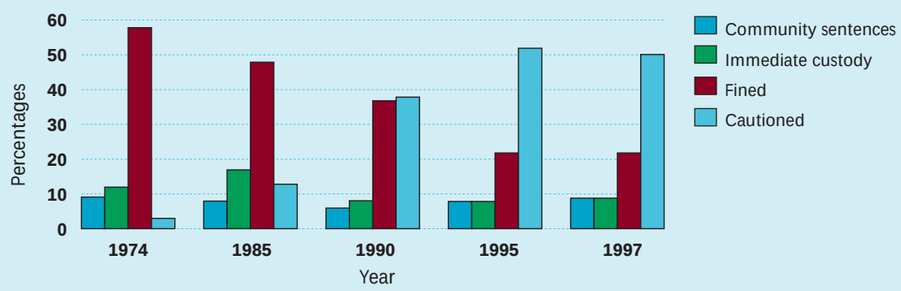
Relationship of cannabis offenders to total drug offenders, 1985-1997



Source: *Drugs and the law: Report of the Independent Inquiry into the misuse of Drugs Act* 1971. Published in *Drugs and the Law,* The Police Foundation, 2000.

Figure 5

How drug offenders were dealt with 1974-1997



Source: *Drugs and the law: Report of the Independent Inquiry into the misuse of Drugs Act* 1971. Published in *Drugs and the Law,* The Police Foundation, 2000.

Public attitudes to drugs

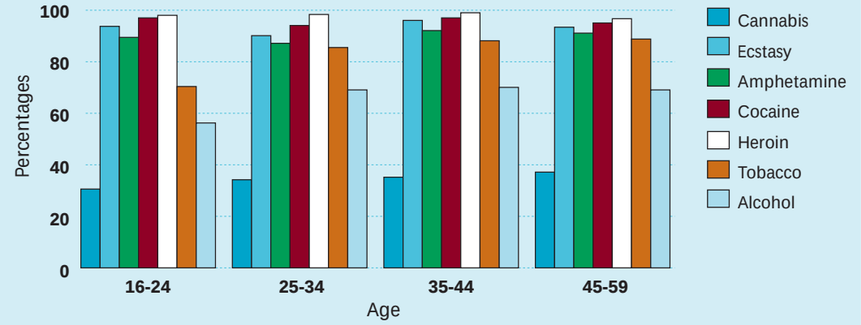
Public opinion in Britain does not view all drugs as equally harmful.

MORI surveys commissioned by the Police Foundation Independent Inquiry found that the vast majority of adults judged heroin, cocaine, Ecstasy and amphetamines to be very or fairly harmful. A majority in all age groups also considered alcohol and tobacco to be harmful. By contrast, only a third took the same view of cannabis.

Schoolchildren aged 11 to 12 tended to see all drugs, including cannabis, as equally harmful. But the views of 15- to 16-year-olds were similar to those of adults.

Figure 6

Ranking of drugs as very or fairly harmful by 16- to 59-year-olds



Source: *Drugs and the law: Report of the independent inquiry into the Misuse of Drugs Act*, 1971. Published in *Drugs and the law,* The Police Foundation, 2000.

International comparisons

The United Nations' conventions on narcotic drugs (1961), psychotropic drugs (1971) and illicit trafficking (1988) require states to meet certain broad obligations, including the creation of criminal offences. However, they leave considerable leeway as to how these obligations might be met with regard to possession offences. There is express provision for imposing treatment programmes, education, and rehabilitation in addition to conviction, or as an alternative. A comparative study of drug laws in France, Germany, Italy, Spain, the Netherlands and Sweden – commissioned from the Institute for the Study of Drug Dependence by the Police Foundation Independent Inquiry – shows convergence in legislation against trafficking. However, there is diversity in the way that personal possession is treated. For example, possession for personal use in Italy and Spain is treated as an administrative, not a criminal offence. In the Netherlands, it is normal practice to take no action against possession of small quantities of drugs for personal use with the same principle applied to sales of small amounts of cannabis (up to five grams) from coffee shops. The UK is unique in Europe in having a three-tier classification for drugs based on an assessment of their relative harmfulness with penalties attached. It is also apparent that Britain has a more severe regime of control over possession offences than most other European countries in the study.

Key issues and findings from the Royal Colleges' Working Party report

- **Spending on prevention**: Three-quarters of UK expenditure is devoted to enforcement and international supply reduction. There is little evidence that this is money well-spent. The proven cost-effectiveness of methadone maintenance and abstinence-based programmes for heroin addicts suggests that more of the available budget should go to treatment programmes. New money for treatment announced by the Government is welcome, but calls for expansion of unproven and untested treatments must be resisted.

- **Research**: Current UK expenditure on drugs research does not begin to match the magnitude of the problem. Just one per cent of the annual drugs prevention budget would inject £14 million into research – over double the current spend.

- **Improving the value of treatment**: Systematic investment in staff training, monitoring of patients and essential support services is needed to bring improvement rates achieved by UK treatment programmes closer to those in the United States. In particular, more extensive drug treatment facilities are needed for adolescents.

- **Private prescribing**: Private prescribing of substitute drugs leaves scope for malpractice that comes close to 'buying a prescription'. Doctors treating drug-users outside the health service are not currently required to have extra training in addictions and receive little monitoring or regulation.

- **Drug-testing by employers**: Although expensive and surrounded by legal and ethical issues, the technology exists for drug-testing of employees using hair samples. This provides a record of drug-use over the previous three months and could, therefore, have a major impact on the prevalence of drug-use in future.

- **Ecstasy**: Many young people use Ecstasy, and some drugs education campaigns may have proved counter-productive. Any advice given to young people should take account of the likely impact on those who continue to use drugs as well those who will be deterred.

- **Amphetamine**: Dependence on amphetamine, especially when injected, probably carries more risk to users and public health than heroin. Little research has been carried out into dependence or treatment.

- **Cannabis**: Cannabis is not a harmless drug, but its ill-effects on health are almost certainly less than those of tobacco or alcohol, which are legal. More research is needed into the medicinal benefits and long-term ill-effects of the drug. Legislative experiments, as in the Netherlands, should be encouraged. People requiring cannabis to relieve disabling medical conditions, such as multiple sclerosis, should not be prosecuted.

- **Future policy**: The Government's Ten-Year Strategy for Tackling Drug Misuse recognises the need for greater investment in treatment. But there are no easy answers, and ambitious targets for reducing the proportion of young people using heroin and cocaine by 50 per cent by 2008 are unlikely to be achieved by the modest initiatives announced so far. Attempts to curb the illegal international drugs trade have consistently failed and will probably continue to do so. If the prevalence of drug-use and drug-related crime continues to rise, the pressure on the UK and other governments to change policies that are clearly failing is bound to increase.

Reforms to the Misuse of Drugs Act, 1971 proposed by the Police Foundation Independent Inquiry

The Inquiry concluded that careful reform of the 30-year-old legislation is needed as part of an overall strategy to reduce the harm caused not only by drugs, but also by the law itself.

- **Reclassification**: No drug currently covered by the Misuse of Drugs Act should be legalised, but changes to the classification of drugs and related penalties are needed. Establishing a more accurate 'hierarchy of harm' will help to target policing, prevention and treatment resources more effectively:

  - Heroin and cocaine should remain as Class A drugs, reflecting their exceptionally powerful, addictive potential.

  - Ecstasy and LSD should move from Class A to Class B, placing them in the same category as amphetamine.

  - Cannabis should move from Class B to Class C.

  - Buprenorphine, a synthetic opiate, should move from Class C to Class B.

- **Penalties for possession**: Occasional drug-use can be tackled more effectively by credible education than by harsh penalties. Prison should no longer be available as a penalty for possession of drugs in Classes B or C. The maximum sentence for possessing Class A drugs should be reduced to one year and/or an unlimited fine on indictment – and only imposed where community sentences have failed or been rejected.

- **Cannabis possession and cultivation**: The law on cannabis causes more harm than it prevents. It is expensive of police time and bears most heavily on young people on the streets of inner cities – especially those from black and minority ethnic communities. The normal sanctions for possessing or cultivating cannabis for personal use should be cautions, fixed fines and other out-of-court disposals that do not incur a criminal record.

- **Powers of arrest**: Police should retain their power to stop and search for drugs and to arrest those suspected of possessing Class A and Class B drugs. Possession of cannabis and other Class C drugs should no longer be an arrestable offence.

- **Dealing and trafficking**: Despite large increases in the number and quantity of seizures there is no evidence that drugs have become harder or more expensive to obtain. To strengthen the law against dealers and traffickers, there should be:

  - a new offence allowing courts to sentence for a pattern of dealing in drugs, as opposed to single acts of supply;

  - a National Confiscation Agency (also proposed by the Home Office) to improve the efficiency of procedures for removing drug-related assets from traffickers;

  - transfer of responsibility for enforcing confiscation orders to the Crown Court;

  - statutory sentencing guidelines to ensure that courts take account of aggravating factors such as involvement in organised crime, use of firearms or supplying drugs to children.

How to get further information

The two reports summarised in this publication were published in 2000.

***Drugs: Dilemmas and choices by a Working Party of the Royal College of Psychiatrists and the Royal College of Physicians* is published by Gaskell, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Price £9.50 including p&p.**

***Drugs and the law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (Chairman: Viscountess Runciman DBE) is published by The Police Foundation, 1 Glyn Street, London SE11 5RA. Price £20 plus £2.50 p&p.**

The Independent Inquiry into the Misuse of Drugs Act was jointly funded by the Peacock Trust, the Esmée Fairbairn Charitable Trust, Minerva plc, the Joseph Rowntree Foundation, The Prince's Trust, The Pilgrim Trust, The Hayward Trust, The Wates Foundation and The Tompkins Foundation. The following reports which informed its work are available on request from The Police Foundation (address as above):

***Room for manoeuvre: Overview of comparative legal research into national drug laws of France, Germany, Italy, Spain, the Netherlands and Sweden, and their relation to three international drugs conventions* by Nicholas Dorn and Alison Jamieson, Institute for the Study of Drug Dependence, London, 1999.**

***Despite the law: The dynamics of deciding to use illicit drugs* by Howard Parker, The University of Manchester, November 1998.**

***Financial measures against illegal drugs: An overview* by Michael Levi, The University of Cardiff, May 1999.**

***Attitudes towards the law and drugs: Schools' omnibus survey,* MORI, London, April 1999.**

***Attitudes towards the law and drugs: Adults' omnibus survey*, MORI, London, April 1999.**

***Regulatory drug-use* by Robert Baldwin, London School of Economics, January 1999.**

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