A Brief History of British Drug Policy; 1950 – 2001

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Abstract

Following the establishment of the so-called "New British System" (based on the recommendations of the Rolleston Committee in 1926), numbers of recorded opiate and cocaine addicts fell significantly in the early 1930s and remained stable and at a relatively low level for the next two decades. It was in the latter part of the 1950s that reports of a new drug "epidemic" began to circulate. Concerns centred on the use of drugs by ethnic minorities, notably black West Indians and Africans in 'blues clubs' and visiting black American musicians in jazz clubs. Once again the drugs epidemic was associated with jazz ("jungle") music and colour. By the end of the 1960s, young white teenagers had become involved too and the world had seen the student riots in Paris; the birth of Swinging London with its attendant Merseybeat; the hippy revolution in San Francisco; and a growing youth protest, both in the USA and Britain, over western military involvement in Vietnam. Politicians and journalists invariably associated these events with the use of drugs by young people. Over the last four decades of the 20th Century, the use of drugs by young people (and the attendant treatment industry) has grown exponentially and the focus has moved from individual treatment to public health and infection control to the current preoccupation with drugs/crime connection. This brief history attempts to summarise these developments in a short article chronicling the major milestones and events.

Absolute Beginners

Despite the unimaginable cost - both economic and in terms of human life - of World War Two, post-war Britain of the 1950s was an extraordinary period of self-confidence and optimism. Even the instinctively austere new Labour administration of Clement Atlee was prepared to spend huge sums on the mounting of a *Festival of Britain* with its vision of a future Britain of stainless steel and formica.

To some extent, the 1950s resembled the 1920s. Both decades began with a flurry of interest amongst the young, in new music and new fashions; in dress and language. In both decades, jazz was an important precursor to the development of new musical forms.

Perhaps the essential difference between the two decades was that the depression years of the 1930s had proved to be a great leveller. Whereas the 1920s of the flappers was almost entirely the preserve of the rich, the new leisure/fashion/music phenomenon of the 1950s had an impact upon all classes. The radio (and in the 1960s, the television) brought music into thousands of working-class homes. No longer was new music and dance the exclusive preserve of an Edwardian elite. Furthermore, the abolition of restrictions on hire purchase in 1958 added further impetus to the burgeoning youth industry. By the early 1960s, it was quite common for clothes, musical instruments (particularly guitars and drum kits) and household electrical items (particularly record-players for teenagers' bedrooms) to be purchased "on tick" (Yates, 1998).

Throughout the decade, the official addiction figures climbed steadily upwards with most of the increases being of young heroin users. The increase in young heroin users - and the

increasing reporting of it - should be set against a growing unease in Britain about the 'teenage problem'. James Dean had become a youth cult hero overnight with the film *Rebel Without a Cause*. *The Wild Ones*, starring Marlon Brando, another youth cult hero, was banned in British cinemas (Thomson, 1994). *The Blackboard Jungle*, an otherwise unmemorable film featured the song *Rock Around the Clock*. The singer, Bill Haley, an aging, overweight bandleader, was an unlikely hero, but the song caught the imagination of the Teddy boys; an emerging youth movement. The filmmakers hastily produced a second film entitled *Rock Around the Clock* as a vehicle for Bill Haley and his Comets (Clayson, 1995). When the film was premiered at the Troccadero in London's Elephant and Castle, the Teddy boys went wild and destroyed much of the interior of the cinema. Rock 'n' Roll was born in Britain (Yates 1999).

From the beginning of the 1950s there were some limited indications that the existing pattern of middle-class morphine addicts ministered to by largely sympathetic medical practitioners was beginning to change. In May 1951 a young drug user broke into a hospital dispensary just outside London and stole large quantities of morphine, cocaine and heroin. Much of the morphine was recovered; which perhaps indicates that already the opiate of choice - at least amongst the young - had become heroin. It would certainly suggest that the young man and his acquaintances had little social contact with the established addict group. By the end of the decade, over sixty heroin users in the London area who traced their drug using career back to this one episode had been identified (Spear, 1994).

Many were jazz musicians or regular visitors to jazz clubs where heroin, cocaine and cannabis were regularly used. These newer, younger addicts were increasingly gravitating

to the West End of London where a small number of general practitioners were becoming known as 'junky doctors' as a result of their willingness to prescribe.

Of this small group of London doctors - some genuine in their belief that they could help; some weak (and occasionally corrupt); some simply gullible - Lady I. M. Frankau is perhaps most notorious; though not necessarily best remembered. Lady Frankau, a Wimpole Street psychiatrist claimed to have treated approximately 500 addicts between 1958 and 1964: an astonishing number given that Home Office notifications in 1964, for the UK as a whole, were 753. The figures for the period were 1959, 454; 1960,437; 1961, 470; 1962, 532; 1963, 635; 1964, 753. In comparison to the stability of the figures for the previous quarter of a century, this five-year increase represents a quite unprecedented upward spiral (Glatt, Pittman, Gillespie & Hills, 1967).

Public opinion, steered by the media and quoted by them with great authority, was ripe for reaction to the flood of drugs epidemic stories which began to appear with increasing frequency in the late 1950s and early 1960s. In the 1920s it had been the dilettante rich and the louche, now it was wayward youth. Youth was out of control. They wore different clothes; they listened to "jungle music" and they scorned the attitudes and ideals of their elders. The "generation gap" had been identified and, probably, no-one expressed it better than Colin MacInnes:

> *"No-one could sit on our faces no more because we'd loot to spend*
>
> *and our world was to be our world, the one we wanted"*
>
> (MacInnes, 1980).

Despite this growing public unease, the report of the first Government committee to consider drugs and addiction in thirty years was a model of complacency - superficial in its consideration of the evidence and almost totally without vision. The emergence of new drugs such as methadone (physeptone) and the discovery that some tranquillisers (at that time thought to be non-addictive) could be used in the management of withdrawal prompted the government in 1958, to establish the Interdepartmental Committee on Drug Addiction *"to review.....the advice given by the Rolleston Committee in 1926 including the possible application of any new suggestions to other addictive or habit-forming drugs; and to advise on any possible need for additional special treatment facilities or administrative measures"* (HM Government, 1961).

Their report (usually called the *First Brain Report* after its chairman Lord Brain) was published in 1961. It found that there was little need to make any radical change. There was, they said, no significant increase in numbers (there is some suggestion that the Home Office failed to provide the Committee with adequate evidence) and the small post-war increase was mainly the result of increased vigilance (Spear, 1994).

Members of the Committee who attended the annual symposium of the Society for the Study of Addiction later that year were embarrassed to hear a London pharmacist point out that he himself was dispensing heroin and cocaine to more patients than those identified in the Committee's report (Glatt et al, 1967).

Over the next few years, newspaper reports of the heroin 'scene' in London's West End and of the 'purple hearts' (drinamyl) craze in Soho dance clubs increased the pressure and in 1964 the government reconvened the Committee. At Lord Brain's insistence, the terms of reference were narrowed to: *"review the advice they gave in 1961 in relation to the prescribing of addictive drugs by doctors"* (HM Government, 1964). This seems to have been mainly because annual reports by the Home Office Drugs Inspectorate appeared to have already identified the problem: the over-prescribing of heroin and cocaine by a small group of doctors in London (Spear, 1994). But the net effect of this narrowing of the focus meant that the *Second Brain Report* virtually ignored the emerging patterns of drug use outside London and the widepread use of amphetamines.

The *Second Brain Report* was published in 1965. It was a further two-and-a-half years before the recommendations of the report were implemented within the provisions of the Dangerous Drugs Act 1967. Most of the major recommendations of the Second Brain Committee were implemented. In the future, although the basic tenets of the Rolleston model were to be retained, prescribing of heroin and cocaine would require a special license to be issued by the Home Office. Licenses would normally only be granted to psychiatrists working in specialist treatment units (based upon a model pioneered at All Saints Hospital, Birmingham) which were to be established across England at Regional Health Authority level. These were to be called Drug Dependency Units (DDUs) although almost every drug user subsequently referred to them simply as 'the Clinics'. No parallel provision was envisaged for Scotland, Wales or Northern Ireland where there was not thought to be a problem (Yates, 1981).

The establishment of the DDUs was paralleled with the growth of a significant and often influential range of drug services in the voluntary sector. By the mid 1970s the vast majority of beds available for rehabilitation (though not for detoxification) were managed within the voluntary sector (Rawlings & Yates, 2001). Non-residential services were also provided by the voluntary sector although most of these were London-based (Yates, 1992; Turner, 1994).

Many commentators, particularly American commentators (Schurr, 1963; Schur, 1964; and Trebach, 1982) have pinpointed this moment as the time when Britain abandoned the 'New British System' and opted instead for a US-style penal policy. This is however, a misreading of the facts. Although it is true that the Dangerous Drugs Act 1967, in line with the recommendations of the Brain Committee, extended the powers of the police, this was not at the expense of the old Rolleston model of substitute prescribing which was left intact though it was restricted (in theory, though perhaps not in practice).

Firstly, Britain did *not* abandon the Rolleston principles though it did restrict the prescribers who were eligible to carry them out. The fact that this was not resisted by doctors is further indication that most doctors were unwilling anyway to treat this kind of patient. In other words, the restriction in numbers of prescribers may have been in theory only. Kenneth Leech, then curate at St. Annes in Soho was of the opinion that there were only around 12 doctors in London prepared to treat addict patients - the new arrangements saw the establishment of fifteen specialist treatment units (Spear, 1994).

Secondly, by the time these changes were introduced in 1968, the numbers of users - particularly those under thirty - had *already* begun to spiral out of control and a blackmarket was already established; in London at least. In other words, the new arrangements in 1968 did not *cause* the changes in the drug-subculture; rather, they were an early response to those changes.

Thirdly, the analysis fails entirely to take account of the establishment of a National Health Service with treatment (and medication) free at the point of delivery. It seems hardly surprising that the majority of addicts in the 1930s and 40s were middle-class professionals when we take into account that at that time, they would have had to pay for their supplies.

Finally, the analysis also fails to take into account the enormous cultural upheavals - particularly amongst the younger generation - that were taking place in Western society at that time. These were often changes with which drug use became associated (although the use of drugs was not necessarily fundamental to them) (Yates, 1994).

There seems little doubt that a blackmarket in drugs would, sooner or later, have become established in the UK but there is some truth in identifying this time as its genesis. In London, the uncertainty, both of doctors and of their addict patients, during the interval between the publication of the Brain Report and the enactment of the recommendations may have been the reason for a significant increase in the use of blackmarket Chinese heroin; often by drug users who had been struck off their doctor's list as soon as the report was published (Yates 1992).

Outside London, where the impact of the DDUs was less significant, users turned to the use of barbiturates and mandrax, opioids such as palfium and diconal and pharmaceutical heroin or morphine diverted from pharmacy burglaries (Yates, 1981).

Throughout the 1970s, the numbers continued to grow. The punk revolution in the mid-70s caused an outbreak of concern about the sniffing of volatile solvents. It seems clear that the punks deliberately chose glue-sniffing (often combined with lager and cider) since this was perhaps the most visibly distasteful substance they could use. When the dramatic expansion of the heroin blackmarket began in 1979, the punks were among the earliest recruits (Savage, 1992).

Smack City, UK

The arrival of heroin in 1979 in cities throughout the UK took most observers by surprise. Most of the new heroin flooding into the UK was Middle-Eastern smoking heroin which was unsuitable for injection without being first changed into a heroin salt by the application of lemon juice, acetic acid etc. (Griffiths, Gossop & Strang, 1994). This fact, coupled with the existence of a large population of Iranian students apparently able and willing, both to sell heroin and to induct novitiates into the art of heroin smoking, resulted in a huge increase in heroin users. Many potential users who had been deterred by the thought of injection were attracted to this apparently painless method. For some time, there was an unshakeable belief in some drug-using circles that heroin was 'non-addictive' if smoked (Yates, 1999).

To some extent, heroin smoking became most prevalent in areas where there was a tradition of non-injecting drug use. Where injecting was part of the culture, the new heroin was mainly injected and lemon juice or citric acid became simply another item on the drug injector's shopping list. But the expansion, like the existing drug subculture was patchy and unpredictable. Most of the new heroin went to those areas where there was an existing drug using culture of some kind. It was some time before it broke into completely 'clean' areas. Even in those cities and towns where there was a well established drug-using tradition, prevalence could change dramatically from district to district (Power, 1994).

In 1982, the Advisory Council on the Misuse of Drugs (ACMD) published their report: *Treatment and Rehabilitation* (ACMD, 1982). The ACMD was a body set up within the provisions of the Misuse of Drugs Act 1971; an Act which was introduced to rationalise and consolidate an untidy bundle of UK laws on dangerous drugs. The ACMD was charged with the responsibility of advising the government on *"measures....which....ought to be taken for preventing the misuse of drugs or dealing with social problems connected with their misuse"* (Shiels, 1991).

Previous ACMD reports, throughout the 1970s, had received little attention from the government. But by 1982, the issue of heroin addiction in inner-city housing schemes had become a serious political issue. Ironically, the main impetus for this had not been the press or right-wing backbench MPs but the deputy leader of the Labour Group on the Liverpool City Council. Contemporary reports would seem to indicate that it was Derek Hatton who deliberately orchestrated media coverage of Liverpool as 'smack city' in order to highlight the plight of the inner-cities and the failure of the Thatcher Government to address the

needs of the young, unemployed, urban poor (Parry, 1991).

Almost overnight, the media spotlight was turned onto the growing heroin problem in the UK's inner-city areas. By the time the ACMD was due to publish its report in the late summer of 1982, 'heroin in Britain' had become almost constant headline news. The publication of the report was held back until December when it was announced in the House of Commons by the Secretary of State for Health that not only had the Government accepted all the reports major recommendations, but that it was providing a substantial sum of central money to 'pump-prime' an expanded network of treatment services. The initial sum announced was £2 million but over the course of the next two years, the fund was increased for a variety of reasons and ultimately reached a total of just under £18 million (Yates, 1983; MacGregor, 1989).

In Scotland, similar central funding was made available under the usual 10% formula and a smaller fund was established in Wales. No provision was made for Northern Ireland which was adjudged not to have a drugs problem at that time. Outside England (and even within England in many areas), this effectively meant the establishment of a completely new network of treatment services since virtually no dedicated services had existed prior to that.

The net result of this activity was a dramatic expansion of treatment services. Most of the new money went into community-based services with almost 60% going to new community services (voluntary and statutory) and a further 10% going to existing voluntary agencies; most of which were also community-based. The extent to which the DDUs had been marginalised by the rapid expansion of the blackmarket can been seen by the fact that they

secured less than 15% of the allocation (MacGregor, 1994).

However, the role of the DDUs and in particular, the consultant psychiatrist (the prescriber), remained crucial. The report had recommended that each Regional Health Authority Area (the report failed to recognise the distinctive nature of the Scottish NHS structure - perhaps not surprising since the Committee had no Scottish representation) should establish a Regional Drug Problem Team (RDPT) with District Drug Advisory Committees at the local level. The ACMD made no specific recommendation for service provision at the local level but this soon began to emerge with the development of a blueprint in North West England for multi-disciplinary Community Drug Teams as local specialist providers (Strang, Donmall & Webster, 1991).

The proposed new RDPTs were, in effect, revamped DDUs and in many areas, little else changed for a number of years. But the central funding initiative did usher in a new period where specialist drug treatment provision was overwhelmingly community-based and largely non-medical.

The Public Health Imperative

From the middle of the 1980s however, the emergence of HIV/AIDS began to bring about a fundamental change in direction. The concern that those who continued to inject drugs (and therefore, by implication, continued to share injecting equipment) might be instrumental in spreading the infection led to a change in agency priorities (Berridge, 1994).

In 1988 the ACMD published its report *AIDS & Drug Misuse Part 1* (ACMD, 1988). Once again, the ACMD had produced a highly significant and influential document. The reports conclusion that: *"HIV is a greater threat to public and individual health than drug misuse"* has since become firmly established in the lexicon of drug field mantras. Few practitioners and planners refer to the remainder of that recommendation.

AIDS & Drug Misuse Part 1 was not, as some have claimed, a u-turn in British drug policy legitimising 'low threshold' maintenance prescribing. It was in many respects, a restating of the central tenets of Rolleston for a modern era. The recommendation goes on to say:

> ".....The first goal of work with drug misusers must therefore be to prevent them from acquiring or transmitting the virus. *In some cases this will be achieved through abstinence*. In others, abstinence will not be achievable *for the time being* and efforts will have to focus on risk-reduction. *Abstinence remains the ultimate goal* but efforts to bring it about in individual cases must not jeopardise any reduction in HIV risk behaviour which has already been achieved" (HM Government, 1982), (my italics).

The implication here is clear. There was no sanction for prescribing forever. (There was no such sanction in Rolleston either). The goal is abstinence. Achieving this goal can legitimately be delayed in two circumstances: where circumstances dictate that it cannot be immediately achieved and where to attempt an abstinence intervention may undermine risk reduction initiatives already underway These are significant caveats which have often since

been lost or distorted in the retelling.

Prior to the emergence of HIV/AIDS, most treatment agencies had seen their customer base consisting primarily of those who had decided to modify, or abandon altogether, their use of drugs; with a smaller number who had not yet reached that decision being offered soup-kitchen, day shelter and detached work provision. Now the priority was to be making and maintaining contact with those drug users (often deeply suspicious of specialist drug services) who were at greatest risk of continuing to share needles. In other words, those who had no intention of stopping.

In order to encourage these drug users into services, community-based agencies were provided with a prescribing capability. Methadone became more readily available with many agencies also offering an injection equipment exchange service. In fact, in South Wales, one GP group practice had been quietly offering this facility since the early 1970s in response to a local hepatitis outbreak whilst some voluntary sector services had originally offered this facility in the late 1960s (Turner, 1994).

The move towards the prescribing of methadone as a central plank in drug treatment services has brought general practitioners back into the field although to some extent they have continued to show the same reluctance to be involved as was the case in the early 1960s.

Much of the service development and planning throughout the 1980s was led by the National Health Service with local authorities merely providing background support in most

areas. This came about mainly as a result of the channeling of the additional central government funding through the NHS. Both the new network (CFI) money and funding to develop HIV/AIDS services later in the decade was allocated through the health service.

However, in recent years, a number of trends have conspired to increase the relative importance of the local authority contribution. Firstly, with the implementation of Community Care, local government has been allocated a central gate-keeping role in the allocation of resources; mainly, though not exclusively, access to residential rehabilitation. Secondly, as HIV/AIDS-related health concerns have receded, the twin issues of community safety and crime prevention have increased in importance and there are signs that these imperatives may be significantly altering the directional flow of policy away from the public health priorities of the previous decade (Stimson, 2000). Thirdly, as the age range within the drug-using community becomes more reflective of that within the wider community, there are increasingly more drug-using parents the care of whose children is, by definition, an issue for local authorities.

The Re-emergence of Psychedelia

In the late 1980s, the UK experienced an almost totally unprecedented and unexpected wave of drug-taking which centred on the use of ecstasy in dance venues or 'raves'. The sheer scale of this development was staggering. By 1995, the Home Office's own estimates were that 1.5 million ecstasy tablets were being used every weekend. Moreover, the apparently distinctive nature of the development (there were little or no links with the pre-existing injecting drug scene and users saw themselves as quite different to injecting drug users

whom they generally disparaged) made existing drug treatment services almost irrelevant.

To some extent, this development had its roots both in the continuing interest in the use of stimulants (particularly in conjunction with dance events) (Yates, 1999) and in experiments (in psychiatry and amongst the lay population) with the use of hallucinogenic or psychedelic drugs to unlock the unconscious (Melechi, 1997).

Interest in the possibility of "unlocking" the unconcious through psychoactive drugs had been heralded by both Jung and Freud (Stevens, 1993). By the 1950s the use of drugs in mental health was widespread and a number of forward-thinking practitioners were experimenting with a new drug called Delysid (LSD 25) both as a psychotomimetic, to mimic (and thus explore the origins of) schizophrenia in selected study groups (including doctors themselves) and as an aid to psychtherapeutic intervention.

In the UK, Dr. Ronald Sandison was conducting experiments in LSD therapy at Powick Hospital using a combination of group and individual therapy, coupled with dramatherapy techniques and the administration of LSD (Sandison, 1997). The Scottish psychiatrist R. D. Laing and other collaborators in the Philadelphia Group were conducting similar studies in London. In Canada, Humphrey Osmond who in the early 1950s had introduced Aldous Huxley to mescaline, was claiming to have achieved extraordinary rates of success in using LSD in the treatment of alcoholics (Stevens, 1993).

This relatively uncontrolled experimentation with a powerful new hallucinogenic led inexorably to the promotion of LSD (by Ken Kesey, Timothy Leary, Michael Hollinshead

and others) as the central ingredient of a mass youth experiment characterised by new, introspective forms of music, Eastern mysticism, pacifism and a return to nature (Reynolds, 1997). However, the interest in psychedelic (a term coined by Osmond) drugs was short-lived. The demonisation of LSD by the popular press effectively stifled the interest within psychiatry (Melechi, 1997) and within youth culture, the interest in psychedelia was largely confined to a middle-class intelligentsia which proved incapable of sustaining popular interest (Yates, 1999). By the mid-1970s, LSD had all but disappeared from UK streets (Yates, 1992). There was a resurgence of interest in the 1980s, but this was largely swamped in the media by the spiraling interest in ecstasy.

In the summer of 1987, young British holidaymakers on the island of Ibiza discovered the combination of ecstasy and 'acid house' music. 'Acid house', or 'Balearic beat' was an amalgam of British 'indie' music of the time with American 'hip-hop' and the new 'house' music emerging out of the gay dance-club scene in Chicago (Yates, 1999).

By the summer of 1988, afficionados of rave culture were proclaiming the 'second summer of love'. But once more, the innocence and euphoria were short-lived. Exponents of the new heroin distribution system had already branched out into cocaine and rock cocaine (crack) in the early 1990s. By the middle of the decade, they had muscled into the distribution of ecstasy too. Raves became more tense as dancers were increasingly subjected to assaults, knifings and shootings (Champion, 1997).

Specialist treatment services have struggled top respond to this new phenomenon. In most cases, the new drug users have been reluctant to make use of services which they perceive

as services for 'junkies'. Some established services have managed to make and maintain meaningful contact through the production of information leaflets. Others have organised detached work services offering on-site advice and information. Many of these new services are finding that they are also being called upon to offer advice and information about the increasing use of alcohol by young people (Calafat et al., 1998).

However, the use of ecstasy and other stimulants appears to be leveling out – particularly amongst teenagers – and alcohol has returned as a major mood-altering substance amongst this age group (Alcohol Concern, 2000; Drugscope, 2000).

Into a New Millenium

The final decade of the 20th Century has seen dramatic changes in policy. The expansion of the treatment service network and the subsequent changes in operational focus as a result of the concerns around HIV infection in the early 1980s marked the opening of a period of some instability within the field.

The response to the emergence of HIV/AIDS saw treatment agencies move into the public health arena as part of the vanguard of infection control policy (Berridge, 1996). For many agencies, the concern over the use of 'dance drugs' further consolidated this change through the development of their emergent health promotion capacities.

But it is in the area of designing, commissioning and evaluating services that Government policy has seen the most dramatic upheavals.

In the last years of the Conservative administration, the Leader of the House was given the job of co-ordinating Government policy on drugs and overriding the territorial concerns and traditional rivalries of the ministries responsible (mainly the Home Office and the Department of Health). This central co-ordinating unit was further strengthened by the incoming Labour administration in 1997 with the creation of the post of UK Anti Drugs Co-ordinator.

The framework for a national strategy for the constituent parts of the UK had already been established (HM Government, 1995; Ministerial Drugs Task Force, 1994) in a somewhat loose format. The new UK Anti-drugs Co-ordinator – almost universally described as the "drugs czar" - set about the task of drawing these together into a single UK-wide policy (HM Government, 1998).

The new UK policy is significant particularly since it signals a change in government attitude to drugs. For the first time in two decades, there is a recognition of the role played by social exclusion and other environmental factors in fostering drug problems in deprived communities. In some respects this is merely an official government echo of the findings of the Advisory Council on the Misuse of Drugs (ACMD) in their report: *Drug Misuse and the Environment* (1998). Published in the spring of 1998, the report was quickly overshadowed by the publication of the government's own strategic document.

Some commentators (Stimson, 2000) have detected in these developments the tightening of the policy reins by a government reluctant to allow dissenting voices in the war against

drugs. *Tackling Drugs to Build a Better Britain,* when discussing the role of the ACMD notes:

> *"Its composition and focus of work need to be harnessed as closely as possible to the thrust of this long-term strategy and to the work of the Coordinator, and its future work priorities will evolve in that context".*

Many commentators have suggested that this might indicated a determination on the part of the UK Anti-Drugs Co-ordinator to stifle the traditionally independent voice of the Council.

Tackling Drugs to Build a Better Britain also signals a change in the role of DATs in Scotland from a co-ordinating and planning role to one of directly commissioning and evaluating the quality and value for money of the drug response (both treatment and other) at the local level. It is by no means clear how DATs will adapt to this new challenge incorporating as it does, a responsibility for resource transfer and open "cross-disciplinary" evaluation which runs directly counter to the budget protectionist inclinations of most, if not all, of the partner organisations.

Finally, within the past few months has come the news of an apparent downgrading of the role of the UK Anti-Drugs Co-ordinator and a transfer of the levers of power to the Home Office. Whatever else may happen in the 21st Century, it seems clear that the issue of drug misuse is now a critical policy issue which, at least for the time being, is seen as inextricably linked to crime.

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