

Crime Detection and  
Prevention Series  
Paper 80

# Tackling Local Drug Markets

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First Published 1996

**Police Research Group: Crime Detection and Prevention Series**

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ISBN 1-85893-764-7

## Foreword

The situational approach to crime prevention has been widely applied to conventional crime problems, with a great deal of success. This report examines the scope for applying such measures to drug misuse, focusing on open and semi-open drug markets where drug dealing takes place on the streets. The report provides a good example of a 'problem-solving approach' to drug misuse, showing that there is a great deal of scope to develop situational measures within a drug strategy, alongside treatment and enforcement activity.

This report will provide a useful focus for Drug Action Teams (DATs), providing practical advice on how the police, local authorities and health service agencies could work together strategically to tackle local drug markets. As this report shows, the potential benefits of such an approach go beyond drug misuse to the wider issue of community safety.

**S W BOYS SMITH**

*Director of Police Policy*

*Home Office*

*December 1996*

## Acknowledgements

In a study of this nature, debts of gratitude accumulate quickly. Special thanks are due to Peter Child (CADA), Tim Green (Project Manager, APA) and Eddie Killoran (Area Manager, APA) who all offered valuable advice and help throughout the life of the project. Many others have been helpful in many ways, including Jud Barker, Alan MacFarlane, Darian Mitchell, Geoff Monaghan, Janaka Perera and the staff of the Westminster Drug Project, CADA and DASH.

We are grateful to several drug agencies and probation offices whose staff wish to remain nameless to preserve the anonymity of the markets involved. They provided much helpful advice and guidance, putting us in contact with their clients and providing facilities for interviewing them.

We would like to thank Godfrey Lee and Andrew Clatworthy from the Metropolitan Police Laboratory for providing us with access to their statistics. We also wish to thank numerous Metropolitan Police officers from Area Drug Squads and from territorial divisions for the insights they gave us about drug markets in their areas.

We are very grateful to the Home Office Police Research Group for funding the study, and for Warwick Maynard's help and support throughout the research.

Finally, we would like to thank all the respondents who gave up their time and provided the information which enabled this project to be undertaken.

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PRG would like to thank Professor Howard Parker of SPARC at the University of Manchester for acting as independent assessor for this report.

## Executive summary

### **Aims of the study**

This study has analysed ways of tackling retail drug markets in London. It is action-focused on those retail markets which deal largely in Class A drugs. Markets were selected as the unit of analysis since this is where supply and demand combine; they are also the places where the collateral damage caused to local communities can be identified, and hopefully be reduced.

### **Case studies of markets in London**

The core of the study comprised six case studies of street level dealing sites in London. A picture of each site was built up using interviews with people who used the market (roughly thirty per site), and interviews with drug workers, police officers and probation officers who knew the market. Interviews with drug users took place around the site, providing the researcher with extensive opportunity to get to know the area in depth.

Some of the six markets were substantially closed to outside access: before anyone could break into the social networks around which they were built, they would have to surmount significant barriers. Others were classic open markets: provided that buyers met basic criteria - looking and talking like users - they could rapidly make a deal. The most open markets tended to operate in locations which were clearly defined, central and easy-to-reach. They catered for a wide market, drawing people from across London - and from further afield. Others catered for a more local market. The more open markets were all supported by a core of dependent users; and sex work (ie prostitution) appears an important stimulus to these markets.

The overarching aim of preventive action against drug markets is to ensure the number of buyers using the market falls short of the threshold population needed to sustain that market. There are two well-established approaches - providing *treatment services* and *enforcement* - and a third which can be developed further in relation to open markets - situational prevention.

### **Treatment services**

Providing treatment services is a demand reduction strategy which involves reducing the value of illicit drugs to buyers, rather than increasing their cost. It should be a central strategy for addressing retail markets which are sustained by the purchases of problem drug users. It is unlikely to be of much benefit in addressing markets which cater largely for recreational or occasional users.

The research evidence is persuasive that a range of treatment options 'work' and can often be highly cost effective. Although the medical and ethical considerations in

substitute prescription are complex, it is clear that community safety benefits can be bought through a more flexible and responsive NHS prescription regime. The more that users' prescriptions approximate to their ideal, the less they will 'top up' with illicit drugs, funded by acquisitive crime or dealing. Any such increases in flexibility and responsiveness would have to be accompanied by tighter controls in dispensing, to avoid spillage onto the illicit market.

More problem drug users probably pass through the hands of the police and the courts than through any other agency dealing with drug misuse. This makes the criminal justice system a potentially pivotal component in the machinery for bringing treatment services to problem drug misuse. This potential is not yet being fully exploited.

### **Enforcement**

The evidence from - mainly American - research is overwhelming that markets can be disrupted by low level enforcement. Our research provides support for this, in that respondents were preoccupied about enforcement activities. Local enforcement strategies in each area were a source of constant discussion and gossip. 44% of users interviewed as part of this study said that the risk of enforcement was a crucial factor when deciding which drug market to use and when to use it.

Experienced users certainly *adapt* their behaviour in response to policing, but whether they reduce their purchase of drugs is questionable. Dependent drug users simply go to greater lengths to avoid detection; less experienced or novice users may well be deterred from buying drugs in markets.

Although low level enforcement may result in the dispersal of a market or its transformation from an open to a closed system of operation rather than its elimination, good reasons for doing this are that:

- there is unlikely to be 100% displacement;
- dispersal may reduce the 'collateral damage' suffered by communities; and
- the market's reputation is likely to suffer.

The main source of supply to pharmaceutical drug markets is leakage from the private prescription system. This leakage would be reduced substantially by tighter controls over private prescription and pharmacy dispensing.

### **Situational prevention**

Situational prevention comprises measures directed at specific forms of behaviours which involve management, design or manipulation of the immediate environment

in which the behaviours occur. Open retail drug markets are amenable to situational prevention, but closed ones are less so. Four main types of situational measures can be applied to drug markets:

- measures which are adjuncts to enforcement
- those which reduce the amenities of the markets to buyers and sellers
- measures which interrupt the street drugs scene
- measures to reduce the threshold population by tackling street prostitution.

#### Situational prevention as an adjunct to enforcement

This range of activities involves increasing the amount of surveillance at the sites, either informal or formal. The former will include people such as food outlet managers, transport workers and park attendants by asking them to help reduce drug use in the areas under their control. More formal surveillance will involve the extension of policing tactics already in use - for example CCTV and monitoring mobile telephones used for dealing.

#### *.Reducing the amenity of markets to buyers and sellers*

The amenity of retail sites will be determined by such factors as ease of access, the level of street activity, access to phones, or good using sites. Many such amenities can be modified to make such sites less attractive to buyers and sellers.

#### Interrupting the street scene

Participation in a street scene which revolves around open drug markets is a way of life for many users. Gatekeepers, such as local planning or housing agencies, have at their disposal some of the means to interrupt rather than sustain these street scenes. Concentrated locations of health service facilities (such as needle exchanges) and prescribing chemists also attracts large numbers of buyers and sellers to particular sites.

#### Street prostitution and drug markets

If the aim of prevention is to drive down the pool of buyers to a level below the threshold population, an efficient approach may be to target users with high and persistent levels of use. The clearest example of such groups were sex workers: prostitution was well established in four of the six markets we examined, and sex workers may be central in sustaining levels of transaction in some open markets. Treatment, enforcement and situational measures can all be tailored specifically to this group.

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# 1. Introduction

## Background

This study looks at ways of tackling drug markets in London. It focuses on street level dealing in Class A drugs, and examines ways of reducing the number of retail drug transactions which take place in public or semi-public places. The pay-off in taking effective action against retail drug markets could be high. Leaving aside the simple fact of the illegality of buying and selling controlled drugs, there are three main sorts of social harm associated with drug markets:

- illness, unemployment and other social problems associated with problem drug use
- acquisitive crime committed to support purchases in drug markets
- the 'collateral damage' suffered by communities within which drug markets are located - the downward spiral of crime, fear of crime and disinvestment which markets can precipitate.

The costs of these harms can be high. For example, the cost to the Health Service of treating a single HIV patient from the point of diagnosis is estimated at £75,000; the likely costs of care for those with Hepatitis C can for the present only be guessed at. Estimates of the costs to victims of crimes committed to finance purchases in drug markets and of the costs to the criminal justice system in dealing with these crimes have been well documented. The cost of regenerating areas which have been blighted by drug markets is unknown but substantial.

The analysis in this report is based on detailed descriptions of selected market sites. It does not claim to provide definitive information about effectiveness, which can be yielded only by evaluative research. Some may ask what we have to say that is new. We do not claim to have identified any totally novel preventive techniques; rather, we are advocating a particular form of analytic approach which has proved itself in other areas of crime prevention<sup>1</sup>.

## Methodology<sup>2</sup>

The study involved six case studies of drug markets in London. The markets were chosen to represent a spread of types, after discussion with police and a survey of seventeen drug agencies. The sites are anonymised at the request of the drug workers who helped us to locate respondents, and to avoid needless stigmatisation. Six drug markets were selected on the basis that they:

<sup>1</sup> No drug market in this country has been subject to the sort of comprehensive strategic approach advocated in Section 4 with the possible exception of Kings Cross - and even there there is scope for greater co-ordination of enforcement and treatment approaches.

<sup>2</sup> Details of the methodology, including the survey instrument and the personal protection guidelines, are available on request from the authors at South Bank University.

## INTRODUCTION

- largely involved retail transactions;
- involved dealing on the street;
- covered a variety of market types;
- were accessible to researchers.

The case-studies rely on information provided by local police officers and drug workers, and by a survey of people who bought or sold at the sites. Survey respondents were recruited from drug agencies and probation offices near the selected sites. The questionnaire comprised a mix of closed and open-ended questions, and respondents were allowed to amplify on their responses. 191 structured interviews were carried out in the period from November 1995 to March 1996.

Each market was subject to a formal site assessment once interviewing there had been completed. In some cases this was done with the collaboration of an experienced ex-user. Guidelines were drawn up to minimise personal risks to researchers when interviewing and conducting site assessments.

The study has also examined available statistics generated by enforcement and treatment agencies. By combining statistics on seizures and arrests with information from the Metropolitan Police Laboratory, we have managed to produce a fuller profile than hitherto of enforcement activity in London<sup>3</sup>.

<sup>3</sup>We originally undertook this analysis to help identify markets in London. As it happens, the data provided little help in this.

### 2. Drug markets in London

This section discusses concepts for examining markets, and then puts some very tentative estimates to the scale of London's drug distribution system, combining the available statistics with findings from our study. We have borrowed some concepts from retail geography and economics, though our overall approach is that of environmental criminologists. Similar work has been done in the United States (cf Eck, 1996, Hope, 1994), but none to date in this country.

#### **Open and closed markets**

A market is a set of arrangements which bring buyers and sellers into contact in order to trade. Markets can be analysed at different levels, from the global to the local. This study is at the local level, focusing solely on retail markets for illicit drugs. Buying and selling illicit goods confronts people with the problems encountered in the licit market place, and some other ones besides. Buyers want some certainty that they can make a purchase, some assurance of quality, or at least value for money, and ready access to the goods when they want them. Sellers want easy access to buyers; they want to maximise their price, whilst minimising *problems* from disgruntled buyers. In licit exchange systems buyers pursue two main strategies to ensure a good deal. The first is to use a reputable open market. Open markets are those which allow equal access to all; they generally operate from fixed sites at defined times<sup>4</sup>. The second strategy is to use a closed market - one in which access is limited to known and trusted participants. The strength of *closed markets* lies in the trust that buyer and seller can place in each other. Their disadvantage is that buyers have access to a limited range of goods, and sellers have access to a limited number of buyers.

Illicit transactions have the complication that both buyer and seller run risks from third parties - the police, those who provide informal policing and those who realise that crimes can be committed against both sellers and buyers with virtual immunity against the law. Open markets are thus doubly risky places, and beset by problems of trust. Given the option, therefore, most people would use a closed market (or network) rather than an open one to buy illicit drugs.

#### **The geography of open markets: local and central places**

Open markets are generally place-specific. If they were not, buyer and seller would find it hard to locate one another, though markets which rely on mail order or telephone sales need not be at fixed sites. Closed markets, by contrast, are only loosely attached to places - they are as geographically dispersed as the social networks through which they operate. Spatial analysis of retail markets has preoccupied geographers for years, and two concepts of central place theory'

<sup>4</sup> Most licit open markets now derive their reputation from state regulation, in the shape of consumer protection laws.

## DRUG MARKETS IN LONDON

(O'Brien and Harris, 1991) can be usefully applied to open drug markets - that of *threshold population*, and that of *range*.

Central place theory argues that retail markets for any commodity are shaped by demand for that commodity, and its range - that is, the distance which people are prepared to travel to buy it. A market will be stable, or will grow, if the population threshold - the number of people needed to sustain it - lies within the market's range. Local markets flourish for everyday items because there is high demand but low range. Markets for high value goods - with high range but low demand - tend to be located in central places. Figure 1 shows how threshold and range can interact to yield thriving and failing markets.

Central place theory implies that centrally located open drug markets will emerge (or survive) if there is a subset of drug users who spend a great deal on drugs and place enough value on their purchases to travel far to buy them. Central place theorists built their theories around licit open markets, and their concepts are not especially useful in explaining the emergence of closed markets - or indeed how closed markets can evolve into open ones or *vice versa*.

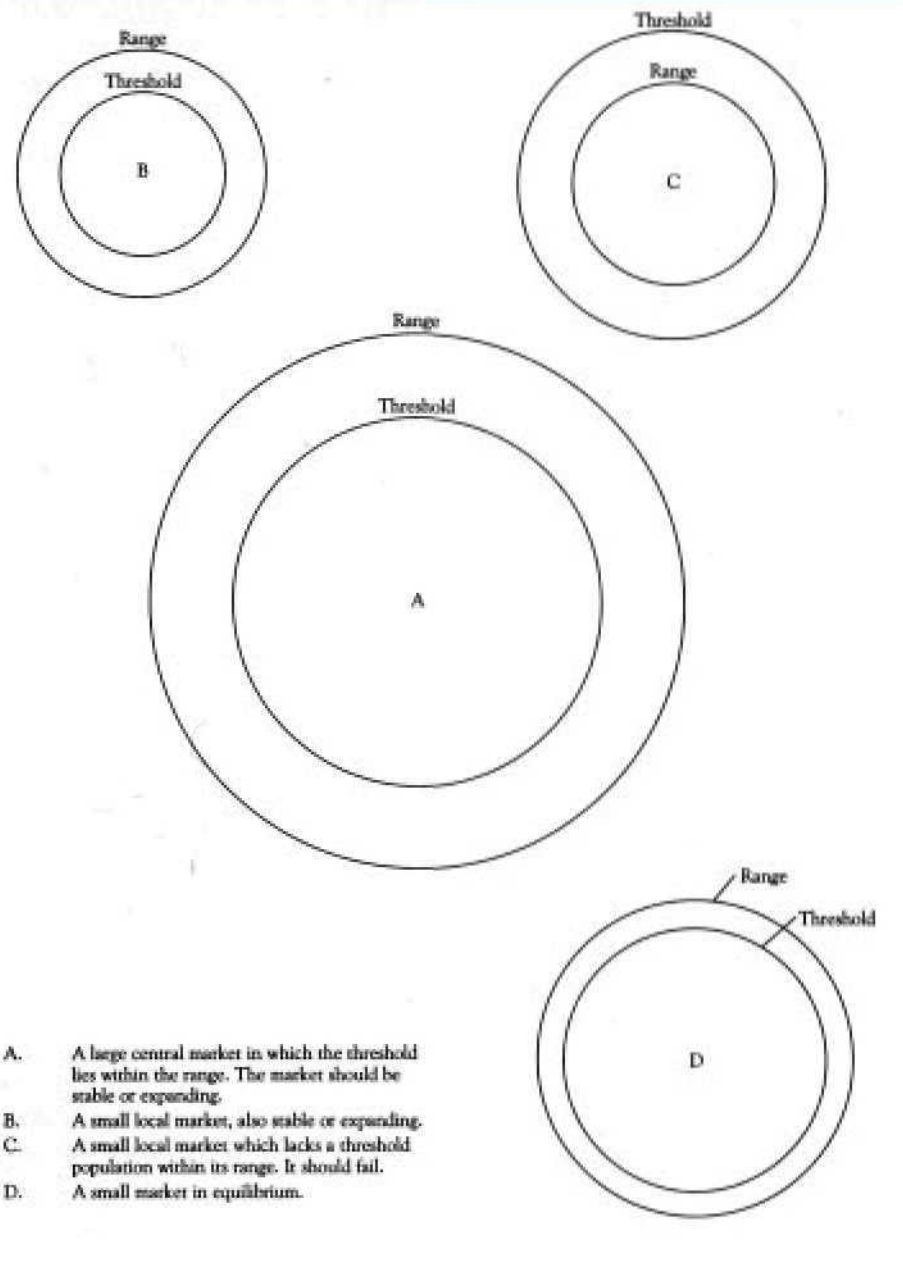
### **Dependency and elasticity of demand**

Concepts of dependency or addiction translate into economists' jargon as inelasticity of demand. Most illicit drug use is recreational and involves sales in small amounts; purchases are often opportunistic; and if a specific drug is in short supply, there is a range of licit and illicit alternatives. There should therefore be considerable elasticity of demand in response to price changes. For drugs of dependency, there will be much greater inelasticity (cf. Thomas, 1992). The extent to which dependency locks people into a state of irresistible demand is open to question (cf. Ditton and Hammersley, 1995). The more it does so, however, the more that levels of demand will be insensitive to changes in price.

Inelasticity of demand should create the conditions necessary for centrally located open markets implied by central place theory. It should yield high prices, and so a high range. It should also create difficulties for policing: enforcement strategies whose rationale is to add additional costs to the price of illicit goods will be less successful where elasticity of demand is low. Another aspect of dependent drug use which may drive buyers to open markets is their regularity of demand, which may exhaust the patience and supplies of social networks.

This is not to suggest that dependent users are the only users of open or semi-open drug markets. Novice users who are unable to access a network may do so. Dance drugs are also largely distributed through semi-open market systems based around clubs and pubs. As this study was restricted largely to street dealing, we can say little about the distribution system for dance drugs - except to say that it is substantially

Figure 1: The interaction of threshold population and range



## DRUG MARKETS IN LONDON

different from street markets whose core clientele is made up of dependent drug users. We found some other rationales for using open markets. Those in treatment may, for example, use open markets to minimise contact with networks of users and be assured of anonymity.

### Open markets, site amenity and reputation

The precise location of open drug markets is likely to be a product of the spatial pattern of demand and the amenity which particular places can offer to those buying and selling drugs. Amenity for a seller will include: features of the physical and social environment which offer protection against enforcement; places to wait for buyers; payphones; escape routes; lookout points; and enough legitimate street activity to disguise their selling. Buyers will value some of the same features, but some will also want good using sites, opportunities for raising money, sources of drug-using equipment and ease of access.

Whilst demand and amenity may lead to a market's development, its reputation is likely to be a key feature in sustaining its level of activity. Reputation is likely to transform a closed market into an open one. Once a market's existence is widely known, people will go there to make transactions - both as buyers and sellers - without prior knowledge of the regular participants.

### The retail drug distribution system in London

Some very tentative estimates can be made of the shape of the retail drug distribution system in London, assembling information on:

prevalence of drug misuse, from self-report surveys and health services statistics;  
the enforcement process, as reflected by police statistics; and  
users' *views*, gathered from respondents contacted through treatment agencies.

### The prevalence of *drug* transactions in London

The British Crime Survey (BCS) suggests that at least half a million people in London regularly use illicit drugs, mainly cannabis. A small proportion will be problem drug users<sup>5</sup>. The Regional Drug Misuse Database recorded some 8,000 users in treatment in 1994. Allowing for those who do not seek help (or whose treatment goes unrecorded) a more realistic estimate of problem users may be between 20,000 and 40,000 (Hartnoll and Lewis, 1985).

<sup>5</sup> Following the ACMD (1982, 1988), we define problem users as those who experience social, psychological, physical or legal problems related to dependence or excessive use, and anyone whose misuse could create risks associated with HIV/AIDS.

## DRUG MARKETS IN LONDON

Estimating how many illicit retail drug transactions take place each year is highly dependent on assumptions about regularity of use, size of purchase and the proportion of drugs which is shared rather than bought. If one assumed that all problem users buy once a day, and all the remainder buy once a fortnight, and that no user gives away or sells on any drugs, this would yield in the region of 20-30 million retail transactions a year in London.

Estimating what proportion of these transactions take place in open or semi-open markets is almost impossible. On the basis of previous research (Dorn et al., 1992) and the views of users and drug workers in this study, we believe that geographically fixed open markets are:

marginally important to the distribution of cannabis, amphetamines, ecstasy and LSD;

important for heroin and for cocaine (especially as crack/cocaine); and

central to the distribution of those prescription drugs which leak onto the illicit market.

### *Open markets in London*

A large minority of illicit retail drug transactions probably take place in open markets. Most of our respondents used open markets as their usual source of drugs and had been using their main market for 2-3 years on average; 80% had made their latest purchase in one. If around half of all problem users in London buy in open and semi-open markets, and if they buy once a day for two thirds of the year, this would yield some 3-5 million transactions in such markets annually, without taking into account the 'passing trade' from novice and casual users.

The markets we examined functioned around drugs of dependence - street heroin, crack and various pharmaceutical drugs. The emphasis varied between markets. Our impression is that cannabis was widely available in our markets, but that our respondents regarded this as completely unremarkable or self-evident. Few respondents had recently bought any illicitly manufactured amphetamine, by contrast, and this did not emerge as a significant drug within the markets we examined<sup>6</sup>. Over half (61%) of our respondents used more than one market. Most by choice used a regular seller, and two thirds said that they could raise credit from their seller. Three quarters now used phones to contact their sellers. Other markets were used in times of scarcity and/or to make large pre-arranged buys. Many of our respondents were 'scripted' (mainly for oral methadone), reflecting their recruitment largely from drug agencies. Some had stopped buying illicitly, others were 'topping up' and others traded in prescription drugs. Purchases of street heroin were typically £10 for a (notional) 0.1 g bag. In some markets heroin was sold in £5, £20 and £25 bags.

<sup>6</sup>Though it sometimes substituted for dexamphetamine in Market F in times of 'drought'.



## DRUG MARKETS IN LONDON

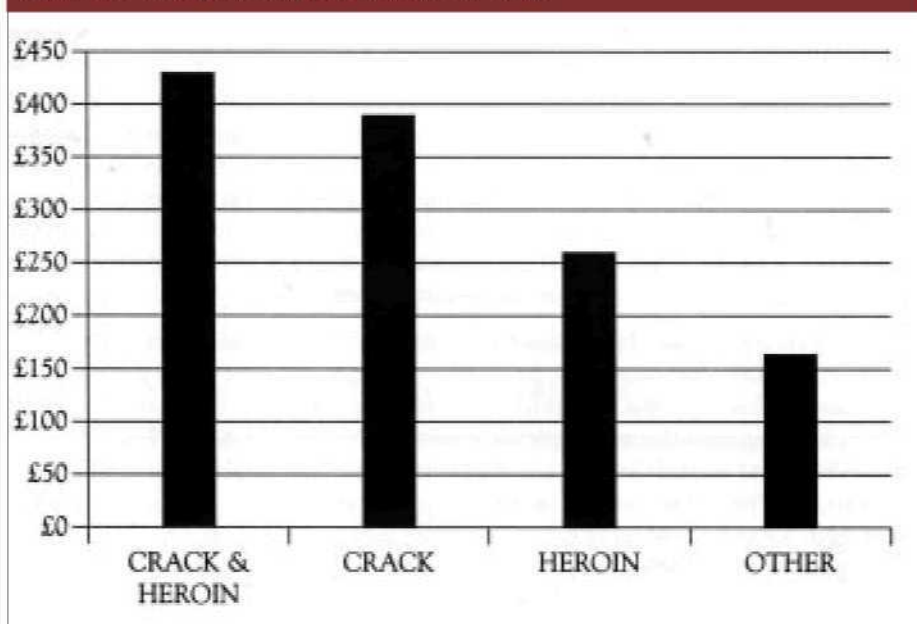
Crack was £20 per rock (notionally 0.2g). Respondents said that quantity and quality varied widely.

Our users' average weekly expenditure was £333, or £17,300 per year. Figure 2 shows expenditure by four user groups: those who use heroin but not cocaine; those who use cocaine but not heroin; those who use both; and those who use neither.

Consistent with previous research, our users financed their drug use in many ways, including dealing, benefits, benefit fraud, other fraud, shoplifting, other acquisitive crime and sex work (ie prostitution).

Open markets emerge as risky places for participants. Two thirds of respondents said that their main market was a violent place. Being mugged - either for money or drugs - was commonplace. Almost half reported 'really bad reactions' from adulterated drugs. Nine tenths had health, social, legal or other problems associated with their drug use.

Figure 2: Average weekly expenditure on drugs



## DRUG MARKETS IN LONDON

### *The policing of the distribution system*

Only a tiny minority of the total of retail drug transactions in London reaches police attention (if our estimate of 3-5 million transactions per year in open markets is anywhere near the right order of magnitude) since there were only some 23,000 prosecutions or cautions within the MPS for possession and supply offences in 1994.

Very rough estimates of the number of arrests relating to retail transactions in open markets can be calculated by combining these arrest statistics with data from the Metropolitan Police Laboratory in the following way. The vast majority of the total proceeded against - nearly 20,000 out of 23,000 - involved cannabis; 3,000 were for class A drugs, and 1,000 for amphetamines. On the basis of analysis of LAB1 forms, roughly half of these 4,000 cases would have involved amounts small enough to be considered at retail level, and in the region of 1,000 might involve arrests at open markets. If the risks of arrest per transaction are low (perhaps one in 4,000), those run by street dealers of being arrested over the period of a year may be quite significant, as they are likely to make several thousand transactions over this period.

## SIX CASE STUDIES

### 3. Six case studies

This section presents six case studies of street-level dealing sites in London. Three main sources of information have been used to build up a picture of each site:

- interviews with people who used the market (30 per site on average)
- interviews with drug workers, police and probation officers who knew the market
- site assessments.

#### **Market A - a closed market**

This market is in a traditionally white, poor working class area, which has seen high levels of ethnic minority immigration. Unemployment is high, and housing poor. The area retains a sense of community. There is a long-established criminal sub-culture, embracing petty and organised crime, which now includes ethnic minority groups who live in the area as well as whites. Heroin use was significant amongst whites in the 1980s. It is now spreading to second generation Bangladeshis, and use in combination with crack is growing. Police activity against drugs has been intense, and has apparently dispersed a previously open market into more closed sub-markets, all heavily reliant on mobile phones.

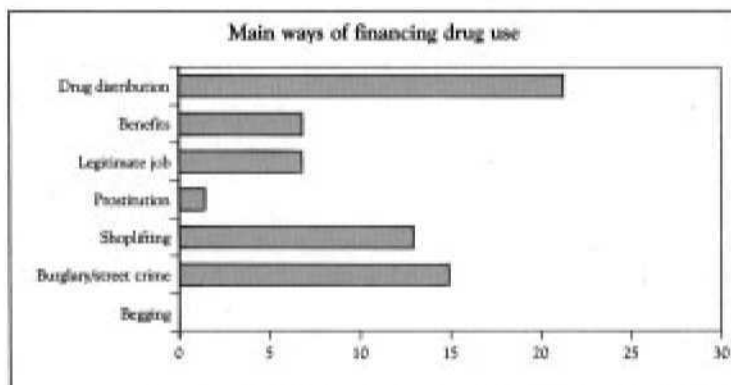
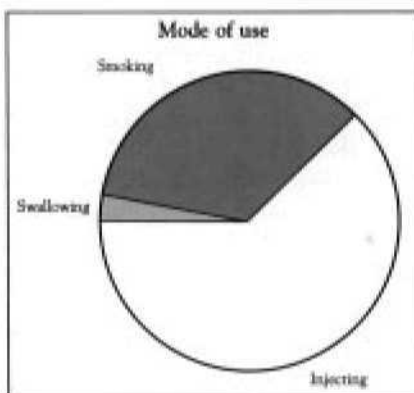
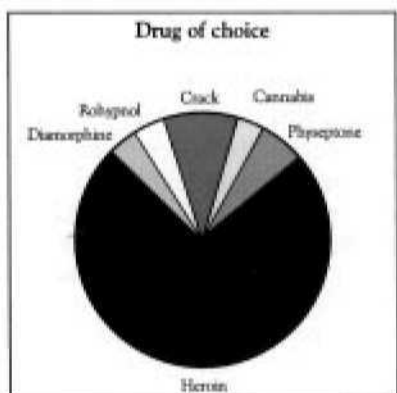
We identified 22 sub-markets in the area. Some were recent, small scale and site-specific; others were built around specific sellers rather than places. Some were mainly heroin markets, but others also offered a wide range of street drugs - cannabis, ecstasy, LSD, cocaine powder, crack and speed - as well as diazepam and temazepam. A pharmaceutical market close to a chemist sold injectable methadone, benzodiazepines (diazepam, temazepam), and dexedrine. At one site street drinkers supplied small amounts of benzodiazepines, to raise cash for alcohol.

The markets showed clear signs of racial divides and tensions. White (UK) sellers sold mainly to fellow whites; whites also were central to the pharmaceutical market. Italian sellers sold mainly to fellow Italians or to white (UK) users. Bangladeshi sellers dealt in heroin and crack, selling originally to fellow Bangladeshis (these dealers were thought by our respondents to be the retail end of a single importing and distribution operation). Recently white UK users were changing to Bangladeshi heroin in view of its quality and availability. Most of those who sold crack were reportedly black. For all the community solidarity of the area, 'grassing' on blacks or Asians was considered acceptable amongst the whites. Not surprisingly Bangladeshis saw white drug users as troublesome.

SIX CASE STUDIES

Figure 3: Profile of respondents using Market A

Males	25	Scripted	Yes	20	No	13
Females	8	Able to get credit	Yes	27	No	5
Total	33	Use a phone to buy	Yes	30	No	3
Problem users	29	Average credit given			641	
Number who buy daily	22	Average money spent per week			£278	



## SIX CASE STUDIES

The sub-markets were used by long-term residents from the immediate area, and depended for their operation on 'street networks'. Most buyers and sellers knew each other by acquaintance or repute long before they got involved in the drug scene - through family, for example, or from school, or through friends of friends. Sellers were well regarded by buyers - as people who were successful and doing something useful in the area. Those without such local links would find it very hard to access the markets. Sellers made sure that their mobile phone numbers were given only to family, friends or people who they felt able to trust. Harsh penalties could be imposed on those who passed on a sellers phone number to unknown outsiders. The seller would "put the word round" and effectively ostracise them from the local markets. Thus, the system was policed by all participants needing to maintain their credibility within the street culture. If buyers lost this, they would have to use more open markets, with all their attendant risks.

Contacting sellers via their mobile phones was the norm<sup>7</sup> (30 out of our 33 respondents did so - though we may have over-represented experienced users with close links to sellers). Some buyers had up to 10 or more sellers' mobile phone numbers. Some mobiles were held legally, but most were cloned or stolen and used for short periods then recycled. New buyers were introduced to sellers by known and established buyers. Buyers contacted the seller via mobile phone and if the seller did not recognise the voice, checks would be made to confirm identity e.g. via the use of nicknames/code names. A meeting time and the size of the deal would be agreed (sometimes in code or rhyming slang). The meeting place would either be pre-arranged, or else would be arranged over the phone. Common transaction sites were pubs, cafes, phoneboxes and local landmarks. Busy streets enabled buyers to wait without arousing suspicion and to blend in with legitimate behaviour. Sellers would sometimes deliver individual orders or else would meet several buyers at once - the main constraint being the amount of drugs that can be carried in the mouth and swallowed if necessary.

Two thirds of our respondents walked to the transaction site and most (29 out of 33) returned home to use. Whilst delivery to a site in public space was the norm, some sellers delivered to buyers' homes. The rationale was that risks of detection were lower when the transaction occurred behind closed doors. (A safer variant was to pay non-using friends to take delivery in their houses.) Some younger users still lived with their parents, and could not readily use (or take delivery) at home; they tended to use those markets which had convenient using sites. Buyers generally trusted sellers enough to obviate any need to inspect the drugs. The transaction would take only seconds, as details were all prearranged and buyer and seller both

<sup>7</sup>There were small static sites which did not rely on mobile phones, where known buyers could turn up 'on spec' and buy drugs.

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knew the "rules of engagement". Drugs and cash were usually exchanged simultaneously<sup>8</sup>.

Sellers' times of operation were either known to buyers, or sellers would tell buyers upon contact if they were 'working'. If a mobile phone was switched off this usually indicated that the seller was not working. Most heroin sellers began any time after 9am and continued until between 10pm and 12 midnight. Crack sellers tended to start later and finish between 3 and 4am. Organised sellers (those working shifts in pairs or more) could maintain a 24 hour service selling a range of drugs including cannabis, heroin and crack. Drugs could be bought seven days a week, though Sunday was the least active day - and the worst for fund-raising. Whilst sellers were responsive to their market, they remained very much in control of transactions.

The respondents rated the quality of drugs they bought as high, especially heroin. Availability was also good, with sellers doing business twenty four hours a day, seven days a week. Sellers could also locate large quantities when this was needed. The value of heroin deals ranged from £5 to £1,000 and crack from £10 to £1,500. The standard heroin deal was a £10 bag (a notional tenth of a gramme) though this appeared to be changing in two ways. More sellers were selling only £25 deals (notionally a quarter of a gramme), reducing the number of transactions and thus risk. On the other hand some of our younger respondents said they could buy a £5 bag of heroin. This suggests that users who previously bought in £10 deals were now buying larger amounts - because their dealer offered them no choice - and subdividing the quarter of a gramme. Thus an extra tier was being introduced into the market, giving young and inexperienced users access to heroin at a unit cost not substantially different to cannabis.

The fact that sellers were keen to move their level of operations from £10 to £25 deals suggests a buoyant market, with its threshold population well within its range. That there were no dry days or times of day also suggests that there was sufficient demand to keep sellers continuously in business. Some of our respondents said that the market was over-supplied, saturating demand. Certainly we were told that competition was spilling over into 'turf wars' involving drug-gangs. But equally, this could reflect the rewards to be made in a buoyant market.

Buyers and sellers both regarded the market as safe - as a direct result of the trust inherent in a closed market, coupled with the protection afforded by new phone technology. The corollary is that closed markets of this sort are now extremely difficult to police.

<sup>8</sup>Some buyers would have to contact or re-contact sellers after they had arrived at the prearranged site, as an added security mechanism, enabling sellers to check out the buyer's behaviour and activity in the surrounding area.

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### **Market B - evolving from closed to open market**

This market is in a deprived inner-city area with extensive public housing and endemic unemployment. A high proportion of residents are of ethnic minority origin. Much of the area is run down, with a good deal of litter, including drug debris around the main shopping area. The shopping area and a nearby park have had a long-standing reputation for prostitution. The area is bisected by an arterial road; side roads form a complex one-way system, and traffic congestion adds to the pollution and grime. Near the shopping area is a series of housing estates with a reputation for drug selling and street crime.

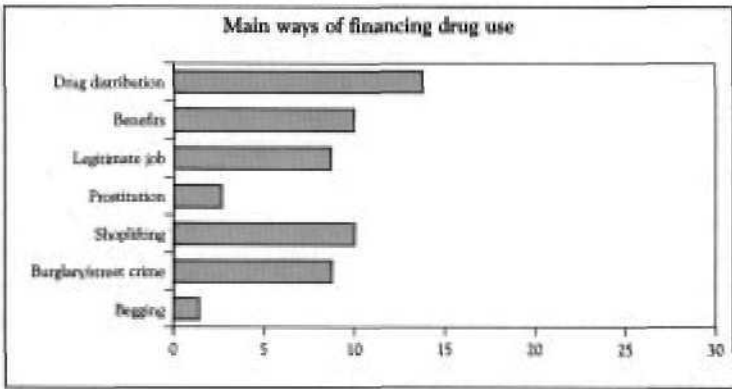
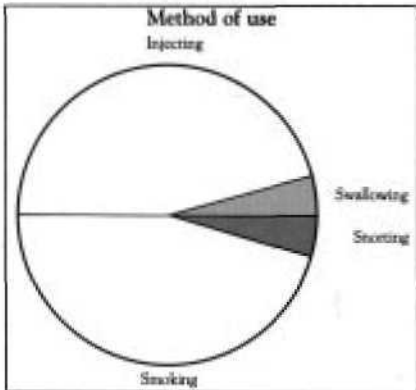
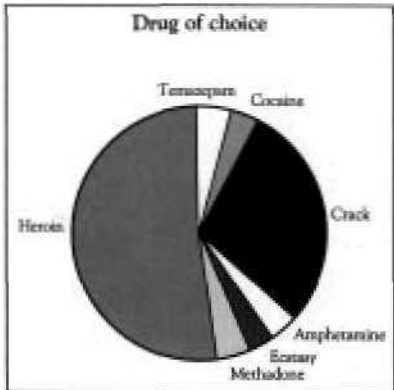
The area had an established drug scene involving older heroin users in the early 1980s. In the mid 1980s an influx of cheap smokable heroin prompted a rapid increase in use. At the same time known criminals became involved in dealing, using a house-based selling system from the estates. Demand burgeoned, and the market shifted from closed to open mode, with dealers employing sellers and runners on the estates. With the introduction of crack, the market became more obviously controlled by West Indian criminal networks. At this point levels of violence on the estates grew to such an extent that public utilities refused to operate there. This prompted intense police activity, which substantially reduced levels of dealing; open dealing moved off the estates, relocating in the shopping area and the park.

There were two inter-linked sites. The first stretched from the park to the shopping area, and focused on crack and heroin. Drugs could be bought on the street or from late night opening retail outlets and minicab offices. The second included the estates and surrounding side streets; heroin, crack and cannabis were sold from flats or in pre-arranged meetings on the street. Most heroin and crack sellers were believed to be black - some West Indian and some African.

The police thought that around half a dozen large-scale crack dealers operated in the area, using 20-30 lower-level operators and runners. At street level, sellers tended to be local users. They would buy their supply in the morning, selling it all by the evening. We were told that sellers are sufficiently organised to work a shift system to ensure their patch is covered 24 hours a day. The market catered partly for local users, and partly for a wider clientele. Our respondents largely fell into the first category (tending to use at home or in friends' houses rather than at using sites), though we found users who travelled large distances to this market in preference to closer ones. Sex workers, who tended to operate in the shopping centre and park areas, were an important element of the market's clientele.

Figure 4: Profile of respondents using Market B

		Yes	No
Males	15	20	0
Females	11	24	2
Total	26	25	1
Problem users	21	5	
Number who buy daily	22	4	
Average credit given		£87	
Average money spent per week		£346	





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Most of our sample bought from a regular seller and nine tenths arranged meetings over the phone whenever they could. If sellers were suspicious of phone buyers they would arrange a meeting and check out the buyer unobserved before going ahead with the deal. On meeting their seller, half our sample made the exchange on the move, notably in the shopping area where a CCTV system had been recently installed. Most did not inspect their purchase on site - doing so might either attract police attention or offend their seller.

Three quarters of our sample met the seller within 15 minutes of arriving at the market and had completed the transaction ten minutes later. On bad days - where arrangements could not be made over the phone - it could take an hour to find a seller and some respondents reported transactions taking 45 minutes, especially when sellers wanted to walk far from the site because of suspected CCTV or police presence. Heroin was mainly sold in the day and could be hard to find on the street at night. Crack was sold more at night.

Sellers tended not to approach buyers. Those who did so were presumed to have poor quality or fake drugs; a degree of detachment - even disdain for the buyer - was taken as an indicator of the quality of goods on offer. Not surprisingly, however, buyers resented sellers who exploited this "powder power". Sellers may not have actively solicited business, but around the park they sometimes tried to interrupt competitors' deals and steal their clientele. Buyers spent about £20 a time on either heroin or crack. The £20 heroin deals (j<sup>o</sup>e<sup>6</sup>y<sup>s</sup>) appeared to be a quirk of this market, as the standard deal elsewhere was a £10 bag. Buyers sometimes grouped together to get a bulk discount, though this was more likely if drugs were bought from flats on the estates. Almost all said that their seller would give them credit (though only for a single deal). This suggests a degree of - albeit limited - trust between sellers and buyers.

Users favoured this market for being accessible, convenient, reliable and economical - and because they knew it well. The shopping area and the estates afforded plenty of escape routes, and the latter had plenty of secluded using sites. Its drawbacks lay in the risks posed to buyers. Three quarters of our respondents said this was a violent market, and that the estates were notorious for street crime. The park market was thought to be particularly dangerous though, interestingly, the added danger was not reflected in lower prices.

As mentioned above, the current market seemed to have evolved as an adaptation to the policing of the estates market in the late 1980s and early 1990s. The most significant recent development appears to have been CCTV. Sellers in particular were very wary of the system, avoiding areas it covered, or failing that, making sure that the cameras could not get a good shot of them. CCTV seems to have encouraged the adaptation of the market to a system where sellers would take orders on a mobile phone and deliver to an agreed site. CCTV was thought to have helped

increase the speed and ingenuity of the drug transaction, e.g. some sellers would walk past a sitting buyer and spit a package at them, the buyer would walk off leaving the money behind to be collected later.

### **Market C - specialisation**

This market was set in a diverse area which includes poor council estates and run-down private rentals, luxury housing, a busy street market selling food, antiques and jumble, and a variety of shops and restaurants. The area is ethnically mixed, with a long history of racial tension. There are two underground stations and a good network of buses. The market comprised several interlinked sub-markets within close walking distance of each other, specialising in different types of drug. Sales were often casual, arranged as and when buyers and sellers met. There were some using sites under the railway bridge.

The area has had a reputation as a place to buy cannabis stretching back at least thirty years. In the 1960s it was a 'symbolic location' for the counter-culture; in the 1970s and 1980s cannabis dealing became associated more exclusively with blacks, and this created significant tensions between the police and the black community. The market's more immediate history resembles that of Market B. Towards the end of the 1980s heroin and crack dealing became particularly well established on a nearby housing estate. Starting as a fairly closed market, it expanded, as did its reputation, as demand burgeoned. Police action substantially curtailed open dealing on the estate, displacing it to other sites within this market. Different sites specialised in different drugs and catered for specific types of buyer. The sites were linked because many users and some sellers move between them.

#### *The street market cannabis site*

The street market was largely pedestrianised and attracted a large number of tourists and others. Cannabis could be bought outside at least two pubs and sometimes from street vendors who overtly sold licit products such as incense. There was also a vigorous market in fake drugs (eg liquorice and oregano pasted with egg white are offered respectively as "hash " and "sensie ") aimed largely at tourists. This market was necessarily open; those selling genuine cannabis tended to be more discreet, and relied on their reputation amongst buyers. We were told that over ten such sellers worked here.

#### *The cafe heroin market*

The cafe heroin market was linked to several Portuguese cafes. Some non-Portuguese respondents tried to sell heroin around these cafes but the resident sellers

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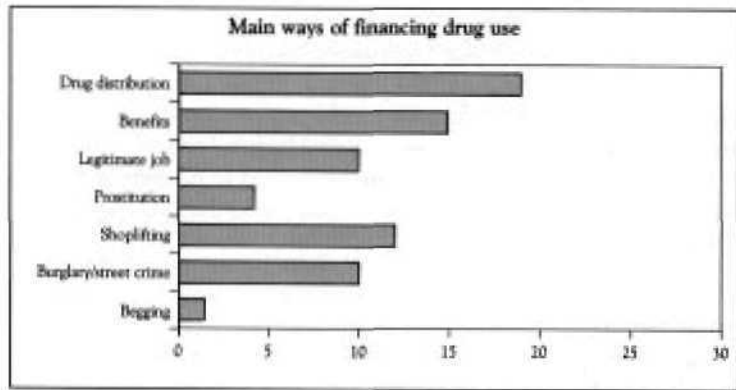
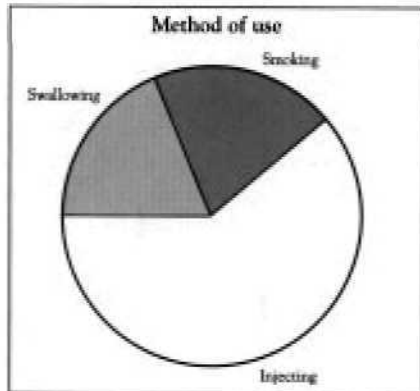
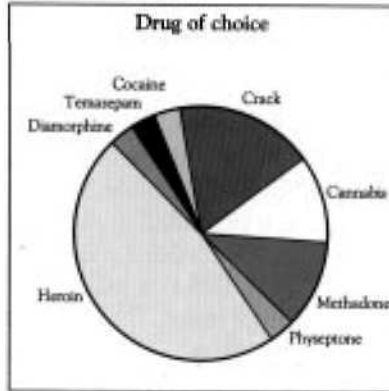
Figure 5: Profile of respondents using Market C

Males	15
Females	11
Total	26

	Yes	No
Scripted	13	12
Able to get credit	18	7
Use a phone to buy	21	5

Problem users	25
Number who buy daily	11

Average credit given	£58
Average money spent per week	£364



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drove away people who tried to buy from them. There were few using sites in this area, the nearby housing estates had security guards and the public toilets had attendants. We were told that around half a dozen sellers operated here between 10am and 8pm.

### The crack market

This evolved from a well established cannabis market. It had a reputation as a largely Afro-Caribbean market. Despite recent gentrification - and persistent policing - discreet selling could still be seen here. Our respondents thought that the drugs market was gradually moving towards a nearby sex working site - either pushed by policing, or pulled by the spending power of dependent sex workers (four of our respondents were sex workers, spending up to £1,500 a week each on crack). Between 10 and 20 sellers operated here from about 10am, finishing about 4am. This was now a substantially closed market and buyers who tried to break into it were liable to be sold fake drugs, if anything.

### The estate market

This was a thriving and open crack market in the late 1980s. Around thirty - reputedly Afro-Caribbean - sellers ran an organised system using teenagers on bikes to deliver drugs. Intensive police operations had reduced levels of open selling by the time of this research. However, some of the empty properties in surrounding streets had become crack-houses, attracting buyers from across London. It was thought that this market had been displaced to the crack market described above.

### The pharmaceut/ca/ market

A quarter of a mile from the housing estate market was a pharmaceutical market, focused around a well known chemist which dispensed private prescriptions. Pharmaceutical drug debris were evident, with methadone ampoules and syringes in an alley across the road. The market operated from midday to the early evening, when a number of (very sick looking) people could be seen waiting outside the chemist. Its operation resembles that of Market F, described later in this section.

We spoke to 31 users, of whom half had also sold in the area. Most of our buyers lived locally, but the markets also attracted casual buyers from across London. Most of our respondents bought from a regular seller and usually phoned the seller on his mobile to arrange the meeting. Most respondents gave money before receiving the drug and did not examine the drug until later, indicating a degree of trust (or lack of choice). Heroin was sold mainly during the day and crack mainly at night, but crack could be obtained in the heroin markets and *vice versa*.

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Our respondents were regular customers, rating the quality of crack and heroin as above-average and reliable. Large quantities (up to £1,000) could be bought in pre-arranged deals, though not on the street. Our respondents usually bought a pea-sized rock of crack for £20 and a (notional) 0.09g of heroin for £10 - similar to elsewhere. Supply was reliable, with the possible exception of Sundays - with shortages caused by the volume of trade on Saturday night.

Seven out of ten respondents felt this could be a violent area. Some mentioned shootings around the crack market, though others felt this reputation was exaggerated. The cafe heroin and street market cannabis sites, operating during the day, were felt to be safe. Buyers commented that this was a pleasant area in which to shop; they would sometimes buy drugs while doing their weekly shopping or sit and have a coffee while waiting for a seller. The stalls, shops and people also provided opportunities for shoplifting or selling goods.

### **Market D - a centrally located open market**

This market was sited in an inner city area with a mix of shops, fast-food and other restaurants, pubs, clubs, and residential housing. The latter is a mix of gentrified housing, cheaper privately rented accommodation, housing association properties and a profusion of hotels, hostels and bedsits catering for budget tourism and the homeless. A large minority of the population are in short- or long-term temporary housing. It is a young, cosmopolitan area with a seasonally fluctuating tourist population and a vibrant street culture. The area has had a minor reputation for years for catering for the seamier side of life, with pubs, clubs, sex-working - and drugs.

Until the late 1980s the drug scene was contained in pubs and clubs, with limited heroin dealing on the street. According to drug workers, two events then played a major role in developing the street scene. Police activity in the late 1980s seemed to have displaced drug selling from pubs to the street; and more recently, intensive police action against Market E (see below) displaced activity from there. Anecdotally, this displacement coincided with the arrival of crack-cocaine.

The market focused on heroin, with crack as a recent addition. Sellers tended to divide between those who dealt mainly in heroin and those who sold crack. Many of the former were Italian, and many of the latter Afro-Caribbean. Most of our users bought heroin; some bought crack, and all said that various pharmaceutical drugs were available, notably diazepam, temazepam, and injectable methadone. A third said that cannabis was also available, with the implication that the market caters for casual users and tourists as well as experienced users. The market was one of the more open we researched, though there were various barriers to access. Some Italians sold generally or exclusively to fellow Italians. Other sellers would only do

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business with known users or those introduced by known users. Even those who operated less cautiously would expect customers to look, speak and dress like drug users (a problem for some of the smarter users we interviewed). Provided that these criteria were met, however, a drug user would usually be able to locate a seller with ease and buy a wide range of drugs.

Obviously our sample is biased, being drawn from local drug agencies, but two thirds lived locally, reached the market on foot, and used the drugs they bought at home. The market operated from 9am until the early hours of the morning. Our users reported that heroin tended to be most often sold in the day, especially between the hours of 9 and 11am and crack through the night, starting in the early evening and finishing in the early morning.

As experienced buyers, most of our respondents used a regular seller. They would either go to the market when they knew sellers would be there, or phoned in advance to confirm times and quantities. Less experienced buyers might have to wait to be approached. The market was essentially static, centring on a tube station entrance. This usually served as a meeting point - most deals were struck within 50 yards - and cash and drugs were often exchanged there.

Two thirds of those we questioned said they usually bought at the station entrance, the remainder moving away to manage the transaction. In the latter case, drugs were typically handed over either after a short walk 'round the corner' or else in one of the fast-food restaurants or shops. Decisions about the transaction site were made by sellers rather than buyers; their choices were shaped largely by individual preference, the trust they could place in the buyer, the weather and police activity. (The latter was the subject of much speculation and rumour, some of it clearly inaccurate.) When the weather or perceived police activity kept sellers away from the meeting site, those buyers who had sellers' telephone numbers phoned from the station to arrange an alternative contact point; others simply hung about until sellers appeared. The market was sometimes disrupted over a period of days, and temporarily relocated; buyers were redirected either by phone or by word of mouth by those 'in the know': sellers often paid associates to perform this function.

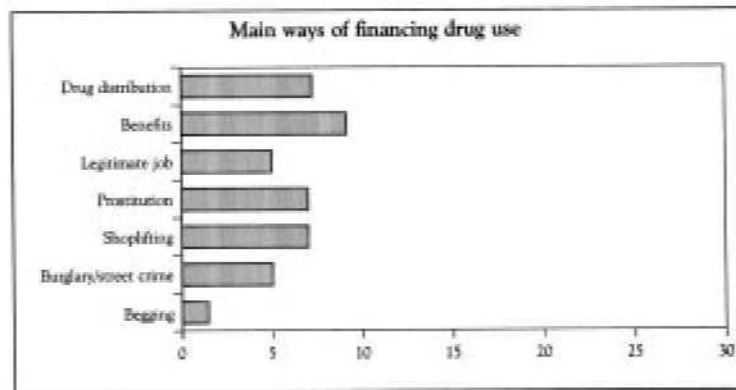
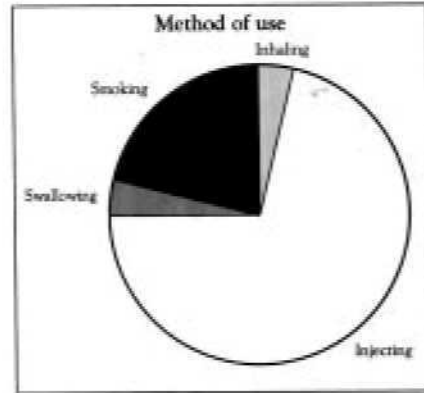
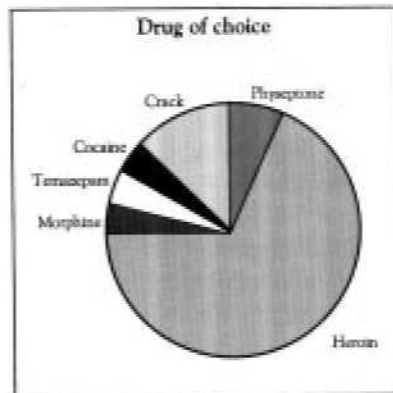
Once the transaction site had been established, the majority of the deals were made straightforwardly, with cash and drugs exchanged simultaneously. Drugs were only inspected cursorily - either by sight or taste - by a third of respondents. Powders were generally heat-sealed in cling-film<sup>9</sup>; inspection would be protracted, would arouse suspicion and would in any case damage the heat seal. A few of our respondents, whether through trust or coercion, paid up-front and collected their drugs later. Buying rarely took more than five minutes and a transaction without inspection could take seconds.

<sup>9</sup> By wrapping powder in cling-film and then applying a flame to the twisted end of the package, one can achieve a good enough seal to allow insertion of the package into the mouth or elsewhere in the body.

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Figure 6: Profile of respondents using Market D

Males	19	Scripted	Yes	21	No	8
Females	10	Able to get credit	Yes	16	No	13
Total	29	Use a phone to buy	Yes	21	No	8
Problem users	23	Average credit given				546
Number who buy daily	16	Average money spent per week				£118



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Our respondents rated the quality of drugs as adequate. Heroin purchases ranged from £2 to £1,200<sup>10</sup>. The standard deal was a £10 bag, containing a notional tenth of a gramme. Large heroin deals could be bought, but these would have to be arranged in advance. The local street price for crack was £20 for a notional fifth of a gramme rock; deals varied in size from £20 to £500 - indicating a well established market. It was also reported that there were very few "dry days" with failure in supply to street level. Stability in supply is again indicated with the practice of credit, showing there are established relationships between buyers and sellers.

The market was seen as safe. This may result from a high level of stability and lack of competitive pricing at street level, with clearly demarcated patterns of buying and selling. Comparing this with markets seen by buyers as more dangerous, a few key factors emerge. This was a predominantly white market, with little racial tension. Arguably the fact that much business was conducted in foreign languages increased security and reduced tension. Other factors adding to buyers' feelings of safety were - paradoxically - the high police visibility, and the levels of surveillance afforded by legitimate activity in the area.

Relationships of trust within the market existed at three levels: between different sellers; between sellers and buyers; and between different buyers. There is information sharing at each different level. Knowledge of market functioning and changes were almost entirely passed on within the market. Sellers informed one another of potentially difficult or untrustworthy customers, sellers informed buyers of changes in times or locations, and buyers discussed between each other "who has the best gear or best prices". These lines of communication were maintained and strengthened as a consequence of the thriving street culture.

There were several obvious links between the drug market and sex working. Many of the local sex workers were dependent crack and heroin users. They had very high incomes - up to £2,000 per week - and spent the majority on drugs. They also got money or drugs as commission for introducing their customers to sellers. (The rate seemed to be one rock - or cash equivalent - for every three rocks of crack sold.) More speculatively, the sex and drugs trades function symbiotically, amplifying the signal to potential customers that this is an area where drugs or sex are to be bought.

The high density of cheap and 'bed and breakfast' accommodation for those on subsistence benefits appears to have combined with other factors in creating a street culture for those living on limited resources in an area with an established drug scene. Significant numbers of people with very little money and large amounts of time were pitched onto the streets throughout the day with nothing to do. Involvement in petty crime and drug use was not surprising.

<sup>10</sup>One user said that his regular dealer would give him £2 deals when he could afford nothing more.



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All our respondents were aware of the high uniformed police presence in the area and the inconvenience methods adopted by them. Almost all expected to be stopped and searched for being in the market area. There was also the belief that the market was almost constantly under covert CCTV surveillance. Most respondents were also conscious of the informal controls exercised by managers in pubs, cafes and shops. They regarded pubs as largely closed to them. Cafe and restaurant owners were seen as less 'clued up' though manner of dress could restrict access. Fast-food restaurants due to the nature of their operation (payment up-front and younger less experienced staff) allowed greater freedom of access.

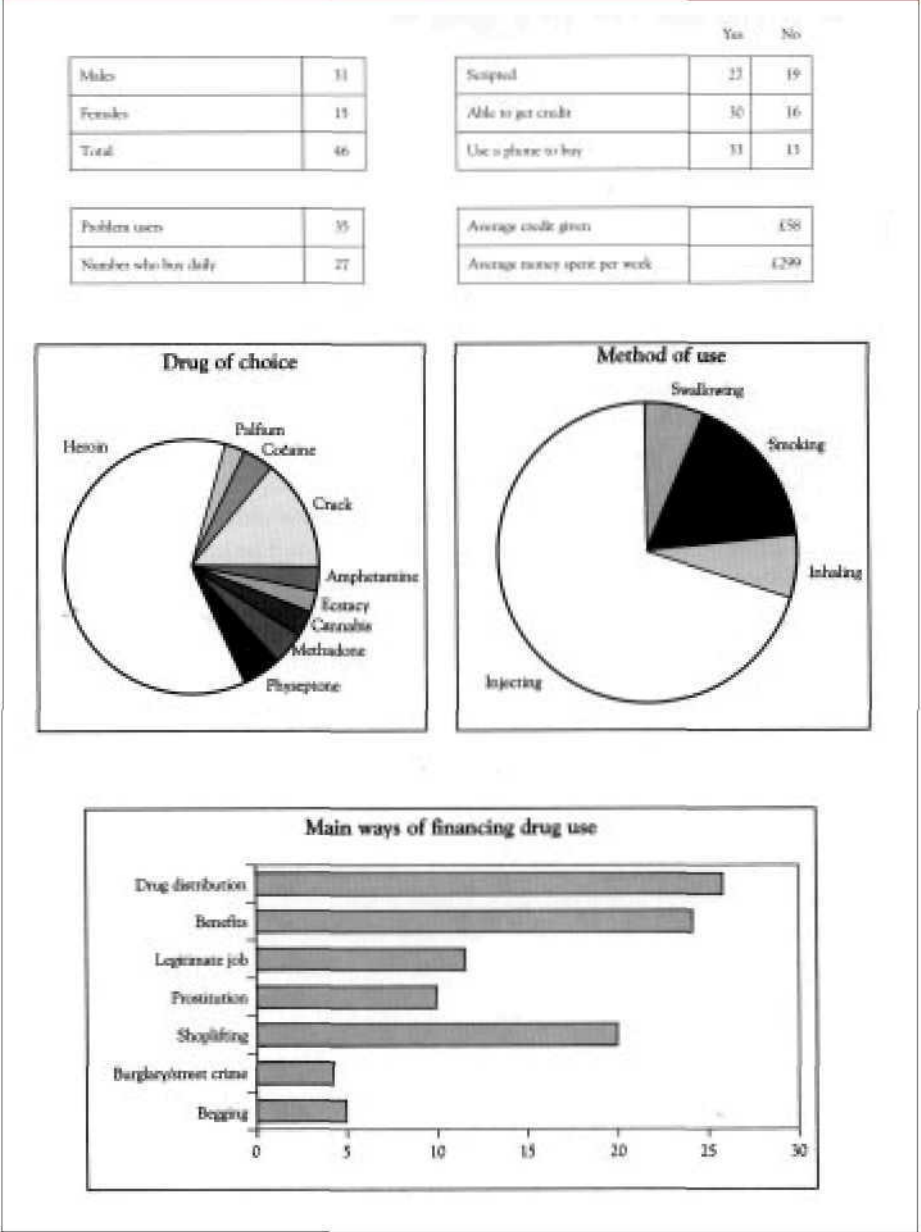
### **Market E - a centrally located open market in decline**

This is a well-known and well-established market. It has good transport links, including tube, rail and buses and lies on two major road routes across London. Consequently thousands of people pass through the area every day. The train station which forms the focus of the market has been associated with sex work since the last century. Street drinkers also gather here. There are several housing estates near the area, but the immediate vicinity is decidedly non residential. Part of this contains shops, fast food restaurants, betting shops, clubs and hotels while the rest consists of garages, warehouses and buildings linked to the railway. Strategies for tackling the market have been held up as a showcase of successful inter-agency partnership. An ongoing series of intensive police and local authority operations have had a clear impact on the market - though it was very much in operation during fieldwork. Since then there has been local spatial displacement, as well as displacement to markets elsewhere. Our sample of 38 respondents was drawn from three drug agencies, three probation offices and snowball interviews. Seven of our sample were sex workers, and eleven had sold as well as bought drugs here.

Heroin and crack were the most common drugs on offer, but amphetamines, temazepam, ecstasy and cannabis were also available. Some sellers specialised, and generally crack and heroin were sold from different sites in the market. However, most of our sample said that sellers could provide more than one drug. The station concourse was regarded by inexperienced buyers as the main site, though regular buyers and sellers met elsewhere. Buyers and sellers travelled from all parts of London and beyond, because this market had the reputation of offering drugs twenty four hours a day, seven days a week.

The market was active twenty four hours a day, though few sellers worked before 10am or after 4am. It was busiest in the evening and at night. Crack in particular was sold at night, often to sex workers. The market operated on two levels. First, there was a relatively open market, in which large numbers of casual sellers sold, often to total strangers. Sellers patrolled the area. They typically approached potential buyers, asking innocuous questions to discover their intentions. Once these were clear, they

Figure 7: Profile of respondents using Market E



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checked the buyers' good faith by testing if they have the vocabulary, knowledge - and even track marks - of a habitual user. Paradoxically, the very lack of organisation of the market resulted in overall stability, as the casual sellers provided a continuity of supply from different sources

Secondly, submerged beneath the open market was a more closed one. This was more structured, with regular sellers serving local users. It had barriers to access such as telephone contacts and special meeting points. Our respondents generally used this side of the market. Two thirds bought from a regular seller, often arranging a meeting over a mobile phone. The sex workers we interviewed were central to this market, with their weekly incomes of up to £1,500 earmarked largely for drugs. Many of the other respondents lived locally, walking to the market and using at home. A minority travelled by public transport and used on-site. Nine tenths would find a seller within ten minutes of arriving at the site. They would generally meet and walk away with the seller (to avoid CCTV cameras) to exchange drugs and money. Most had completed the exchange within three minutes of the meeting. But despite the regularity of the contacts two thirds of the sample did not part with their money until they had received their drug - reflecting the uncertainty of this market and contrasts with other more reliable markets. Half our sample did not check their drug, probably because of the CCTV cameras and risks of arrest. The usual practice of concealing wrapped drugs in the mouth was also common here.

Users who could not access the more closed market regarded Market E as a 'last resort', where desperate people bought drugs of poor quality. The drug debris on the street reflects this desperation. Used syringes, lemons, burnt foil, home-made pipes, pharmaceutical packaging can be seen amongst the litter in alleys, pedestrianised areas and in the entrances to basement flats. On site visits we encountered used syringe containers (sin bins) which had been cut open, indicating that old syringes were being reused.

This was a market in decline, whose notoriety was making it a place of last resort for buyers who had nowhere else to go. Its reputation for low quality and fake drugs, violence and risk of arrest was marked - amongst respondents whose main market was elsewhere. One of our respondents said that he once sold a batch of drugs here that was too poor to sell in his usual market. Another said she sold shredded cigarette-ends in clingfilm as heroin. Nine tenths of the respondents who used the market thought it violent, with regular use of weapons. Many of our sample had stopped using the market. As one said, "Some people are out to rip people off and give them brick dust; I avoid it" .

For the time being, its reputation as a place where drugs were always available seemed enough to offset its drawbacks; it was still able to draw people from across London (and beyond). In the terminology of central place theory, it had a large

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range, with a threshold population still falling within that range. Whether this will continue is unclear. The 'market of last resort' seemed largely to mask the closed market used by our respondents. For those who could access this market, it functioned well. Our buyers spent from £5 to £500 though most spent £20 at a time on crack and £10 on heroin - consistent with markets elsewhere in London. Larger amounts had to be ordered in advance from regular sellers. Two thirds could get credit from their regular seller, mainly for a single deal (£10-£25). For the sex workers who we interviewed the market had considerable amenity, in that its location afforded ample opportunities for earning money.

This area has been the focus of a series of police and local authority operations. Initially the police alone directly targeted street dealing, but then local authorities, transport police and other local agencies became involved. This approach used a combination of :

- large-scale arrests of sellers;
- restrictions of licenses for fast food outlets, which provided cover for sellers;
- targeting of hotels known for drug selling and prostitution;
- situational prevention to design out selling and using sites;
- CCTV and covert surveillance and use of video evidence; and
- cleaning up litter and drug debris in the area.

There has been a clear reduction in the number of sellers (cf Lee, 1996, for a fuller account) - though by our respondents' accounts, levels of casual or amateur dealing would make it very hard to reach a firm figure. Our respondents thought that casual buyers had been frightened off, either by the risk of arrest or by the poor quality of drugs. Most of those we talked to had their own theories about displacement: many argued that sellers had moved to either of two developing sites to the north of Market E; several mentioned Market D as a displacement site; and other more immediately local sites were identified.

We think it has been well established that the policing strategies aimed at Market E have paid off in so far as it is now seen as a market of last resort for the chaotic user, and not a regular and preferred place of purchase. It can thus very much be characterised as a market in decline. However, insufficient attention has been paid to the mechanisms by which the success has been achieved. It is generally believed that policing disrupts the market by removing dealers and deterring buyers. The process is almost certainly more complex. Intensive policing of a well established market should initially remove regular - and competent - dealers, leaving a vacuum to be filled. The very process of replacement will disrupt trust in the market, but those who are prepared to trade in a higher-risk environment may be intrinsically less reliable than their predecessors. Policing also facilitates the selling of fake or

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poor quality drugs, because it limits the scope for inspection. This again erodes trust and the market's reputation. Slowly policing may trigger a downward spiral of trust, turning the market into one of last resort. Once its reputation has inverted, its life as an open market should be limited.

### **Market F - a specialist open market**

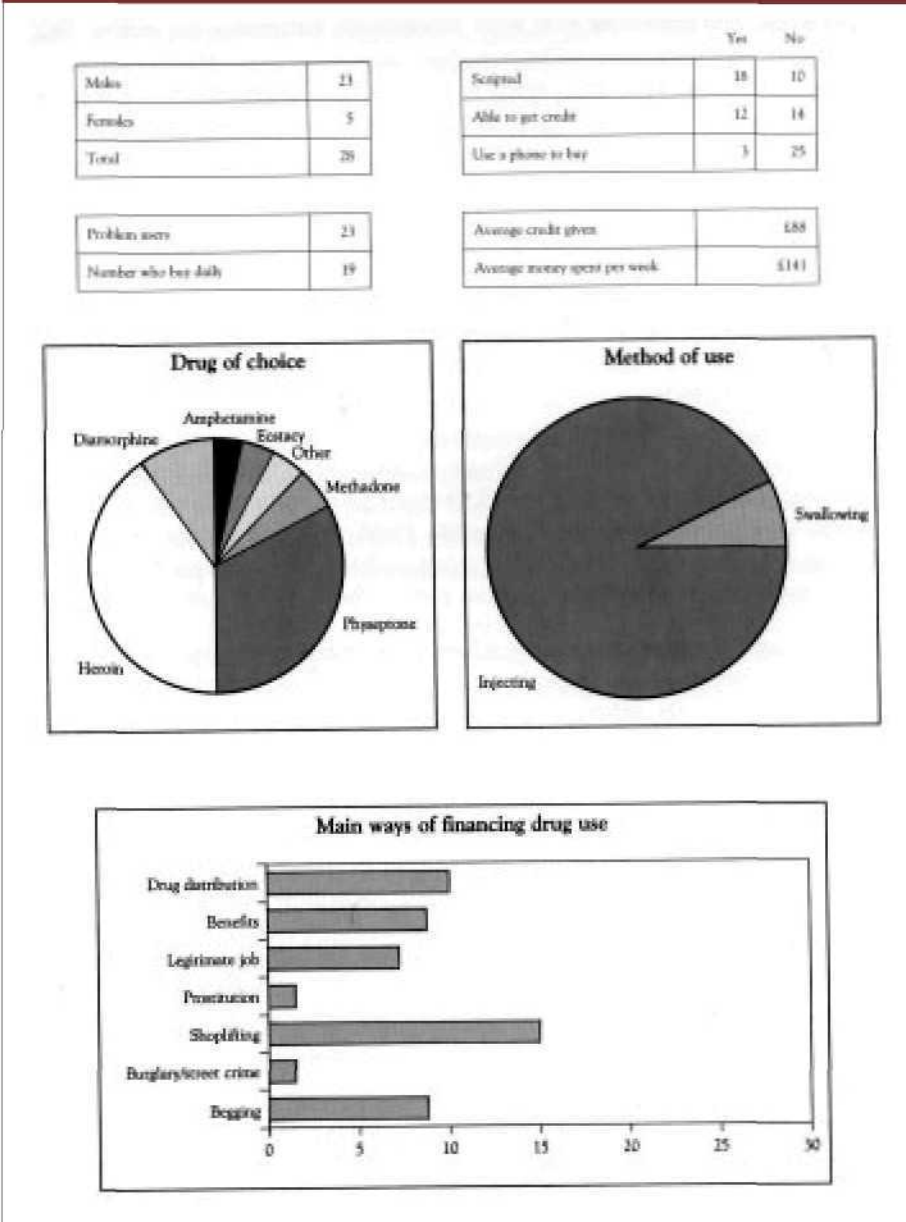
This market is located in a quiet street in the centre of London. Bordering the site is an array of cafes, restaurants, pubs, privately owned houses and flats, and a complex of hospitals and related institutions. The wider area is largely commercial, with a large daytime population which falls steeply at night. It is close to a major shopping centre. The area offers drug users a wide range of local services ranging from hostel accommodation, a Drug Dependency Unit, a needle exchange, and private and NHS prescribing facilities.

There have been drug markets of some sort in this part of London since the eighteenth century. Since the 1960s drug activity in the locality has been associated with the red-light district and nearby theatre and cinema area. Originally the market was primarily in heroin; pharmaceutical drugs emerged with the restrictions imposed on the prescription of heroin by the Misuse of Drugs Act 1971. The market's location has shifted on several occasions, being "pushed" from two sites by enforcement measures and "pulled" to three sites by various amenities: a dispensing chemist, an underground public toilet and a needle exchange.

The market focused on Pharmaceuticals, primarily injectable methadone (known to many users on the streets by its brand name Physeptone), Dexedrine (amphetamine) and benzodiazepines (Rohypnol and diazepam). Street drugs such as heroin and speed were also sold, but rarely and only when the supply of Pharmaceuticals was short. The market was a specialist one, catering for long term drug users and those who have opted out of the street drug scene. (The younger users cited economic factors and the declining quality of street drugs as the reasons why they had shifted to this market.) There were few casual users: policing levels, types of drugs available and the poor physical and psychological condition of those involved in the market all acted as deterrents.

The supply of pharmaceutical drugs for this market comes directly from 'leakage' from private prescriptions whereby the patient goes privately to the doctor, obtains a prescription for an amount in excess of his or her needs, and sells the remainder. (Appendix 1 provides a fuller explanation of how this system operates.) There are several private prescribers within a mile of the market, and several more in easy reach of central London: our respondents mentioned six in the immediate locale and a further six elsewhere. The majority of sellers were in receipt of a private prescription but unable to meet the costs of the doctor's fee and the prescription

Figure 8: Profile of respondents using Market F



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charge from legitimate income. This is not surprising, given that only seven of our 33 respondents were employed and prescription charges and consultancy fees averaged £100 per week. The remainder were more recognisably entrepreneurs, within the irregular economy. Some were young non-dependent users who obtained private prescriptions fraudulently to sell. Others were ex-drug users familiar with the market, who had the finances to buy in bulk either at the market or at the dispensing chemist, which were sold on at the market for a profit.

The market mirrored the opening hours of the needle exchange - 10am to 5pm. After these hours and on the weekends the market re-located to its previous site, in a subway half a mile away. (On this secondary site, street drugs were often available, though pharmaceutical drugs still predominated.) Benzodiazepines were also sold in a nearby square, by homeless street drinkers, providing a cheap back-up source which was "worth a try on the weekends", when the street market did not operate and the subway site was less active.

The pharmaceutical drugs sold on the main site were generally the same as prescribed by private doctors and in the same combinations, most commonly injectable methadone and Dexedrine. (Used together, the two drugs can yield a heroin-like 'rush'; in the long term this has the effects of heavy amphetamine use - highly volatile and paranoid behaviour, sometimes developing into psychosis - cf Ghodse, 1995.)

The market appeared very open. Many sellers would agree a sale simply on the strength of the buyers physical appearance and manner of dress. Others would sell only to known drug users, others only after checking buyers credentials - e.g. by checking that they shared an acquaintance in common. When the market was over-supplied, sellers largely abandoned all safeguards. They would approach potential customers, sometimes open competition ensued with sellers undercutting one another. When there were failures in supply, buyers would approach strangers and ask if they knew "anyone selling". The market appeared to fluctuate between these extremes, though over-supply was the norm during fieldwork.

The market's clientele comprised a mix of those - mainly homeless - users who lived within easy walking distance and those who travelled from all over London by public transport. The market was overwhelmingly white and male. Women seldom bought drugs by themselves, usually opting to buy with male company or 'chipping in' and scoring with others - generally distrusting the sellers.

Roles of seller and buyer were fluid. Unlike other markets, users did not need to establish a regular seller to ensure quality and stability of supply. People sold when they lacked enough money to buy their full prescription. They 'bought out' as much as could be afforded and sold this, later returning to the chemist for the remainder of the prescription for their own use. If the chemist was prepared to dispense the

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prescription only in full, the user had to attract cash buyers to the chemist, e.g. by selling cheap. These processes lent the market some of the characteristics of a co-operative. Regular patterns of transaction occurred, and relationships were formed. The majority of sellers were prescribed weekly, and thus operated on a weekly cycle running from glut (on their prescription day) to drought. All participants had a vested interest in learning who was scripted on what, and how much of it they were selling. In sharp contrast to all our other markets, Market F did not rely at all on mobile phones. All contacts were made face to face on the street.

As many of the drugs held by sellers in pharmaceutical markets are prescribed legally, policing is difficult and complex. Services for drug users on the site also provide a legitimate reason for both sellers and buyers to be in the vicinity - even if remaining in one place will attract police attention and create suspicion. The street was occasionally used as the transaction site, though it was considered risky, there having been several police operations and persistent rumours of hidden surveillance cameras. More often people met in the street and undertook the transaction elsewhere. It was thought to be a dangerous place in which to wait around, with the combined threat of arrest or being mugged. Both sellers and buyers constantly kept on the move, walking round the block trying to locate each other. (There was a short circuit, criss-crossing the street, and a longer circuit.) A variant was for sellers to intercept buyers (or vice versa) as they made their way to the site. Most participants knew each other - and knew the days on which they picked up their script. Individuals were targeted at arrival points such as the tube stations. This allowed transactions away from the focus of police attention. Once buyer and seller located each other, deals were struck and transactions done 'on the hoof'. As pharmaceutical drugs are packaged and marked, they are easily identifiable. Inspecting the purchase thus took seconds.

The quality of drugs in this market was assured as they were pharmaceutical. The standard price for a 50mg methadone ampoule was said to be £10 though some respondents had paid as little as £5; two years previously, the price had been £20. Ampoules were sometimes purchased singly but more often in bulk, up to fifteen at a time. (Bulk purchases were sometimes arranged in advance, but were equally likely to be opportunistic.) Most respondents bought a combination of drugs from one seller. Both our respondents and drug workers in the area said that the use of private prescriptions was growing, with the effect of increasing spillage and reducing prices. Thus, the market was now a market experiencing over-supply. Sellers were finding that they could not sell their drugs. This led them to commit acquisitive crimes to pay for their script. A side-effect was an escalation in drug use; once they paid for their script, they would use the full amount themselves.

Participants considered the market unsafe. The mix of drugs used, levels of use and length of drug use ensured that paranoia and drug psychosis were commonplace (as



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they were amongst a significant minority of our respondents). The atmosphere was being worsened by growing competition caused by over-supply. Users were highly anxious that they would not get their drugs, and that they would be 'struck off' their doctor's list, and lose their script. This would impose delays, whether they were re-prescribed privately or on the NHS. A return to street drugs would involve users in extra cost - which would very probably be raised through acquisitive crime.

### Postscript

In October 1996 - when this report was in draft - we were informed that one of the main private prescribers whose patients supplied this market had been struck off. The market situation reversed sharply from a position of over-supply to a dearth, particularly of injectable methadone. Drugs workers reported that the street scene was now highly volatile with a large number of users desperate to obtain adequate supplies. Increased levels of violence were reported.

### **Key features of the markets**

Figure 9 summarises the key features of the markets examined in this study. Key points are:

- open markets have fewer barriers to entry than closed ones, and are well known
- they generally provide poorer quality drugs and more fake drugs
- open markets are more geographically fixed than closed ones
- open markets need a certain level of amenity to survive
- but in closed markets, the precise location of transactions is coincidental
- in open markets sex workers may be central in sustaining levels of transaction.

Figure 9: Key features of the drug markets

	MARKET					
	Closed ←					→ Open
	A	B	C	D	E	F
<b>MARKET FUNCTION</b>						
Barriers to entry	***	**	**	**	*	*
Well Known	*	**	**	***	***	**
Drug delivery system	***	**	*			
Use of mobile phones	***	**	*	*	*	
Good quality drugs	***	**	**	*	*	***
Fake drugs sold		*	**	*	***	
Sex working (attached to market)		**	*	**	***	
Sex work advertised (in phone boxes)			*	**	***	*
Street drinkers	*		*	*	**	*
Fixed site		*	*	**	**	*
Stability of market system	***	**	**	*	*	**
Credit available	**	**	*	*	*	*
Trust in market	***	*	*	*	*	
Links to housing estates	***	***	**		**	
Tourist area			**	***	*	*
CCTV		*		*	***	*
<b>AMENITIES</b>						
Tube or rail at site	*	*	*	**	***	**
Hotels/hostels				***	***	*
Good bus services		*	*	*	**	**
Shopping centre		*	*		*	***
Fast food outlets		*	*	*	**	**
Other restaurants and cafes			**	**	*	**
Banks/post office		*	*	*	**	**
Pay phones		*	*	**	**	*
Betting shops			*	*	*	
Chemist		*	*	*	*	
Drug using sites	**	*	*	**	***	***
Sex work sites		*	*	**	***	

\* Low      \*\* Medium      \*\*\* High

## TACKLING DRUG MARKETS

### 4. Tackling drug markets

This section examines ways of tackling street drug markets. Conventionally a distinction is made between strategies of supply reduction and demand reduction. However, markets are the places where supply and demand converge, and many approaches for tackling them affect supply and demand simultaneously. The aim of most of the strategies we have examined is to reduce directly the number of market transactions. We have left undiscussed many broader strategies for tackling drug misuse ranging from drug education in schools to training, employment schemes and community development programmes. We have left these 'primary prevention' strategies to one side simply because they are not tightly focused on reducing activity in street drug markets. This is not to imply that they are ineffective.

Our examination is a sort of inverted exercise in retail analysis. The rationale of preventive action is to ensure that numbers of buyers using a market falls below the threshold population needed to sustain it. We have discussed ways of doing this, under three headings:

- treatment services
- enforcement
- situational prevention.

#### **Providing treatment services**

Our discussion of treatment services is cursory, as the ground has been recently covered in depth by the Effectiveness Review (Department of Health, 1996). Hough (1996) and Parker and Kirby (1996) also discuss treatment in the context of the criminal process.

Providing treatment services is a demand-reduction strategy which aims to reduce the value of illicit drugs to buyers, rather than increasing their cost. It is especially appropriate to the minority of drug users who are engaged in such high levels of dependent or chaotic use that they form an important or central segment of a market's threshold population. A wide range of treatment options work for this group - albeit with qualifications (cf. Department of Health, 1996). A range of substitute prescribing practices and therapeutic approaches exists all of which reduce the chances that problem drug users will buy illicit drugs.

Most of our opiate users could specify an 'ideal script' - usually injectable methadone, though the more optimistic opted for diamorphine. They also wanted rapid access to prescription under a non-punitive regime. It is not for us to comment on the medical and ethical justifications of client-led prescribing. But against community safety criteria, substitute prescribing of this sort will have clear gains, reducing illicit drug use and associated crime at modest cost (cf. Parker and Kirby, 1996; Hough, 1996). Crime reduction can be bought through flexible and responsive prescribing regimes.

## TACKLING DRUG MARKETS

If greater flexibility and responsiveness is thought to be desirable, there are several subsidiary questions about the best ways of going about it. Users value easy access to services, without the deterrent of screening processes and waiting lists. Waiting times might be reduced if the prescribing role of GPs was extended (cf Parker and Kirby, 1996). The more that prescription regimes approximate to users' 'ideal scripts', the more important it would be to institute controls to avoid spillage onto the illicit market. Scotland offers a model of good practice, in that supervised on-site consumption in pharmacies is commonplace; this is also facilitated by a prescription system which allows daily pick-up of weekly prescriptions at no extra cost<sup>1</sup>. There are also decisions to be made about the best mix of strategies for drawing in problem users - how much to rely on outreach, and how much to tailor programmes to attract users to them.

Providing effective treatment for problem drug users involves much more than mere prescribing services. Whilst a few Drug Dependency Units have instituted substitute prescribing regimes for those who are dependent on stimulants they are not generally available, and even where prescription forms a central part of treatment, outcomes depend in part on human qualities such as the supportiveness of staff.

### Treatment and *criminaijustice*

More problem drug users probably pass through the hands of the police and the courts than through any other agency dealing with drug misuse. This makes the criminaijustice system a potentially pivotal component in the machinery for bringing treatment services to problem drug misuse. This potential is not yet being fully exploited.

Current enforcement priorities are focused on the supply of illicit drugs. Those buyers who are arrested in the process of enforcement strategies tend to be cautioned or fined for possession, depending on the type and amount of drug. This is probably an appropriate response in terms of criminal justice. However, it fails to make good use of the - often brief - window of motivation to seek help which arrest often prompts amongst problem users. More effective mechanisms are needed to ensure that the criminaijustice system serves as a conduit to drug agencies offering treatment.

Experience to date of arrest referral systems has been mixed (Hough, 1996). The underlying problem is still the one identified by ACMD (1994) that although the police and drug agencies have attempted to develop shared agendas, the enforcement perspective of the former and the client-based focus of the latter have yet to be synthesised adequately. Various schemes are emerging. Some rely on the

<sup>1</sup> The system south of the border means that daily pickup is more costly than weekly.

## TACKLING DRUG MARKETS

police providing information; in others drug workers screen those in custody in police stations and target likely candidates; in others, offenders are given police bail, and told that a decision about prosecution will be made in the light of their progress in seeking help to tackle their drug problems. A Central Drugs Prevention Unit seminar found that there was ample scope for developing other referral processes at other points in the criminal process (Home Office, 1995).

### **Enforcement**

Enforcement strategies are those whereby the police (or other empowered authorities) impose costs on buyers and sellers, in the form of threatened or actual punishment. Imposing these costs on sellers effectively raises the threshold population - the level of demand necessary for the market to survive. Where buyers are the focus of enforcement activity, the principle is to reduce demand for the commodity, driving down numbers of buyers to below the threshold population. In practice most enforcement strategies aimed at retail drug markets simultaneously increase the costs to buyer and seller.

Policing activities directed at the market place are often referred to as low level enforcement. The evidence from - mainly American - research is overwhelming that markets can be disrupted in this way (see Dorn and Murji, 1992; Hough, 1996, for reviews). Our study certainly supports this view. Our respondents were highly sensitive to police activity - or perceived activity, which was sometimes amplified by rumour<sup>12</sup>. Almost half (44%) said that the risk of enforcement was a crucial factor when deciding upon what drug market to use and how to use it. Local enforcement strategies were a source of constant discussion and gossip. The costs of arrest were high especially for dependent users who face the prospect, if arrested, of a lengthy period in a police cell. Police tactics which were mentioned often included covert surveillance, stop and search tactics, and CCTV. For these tactics to be effective there must be some predictability in buyers' and sellers' behaviour. Thus the more open a market's operation, the more amenable it is to low level enforcement.

Sellers and buyers obviously adapt their behaviour in response to increased enforcement. The more intensively open markets are policed, the greater the incentive on both buyer and seller to adopt less open styles of transaction. Mobile phones in particular allow the development of a style of semi-closed operation which is well protected against policing. Those sellers who are arrested clearly have no room for short term adaptation, but others can relocate and/or shift their operation to a more closed style of market or give up. The users to whom we spoke represent only a segment of buyers, and it would be wrong to generalise from their accounts to the reaction of others. Nevertheless, in the face of increased police activity, they told

<sup>12</sup> For example, users told us that CCTV was active in one market in advance of its operation

## TACKLING DRUG MARKETS

us that they would either shift market, or take greater care to avoid detection (e.g. by managing the transaction off-site). None suggested that they would be deterred from buying.

It struck us as improbable that 'inconvenience' policing would substantially reduce demand for drugs amongst this group. Viewed against the other dangers faced by a highly chaotic user, the increase in risk from a police operation may be at best marginal. However, it seems likely that low level enforcement can impact markets in two ways. First, less experienced or novice users may well be deterred from buying drugs in markets. We have no way of saying whether casual users constituted a significant proportion of the buyers in the markets we examined.

Secondly, low level enforcement can set in train a dynamic which eventually degrades open markets by eroding their reputation. Together with the increased risk of arrest comes a more clandestine and thus more uncertain mode of transaction. The chances of low-grade - or fake - deals increases; trust between seller and buyer decreases, and the market becomes a more dangerous place. The clearest example of this comes from Market E (see pps. 24-28)

Displacement - containment versus dispersal

Enforcement strategies pose some dilemmas about displacement. A sceptic might argue that it is a waste of police resources to try to disperse markets: at best, the market is simply kept on the move and at worst the process may yield greater amplification and diversification of markets, in terms of location and methods of operation. Disrupting one market may bring other nascent ones to the population threshold at which they can thrive or may introduce new drugs into those markets. Almost all those interviewed - users, sellers, drug workers and police - had theories about the displacement effects of policing Market E.

However, there are good arguments for using low level enforcement to disperse markets. First, intensive policing of any market is unlikely to result in 100% displacement - some users will stop buying, or buy less; as discussed above, one would expect novice or casual users to be most responsive. Secondly, dispersing a market will reduce the 'collateral damage' suffered by communities in drug dealing areas. American research (and common sense) suggests that licit and illicit economies can be mutually exclusive; and that if drug markets become established, this can lead to a downward spiral of decline, involving increased crime and fear of crime, resident flight and disinvestment by businesses (cf. Johnson et al., 1990). Finally, there is a strong case for dispersing markets before they acquire reputations. Market E demonstrates how difficult it is to dislodge a market once it has acquired a national (and international) reputation.

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### *Supply reduction - private prescription and pharmaceutical drugs*

Most aspects of supply reduction - enforcement activities aimed at trafficking and manufacture - lie well outside the scope of the study. However, our findings point to one approach to supply reduction which could have a big impact on pharmaceutical drug markets. The main sources of supply to these markets is leakage from the prescription system, and from our evidence, the greater part of the leakage comes from the private prescription system. Several of our respondents were being prescribed more drugs than they needed, and were selling the surplus in pharmaceutical markets (see Market F on pp. 28-32 and Appendix 1). The sales covered the cost of prescriptions and consultancy fees. There is a need for action on a variety of fronts:

- firmer action to stop over-prescribing and prescribing in inappropriate combinations;
- clearer guidance on treatment regimes when prescribing controlled drugs;
- pressure on pharmacists not to allow credit for controlled prescription drugs;
- encouraging pharmacists to question prescribers over high levels of prescription;
- discouraging doctors from nominating pharmacies for cashing private prescriptions;
- encouraging daily pickup of weekly prescriptions from pharmacies and on-site consumption.

Where legitimate concerns exist about the legality or public and community health aspects of particular practices by private doctors or pharmacists, these should be addressed on a multi-agency basis. Some action is already in hand to address prescribing issues. The Department of Health will be re-issuing its clinical guidelines early in 1997 to take into account the recommendations of the Task Force to Review Services for Drug Misusers. At the same time, the General Medical Council's jurisdiction will be extended by the Medical (Professional Performance) Act 1995 - which comes into effect in 1997 - by allowing it to deal with doctors whose performance is found to be seriously deficient. The Royal Pharmaceutical Society has stated its willingness to play a greater role in ensuring that best practice as set out in its code of ethics is actually observed, perhaps by establishing a system of routine notification by pharmacists of specified prescribing patterns for particular medicines. There may also be a case for extending the Home Office licensing system to include a broader range of controlled drugs.

Rapid reduction of privately prescribed drugs would create its own problems. Some of those who presently finance their habit by selling surplus prescription drugs would raise the cost of their - reduced - prescription through acquisitive crime. Others would return to buying street drugs. The latter outcome in particular would carry heavy social costs, as dependent use of street heroin tends to be substantially dearer

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than of Pharmaceuticals. Indeed private doctors who knowingly overprescribe can argue that this leads to the least undesirable of several unsatisfactory outcomes. One possible resolution is for NHS prescribers to be more ready to prescribe types, combinations and levels of drugs which approximate to clients' wishes, as discussed above. Indeed, the postscript to the description of Market F reinforces the need to ensure that there are appropriate transitional arrangements available when any action is taken to reduce the leakage of pharmaceutical drugs onto the illicit market.

### **Situational prevention**

Situational prevention comprises measures directed at specific forms of behaviour which involve the management, design or manipulation of the immediate environment in which the behaviour occurs (Tonry and Farrington, 1995). Situational prevention of drug markets is thus by definition targeted at the locations in which dealing occurs. As such, it is applicable largely to markets with fixed sites. Our analysis of the key features of the markets examined in this study (figure 9) suggest several different sorts of situational strategies which can all have the effect of depressing numbers of buyers to below the threshold population:

- measures which are adjuncts to enforcement
- measures to reduce the amenity of markets to buyers and sellers
- measures to interrupt the drug street scene
- measures to reduce the threshold population by tackling street prostitution.

#### *Situational prevention as an adjunct to enforcement*

There are two main groups of situational measures which facilitate enforcement in drug markets. The first extends the impact of formal police surveillance by fostering informal surveillance. This can be done by training 'place managers' in awareness and 'people handling skills' (Eck, 1996). For example in areas where there are drug markets, restaurant staff can discourage drug using on their premises, transport workers can reduce fare evasion, park attendants could reduce dealing and using in parks. Crimes committed to finance drug purchases are often made at or near dealing sites, and the scope for situational strategies to include tackling local property crime is large - but beyond the scope of this study.

The second approach is to use technology to extend the scope of formal surveillance. It has been shown that CCTV can reduce crime (Brown, 1995), and though there has been no formal evaluation of its use in drug markets, we can offer anecdotal rather than systematic findings to suggest that it can have a marked impact. Systems were installed in two of our sites during fieldwork. In Market D, a single CCTV camera was installed in a central location. Local outreach workers complained that



## TACKLING DRUG MARKETS

this immediately made their work impossible: the market had dispersed, and client contact had been reduced to a fifth of its former level<sup>13</sup>. In Market B when a high street system went live, dealing disappeared from this part of the site. We do not know if it was displaced, or if it returned.

It is unclear how long drug markets will take to adapt to CCTV surveillance. Various adaptations can be anticipated. The original site may become simply a meeting place, with transactions handled 'round the corner' beyond the cameras' coverage. Transactions may shift to semi-public space, such as shops and restaurants. The risk of CCTV surveillance may reduce transaction time and thus increase the uncertainty faced by buyers.

There may be scope for situational prevention to facilitate monitoring of dealers mobile phones. These are becoming central to the operation of semi-open markets (as in Markets A, B and C), with dealers generally using phones which have been stolen and cloned. One reason why they do so is to reduce the risks of surveillance or monitoring. This option could be largely closed off if design solutions can be found to minimise the use of stolen phones. It remains to be seen whether long-term technological solutions to cloning can be found (see Natarajan et al., 1996, for a discussion).

### Reducing the amenity of markets to buyers and sellers

The amenity of a retail site - whether licit or illicit - is important in maintaining its viability. Our respondents identified several amenity factors which make for a good market besides the obvious ones of value for money and availability:

- ease of access (by public transport)
- a level of street activity (helpful in masking illicit activity)
- places to 'hang out' (important for sellers waiting for trade)
- good meeting places and transaction sites (e.g. fast food restaurants, betting shops)
- cash points outside banks and Post Office facilities for cashing Giro cheques
- access to equipment (e.g. syringes, water, citric acid or simply lemons)
- good using sites (e.g. toilets in fast food restaurants)
- access to phone boxes (to call sellers on arrival at market)
- opportunities to raise money to buy drugs (e.g. through sex work).

<sup>13</sup> The outreach workers had no prior knowledge of the system's installation, and were ambivalent about the legitimacy of the enterprise - demonstrating the gulf between police and drug agency perspectives.

**Examples of situational strategies for reducing market amenity**

*Ease of access*

Users often evade paying fares when travelling to markets. Local controls over fare-evasion can be improved.

*Access to phone boxes*

Phone boxes can be located under direct surveillance of place managers. If incoming calls are being made to dealers, bar incoming calls.

*Levels of street activity*

Overall levels are not readily manipulable, but flows of people can be redirected to or from buying sites by physical design measures.

*Access to using equipment*

Use of foil ashtrays in meeting sites should be discouraged. Location of needle exchanges should be regularly reviewed.

*Meeting places and transaction sites*

'Place managers' in fast food restaurants and betting shops can be trained to be aware of drug dealing and discourage it. On-site CCTV surveillance can protect blind spots. Managers can discourage long-stay customers who fail to make purchases.

Buyers and sellers sometimes observe the market from tables with street views in restaurants. This can be limited, e.g. by redesigning seating or obscuring vision (though amenity for other customers may also be reduced).

*Cash points*

Cash point machines situated in lobbies with controlled access can reduce opportunities for robbery.

*Shops*

Encourage shop managers to relocate the goods which users favour for shoplifting in parts of the shop which are directly overseen by staff. Discourage managers from selling drug paraphernalia.

*Sex working sites*

Improve street lighting round outdoor sites; restrict vehicle access to sites used for car sex. Restrict access to vehicles and restrict parking. Discourage hotels and hostels from letting premises be used for sex work.

*Using sites*

Install blue lighting in toilets (making injection harder); institute no-smoking policies and smoke alarms in toilets; restrict access to unused basements and stairwells; secure disused buildings; patrol parks and gardens; improve lighting around using sites.

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Many - but not all - of these amenities can be modified to make sites less attractive to buyers and sellers. The box on the previous page offers illustrations. Inevitably, there are often financial or other costs in doing so, which may fall on local businesses or local residents. However, the threat inherent in drug markets of a downward economic spiral can stimulate expenditure. The negative PR value of an association with drug use is an equally potent motivator for some businesses.

The possibility of situational measures backfiring must be anticipated. For example, reducing the availability of drug equipment might simply stimulate sharing or re-using needles, or using more dangerous substitutes (eg lemons instead of citric acid). Care has to be taken that any intervention does not result in the sort of social and medical harms experienced in Edinburgh in the early and mid 1980s.

### Interrupting the street scene

Researchers from Preble and Casey (1969) onwards have pointed out that for all its apparent nihilism, dependent drug use can provide structure and meaning to people's lives. Part of this structure can derive from participation in the street scene which develops around open markets. People who use markets regularly get to know one another and spend time with each other. In Markets D and E decisions by local planning and housing agencies were in our judgement actually sustaining this street scene. For example:

- planning decisions ensured that the surrounding area retained high levels of temporary accommodation such as hostels and bed and breakfast hotels;
- managers of these businesses ensured that residents could spend only minimal time in the accommodation - maximising street use;
- housing associations placing problem drug users in areas known for drug dealing.

From individual agencies' viewpoints there may be persuasive justifications for these decisions and practices. For example, housing associations may have on their waiting lists both problem drug users who are keen to live close to a market and other people who are equally keen not to. From both health and community safety perspectives, however, it is a high-risk strategy to lock vulnerable people into a street milieu in which drug temptations abound. Young people are particularly at risk from involvement in drug street scenes. They have limited access to public housing and benefits and are at particular risk of exploitation both by those selling drugs and those buying sex.

The location of health service facilities and prescribing chemists also has an impact on the development of the street scene. Needle exchanges can attract large numbers of drug users to one site. An alternative is to encourage the development of

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pharmacy needle exchanges, resulting in a dispersed network of provision. A drawback is that users might not receive the advice and information which needle exchanges have expertise in providing - but this problem might be offset by setting up more flexible outreach services.

Private preservers' practice of designating which pharmacist is to dispense their prescription facilitates the development of pharmaceutical markets. Market C provides a good example. The problem could be avoided if - in line with the Royal Pharmaceutical Society's code of ethics - doctors and pharmacists stopped doing this. The ideal should be for patients to be able to cash their prescription near their home, avoiding the concentration of potential buyers and sellers at a single site.

### Sex work and drug markets

If the aim of enforcement is to ensure that the pool of buyers using a market falls below the threshold population, it makes sense to focus on segments of the market which are consistently high-spending. The most obvious group are sex workers. Prostitution was well established in four of the six markets we examined, and probably pre-dated drug-dealing in all four. Though it may simply be that drug and sex markets thrive in similar habitats, the evidence points to sex workers now being central in sustaining levels of buyers at or above the threshold population of some open drug markets. Those we interviewed had high levels of dependency (on heroin or crack or both) and an average weekly spend approaching £600. This was twice the level of other users we spoke to (most of whom had serious problems of dependency). Sex workers also sold drugs to clients, and introduced clients to their sellers. We believe that if levels of street prostitution were reduced in drug-dealing areas, this might significantly impact on markets.

Arrangements for tackling drug dealing and prostitution within the MPS hinder an integrated approach. Responsibility is shared between divisional officers, Area Drug Squads and the Vice Squad. Within the latter, one unit has responsibility for street prostitutes and one for sex work carried out in hotels and flats. Whilst we can see the advantages of specialisation, we think there may also be costs. By itself, intensive policing may simply drive sex workers more rapidly through the 'revolving door' of the courts. Ways of ensuring proper linkages between the courts and drug agencies have been considered in general above; it may well be that programmes are needed which are specifically tailored for sex workers.

There are various situational measures to make the immediate area around drug markets less conducive to sex work, as suggested on page 41. For example, street prostitutes need minimally some semi-public space where they and their client will not be disturbed, and ideally access to a hotel or hostel room. Situational measures can reduce these facilities. Some measures might seem promising on the surface, but may only address the problem tangentially. For example, sex workers cards festooned

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phone boxes in four of our drug markets. Action to remove these<sup>14</sup> might actually swell the number of sex workers working the streets. However, reducing 'carding' might reduce the overall level of 'sleaze' which arguably signals to buyers that they are in an area where sex and drugs are for sale.

One possible way of reducing the role that sex workers play in sustaining street markets is licensing massage parlours. The idea needs further exploration, but could bring significant benefits in removing or reducing the income which sex workers currently bring to street drug markets. There is a complex dynamic between sex work and drug dependence. Prostitution may finance drug use; but levels of drug use may also be increased to alleviate the anxiety of prostitution. Operating in a safer and more controlled environment may well enable dependent sex-workers to moderate their use; it would certainly make it easier for drug agencies to make contact with them. A controlled system may also marginalise those highly chaotic users who work the streets to fund their dependency - if the punters' are attracted by the safeguards offered by a licensing system.

It is beyond the scope of this study to examine the overall case for the decriminalisation of sex work, or to examine the precise mechanisms by which informal - or even formal - licensing systems can be implemented. In Scotland, the running of a brothel or allowing one's premises to be used as a brothel is still a criminal offence. However, under the Civic Government (Scotland) Act 1982, a local council has the power to licence public entertainment premises and the discretion to determine which types of public entertainment should be licensed. Edinburgh City Council has used the provisions in the 1982 Act to licence saunas and massage parlours. Edinburgh newspapers indicate that the number of prostitutes has significantly increased but that fewer operate on the streets. At present, the police in England take the view, particularly with regard to juvenile prostitutes, that they should avoid charging for prostitution wherever possible, but that criminal sanctions must be available for use where appropriate and as a last resort.

<sup>14</sup>Some local authorities have prosecuted carders under the Town and Country Planning Act 1992. More effective action should be possible now that British Telecom and other telecommunications companies have agreed to block incoming calls on phones whose numbers appear on these cards.

### 5. Conclusions

This paper has examined one segment of the systems by which illicit drugs are distributed. It has focused on open or semi-open markets whose clientele includes dependent users. As they operate at present, these markets can inflict a variety of harms on those who are directly involved in them as buyers and sellers, and on those who live or work in the areas where they operate.

Markets of this sort prove particularly intractable to policing with enforcement strategies alone. More effective interventions are likely to be those which combine enforcement measures with situational prevention and with the provision of treatment for users who comprise the core of the market.

The body of knowledge about effective action against drug markets remains scanty. Table 1 is an attempt to schematise what can be said at present about good practice. The conclusions in the table urgently need testing, and the gaps need filling. At present it is simply not possible to offer a more prescriptive set of solutions to the police service and their partner agencies. The best mix of tactics will vary widely according to local circumstances. Some of the approaches advocated in this report - particularly the provision of treatment services - promise to reduce overall demand for illicit drugs. Enforcement measures and those involving situational prevention may have less impact on levels of demand, but they are likely to reduce the damage which open drug markets impose on the neighbourhoods in which they operate, and can interrupt the spiral of decline which open markets can trigger.

CONCLUSIONS

Table 1: Scope for tackling different types of market

TYPE OF MARKET	PROVIDING TREATMENT SERVICES	ENFORCEMENT	SITUATIONAL PREVENTION
OPEN MARKETS	Dependent Users	Market will respond to policing, but displacement will be likely	Plenty of scope for reducing site amenity. Scope for targeting core markets, eg. sex workers
	Casual Users	'Inconvenience policing' may be effective in reducing demand.	Scope for reducing site amenity
CLOSED MARKETS	Dependent Users	Enforcement strategies will be costly (eg. covert surveillance) displacement is very likely.	Limited scope for reducing site amenity. Some scope for targeting core markets.
	Casual Users	Enforcement strategies will be costly, but demand may be reduced.	Limited scope for reducing site amenity

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## APPENDIX 1: THE PRIVATE PRESCRIPTION SYSTEM

### Appendix 1. The private prescription system

The majority of illicit drug sales in London are of illegally imported or manufactured goods. An important minority comprises drugs which have been legally manufactured but have then 'leaked' onto the illicit market. From our evidence, this spillage is particularly associated with private prescription. The following account is based largely on interviews with 28 users who bought or sold in Market F, supplemented by interviews with agency staff working in the area.

There are increasing numbers of private doctors who prescribe to drug users, and increasingly overt advertising of services. Private prescribers range from highly committed professionals to the venal. Amongst the former, some operate little differently from GPs, prescribing similar quantities of various drugs, and providing good health care and regular urine screens; others pursue more liberal prescribing regimes, but still with the patient's best interests in mind. (There is plenty of scope for disagreement within the profession about appropriate prescribing strategies.)

For a very small minority of private doctors, prescribing regimes seem to be driven largely by commercial considerations. Large sums of money are to be made easily by issuing repeat prescriptions on a weekly basis to dependent drug users. The weekly consultation fee is usually £25, payable before the prescription is handed over; and the frequency with which the names of individual doctors came up at interview suggested to us that patient lists were sometimes long<sup>15</sup>. The least scrupulous of private prescribers can maintain high throughput by offering minimal patient care: some respondents told us that they were given prescriptions in the absence of drug screening, medical histories and urine tests; and that prescriptions were unaccompanied by even the most rudimentary health care advice.

There is a tendency for prescription of very high levels of drugs - for example up to ten 50mg methadone ampoules per day. Though we are not qualified to express a medical view, the fact that spillage supports active illicit pharmaceutical markets is incontrovertible evidence that levels of prescribing are excessive amongst a minority of private doctors. Many private prescribers are also prepared to prescribe a wider range of drugs than their NHS colleagues, and in more elaborate combinations. Prescription of injectable methadone and amphetamines are examples of this. The cost of prescriptions after the doctor's consultancy fee had been paid averaged £75 per week amongst those we talked to. If the prescribed drugs carried a 33% mark-up - which we believe is conservative - the profits to pharmacists dealing with high volumes of private prescriptions would also be substantial.

Most private prescribers designate which chemist is to supply the prescription. Some of our respondents firmly believed that their doctor and pharmacist worked in profit-sharing partnerships. Whatever the case, specifying the pharmacy gives the doctor added control over the patient.

<sup>15</sup>Two separate sources told us of doctors with lists of around 200 dependent users. If their lists numbered just 75 then this would yield them an annual income of approximately £100,000.

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Pharmacists often allowed users credit. This enabled the users to collect half their prescription, sell it and then pay off the pharmacist and collect the remainder of the prescription. We have no doubt whatsoever that this practice occurs on a regular basis in some chemists, and that the pharmacists know that some of the prescription is being illegally sold. Our respondents said that private prescriptions can be obtained with ease. Amongst those we talked to, most prescriptions had been 'brokered' by another user. In some cases users introduce acquaintances to their doctor, who then pay an introducer's fee, for example by waiving a consultancy fee. Others work 'freelance', collecting a commission from other users for introducing them to doctors; a common arrangement is for the introducer to get half the first prescription as commission (which may cover one or two weeks' supply). This has the effect of building in from the start an incentive for the drug user to maximise the prescription level to cover more than just dependency needs.

A means-test is required by the doctor at the first consultancy, to guarantee that the user can afford the prescription. Evidence of a bank or building society account with a balance in excess of £500 is usually enough. Our respondents described how this could be arranged - by borrowing a pass-book, for example, or borrowing the money and opening an account for a very short period. Non-dependent users who trick the doctor into prescribing have to pass another hurdle, as urine tests are required as proof of dependency. Again this is simple: a couple of days before seeing the doctor, the user takes a small amount of oral methadone, dexedrine and benzodiazepines, which will all show up in the test. The doctor will then prescribe this range of drugs. The tests used indicate only the presence or absence of drugs in the body, rather than levels of use. Good medical practice is to carry out tolerance tests for each drug - though none of the privately prescribed respondents we interviewed mentioned receiving any form of tolerance test.

Powers to control prescribing are shared between the Home Office and the General Medical Council. The Home Office Addicts Index provides information about who is prescribing, and police inspections of pharmacy records can show how much is being prescribed. At present the Home Office issues licences for the prescription of diamorphine, cocaine and dipipanone - none of which figured prominently amongst the pharmaceutical drugs 'spilling' onto the street market. The Home Secretary has additional powers to issue a Direction to any doctor to stop prescribing other drugs, upon the recommendation of a tribunal. The GMC can also conduct enquiries into the prescribing practice of any doctors and strike off those who it finds guilty of malpractice. Its powers were extended by the Medical (Professional Performance) Act 1995. Powers to control pharmacists' methods of operation fall exclusively to the Royal Pharmaceutical Society. The RPS has a regulatory function defined by statute. Its code of ethics comprises nine principles and numerous detailed obligations which relate to each principle. The most relevant obligations are 1.7 (referring to excessive prescriptions) and 9.1 (referring to associations with medical practitioners).

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