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# Druglink

## Questions of cash

Even if the worst predictions of an atomic winter for drug treatment as fallout from public health disinvestment fail to materialise, the issue of money (or lack of it) will still dominate the policy discourse and hugely influence the outcome for service users.

Our cover story (p.7) maps out the potentially treacherous terrain, but we also highlight in our news story (p.2) and in our interview with Dr Clare Gerada (p.10) concerns that we risk losing much expertise in addiction treatment if the NHS continues to be squeezed out of local systems because the voluntary sector can deliver at a more competitive price.

But it isn't just the NHS where money talks and services walk. While there is much to applaud in the notion of recovery, it appears to be accompanied in some areas by a subtle demonisation of substitute prescribing. But by the same token, tier four services are clearly losing out – and have been for years – when it comes to financial allocations by local authorities – and localism will invariably make that situation worse for those rehabs who rely on a national catchment profile.

The issue of a balanced treatment system should have moved on from the philosophical duelling of harm reduction v abstinence. As Mike Ashton comments (p. 14), that debate ultimately comes down to values not evidence. What service users need is a system that delivers a holistic care package right through the treatment journey. While some might wave the flag of commercial confidentiality, nevertheless, the commissioning process should be more open and transparent than it currently appears to be. We need to ensure that evidence-based service delivery is not unduly influenced either by cash or ideology – or by one posing as the other.

### Harry Shapiro

Editor and Director of Communications/ Information

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Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

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## News

- 2 **NHS being squeezed out of treatment**
- 3 **Drug court funding doubt**
- 4 **Drug mules: have new sentencing guidelines helped?**  
Interview with Hibiscus CEO Olga Heaven. By Jeremy Sare
- 6 **Mcat: 'worst drug I have ever seen'**

## Features

- 7 **COVER STORY: TROUBLE AHEAD? LET'S FACE THE MUSIC AND DANCE**  
The creation of Public Health England and the demise of the NTA threatens the worst funding outlook for drug treatment services in a generation. By Marcus Roberts
- 10 **Druglink interview**  
Dr Clare Gerada, Chair of the Royal College of General Practitioners. Interview by Jeremy Sare
- 12 **The year of living dangerously**  
How influential is the media in dictating drug policy?  
By Malcolm Dean
- 14 **Beg to differ**  
The harm reduction versus abstinence debate will never be settled by evidence argues Mike Ashton
- 16 **Ten years on**  
Colin Brewer reflects on his 2001 Druglink predictions for treatment
- 18 **M&S**  
Methadone or Subutex for prison detox? And does detox work anyway?  
By Laura Shead
- 20 **Moroccan 'roll**  
Morocco says it has its hashish trade under control. So why won't it let UN observers in to check?  
By Adrian Gatton
- 22 **The acid king**  
The story of Owsley Stanley, the man who flooded the sixties with LSD.  
By Andy Roberts

## Regulars

- 5 **Inside DrugScope**
- 24 **Reviews:** cannabis
- 25 **Research:** residential rehab
- 27 **Fact sheet:** MXE
- 28 **Headspace**  
Marcus Roberts on the war against drugs
- 29 **Drugworld diary**  
Sue Goodliffe from Adfam

### ■ Just the Job

Back in 2005, the late Steve Jobs, co-founder and CEO of Apple, was interviewed by New York Times reporter John Markoff, who interviewed him for his book, *What the dormouse said: how the sixties counterculture shaped the personal computer*. Speaking about his youthful experiments with psychedelics, Jobs said, "Doing LSD was one of the two or three most important things I have done in my life." He also credited LSD as a major reason for the success of a company whose mantra was 'think different'. See also LSD feature on pages 22-23.

### ■ Taking the hiss

Partygoers in India have sparked a rapid increase in the sale of K-72 and K-76 pills which contain cobra venom. The venom is processed into a powder that can also be mixed with alcohol, enhancing sensations and boosting energy so that ravers can dance for longer periods of time. While drugs like ecstasy typically cost 2,000-5,000 rupees (£25-60) per pill in India, a pinch of K-72 or K-76 can set you back as much as 20,000-25,000 rupees (£300-400).

### ■ Tantrums over Rosa

Closer to home, the vandalism of a Southampton cemetery by Polish teenagers has been linked to the use of a feminine hygiene product called Tantum Rosa. Available only in some shops selling Polish goods, the product contains benzydamine which has stimulant properties as well as causing delirium and confusion and loss of control.

The Medicines and Healthcare products Regulatory Agency (MHRA) raided four Polish shops in Southampton supported by the city council's trading standards department and police. Benzydamine is licensed for use in other products in the UK including mouthwashes, lozenges, mouth spray and cream, but not in this formulation. A spokeswoman for the MHRA said that the first shop raided would receive a written warning but could face prosecution if it was found to be continuing to sell unlicensed medication.

## Fears for patients as NHS lose out

The transfer of Darlington's substance misuse service from the NHS to a voluntary sector provider has underlined concerns by NHS providers that service users will ultimately suffer through removal of the NHS from local systems. From 1 April, the service will be run by Neca, based in Newcastle, one of the largest third sector providers of substance misuse services in the region. The Darlington Drug and Alcohol Action Team, which commissioned the service, has defended the decision, which it said will bring a service that was previously provided by several partner agencies under one leader. But speaking to *The Northern Echo*, the Royal College of Nurses (RCN), said it feared that budget pressures in the NHS will lead to more services being offered to the third sector, making them unaccountable to the public.

Annette Dale-Perera is Strategic Director for Addictions and Offender Care Central and North West London NHS Foundation Trust. She told *Druglink*. "There are a number of concerns here. Firstly, the playing field isn't level when it comes to costs. Just one example, NHS Trusts have to find 20% cost savings over 3 or 4 years. This is a statutory 'must do'

in the NHS and is impacting on every contract. So we immediately cost 5-7% more.

"Then if you have no NHS in a local system – you lose vast amounts of training of NHS staff in addiction – especially all addiction training of consultant psychiatrists and psychologists. These training placements can only be provided by NHS secondary services and without the NHS, we will have no addiction psychiatrists and general psychiatrists will not have addiction training."

"And critically, there are many situations where users need specialist clinical interventions that the non-NHS cannot provide. I have lots of examples of this with the club drug work we do. For example, we haven't seen one ketamine client that didn't require significant health assessment and involvement of renal specialists.

Some of the worst health trends are with our alcohol dependent clients – where we are seeing physical and cognitive damage at younger and younger ages – that requires medical input. If you haven't got specialist addiction NHS in a system – a lot of this work doesn't happen".

## Tacade closes

After 40 years of delivering drug and alcohol health education, the Teachers Advisory Council on Alcohol and Drug Education (Tacade) has gone into administration.

Established in Manchester in 1968, Tacade was a pioneering force promoting interactive participatory health education. During the 1970's its work expanded beyond drug education to other areas of personal, social, health and well-being and more recently Tacade developed an international profile in countries as far apart as Uganda and the Ukraine.

However says former CEO Martin Buczkiewicz; 'the past few years have been extremely difficult for many charities, including Tacade. Due to a variety of factors, including the demise

of the Healthy Schools Advisers and Drug Education Advisers in many authorities which has led to a cutback in funding available for resource, Tacade found it impossible to continue with its work'.

"Tacade did not receive any direct Government funding, yet we effectively delivered the health and well-being education resources so needed by teachers and other professionals to enable them to deliver the various edicts issued by a variety of Government departments across the UK.

It is a sad reflection of the times that funding was not forthcoming for an organisation that provided so many professionals with materials to work with thousands of children and young people across the UK."

# Funding doubts over family courts



© PHOTOFUSION

Despite a positive evaluation report, there is no guaranteed funding for the roll-out of Family Drug and Alcohol Courts (FDAC) in England. Based on a successful model imported from the USA, the previous government funded an initial three year pilot project in London (extended by a year) which ends this month.

The principle behind FDAC was to speed up the often slow processes of ordinary Family Proceedings Court, enabling the fast-tracking of parents with drug and alcohol problems into treatment facilitated by a multi-agency specialist team attached to the court and working with both parents and children. And according to the evaluation undertaken by Brunel University, the FDAC has fulfilled its objectives; processes were faster, more parents engaged with treatment and were reunited with their children than through normal court procedures and the whole system was welcomed by both parents and professionals.

However, although the report identified some cost savings for local authorities, for example, fewer children

in care and shorter case hearings, the main obstacle to establishing FDACs more widely is the cost. Primarily because of the intensive input from professionals, it is a high cost intervention working with relatively few of the most intractable cases. Any continuation of FDACs is only likely to happen if cash-strapped local authorities are prepared to foot the bill. This in turn means that FDACs would almost certainly need, amongst other things, local champions. One of the reasons why the pilot scheme has received so much publicity is because it has been backed by the high profile and outspoken District Judge Nicholas Crichton. Following a trip to the States, it was Judge Crichton who was influential in setting up the pilot in the first place. There are also some concerns that despite the name, in the new climate of recovery, not enough attention has been paid to the whole treatment journey, with the emphasis more on getting parents to initially engage with treatment. However without local funding and local heroes, the whole initiative will grind to a halt.

## Peru rehab fire

Twenty seven patients died in a fire at a Christian-based rehab centre in Lima at the end of January. One resident, who was forced to jump out of a window, told a local radio station that patients were unable to escape the flames, as the doors were routinely locked to prevent escape. In the aftermath of the tragedy, the International Drug Policy Consortium wrote to the Peruvian government expressing concern at the treatment of service users at the rehab in which they wrote:

“The practices reported at Cristo es Amor did not meet minimum international standards. Offering patients religious instruction and a regime of physical discipline rather than medication and evidence-based treatment is neither appropriate nor effective in addressing drug addiction. While this was a private center, governments are obligated to protect their citizens against cruel, inhuman and degrading treatment in private and public institutions alike.”

## Meth in Mexico

According to intelligence analysts Stratfor, the seizure of 15 tons of pure methamphetamine could signal a turning point in the stalemate of Mexico's vicious drug war.

The big money has been in cocaine. But Colombian criminal groups still control production. Mexican traffickers are middlemen taking most of the risks and needing an unreliable group of intermediaries to get the drug to Mexico and then to the American street sellers.

But what if the Mexican gangs controlled their own market? Recently, meth seizures have gone from kilos to tons; precursor chemical seizures are up 400 percent from 2010-2011. Producing industrial quantities of methamphetamine dispenses with most of the risk and expense of the cocaine trade and, without the Colombians playing one gang off against the other in the drive for profits, makes it more likely that one criminal gang will become top dog

# FAIR DEAL

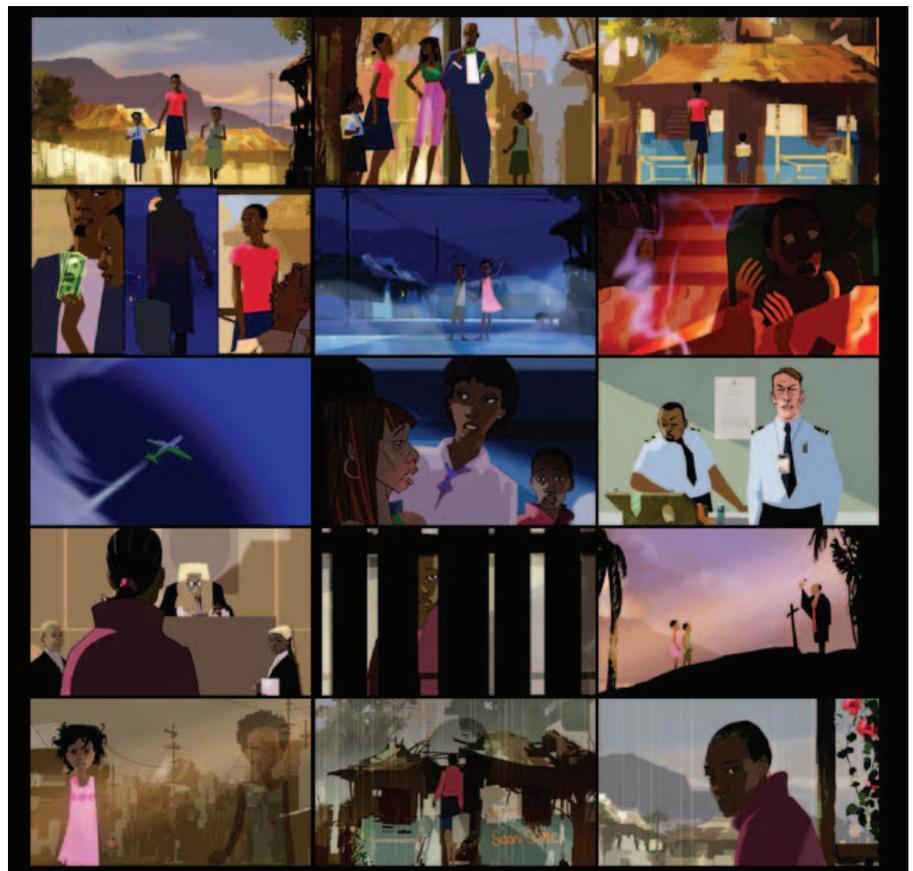
When the Sentencing Council consulted on new guidelines for drug offences, DrugScope were among a number of organisations who successfully campaigned for drug ‘mules’ to be treated more like victims than evil traffickers. Leading the charge on this issue since 1987 is Hibiscus. **Jeremy Sare** interviews Olga Heaven, the charity’s Chief Executive.

Back in the early nineties, a significant proportion of the UK female prison population was made up of Nigerian women convicted of drug offences. Then Hibiscus’ CEO, Olga Heaven took a BBC film crew to Nigeria for a Panorama programme. She believes the film “really was the catalyst to decreasing the numbers coming to the UK. They were all first offenders and they had got excessively long sentences of 8, 10, 12 years. They could not get parole because there was nothing in place in Ghana or Nigeria to prepare for the home circumstances. So we employed a probation officer in Nigeria to produce the reports which allowed them to be freed much earlier. We also wrote pre-sentence reports which helped judges in mitigating their sentences.”

Then, quite suddenly, the drug scene began to change and cocaine started coming into the UK from different routes. In 1994, Hibiscus took its first call from a customs officer about a Jamaican woman who had swallowed cocaine.

“Soon we had over 600 Jamaican women – and 2,000 men – in prison in the UK for drugs importation,” Heaven recalls. “We suspected professional importers carrying drugs would use women as decoys. Most of them were in their forties and fifties and had been recruited from rural parts of the island. I remember one woman who was 61 who said she had grandchildren to feed. She had been told at her age she would not get sent to prison. The children they left behind were their terrible legacy”.

Given that the really large and profitable consignments of drugs come in boats, containers and the like, it begs the question how much a single person can actually bring in? “Maybe 250 grams.



STILLS FROM THE FILM 'EVA GOES TO FOREIGN', © HIBISCUS

But sometimes 800-900 grams. We had one girl who had over a kilogram. You would expect the amounts to be reflected in the sentencing, but there was massive inconsistency. For example, someone carrying 500 grams would expect to get perhaps an eight year sentence. But the next woman would have 600 grams and be given only six years.”

The length of these sentences made it clear that the courts regarded these women as no different from profit-driven organised criminals, says Heaven. “Even with the long sentences, they weren’t deterred. Jamaica has a population of three million. They have one women’s prison which has a capacity of 280, but there were 600 in British jails. When you

# DrugScope pressure pays off

**The Improving Access to Psychological Therapies programme** (or IAPT) has published guidance on working with people with drug and alcohol problems in partnership with the NTA and DrugScope. This is the culmination of nearly two years of lobbying by DrugScope to improve access to the IAPT programme for people in drug and alcohol services, after members reported that some IAPT services appeared to be operating 'blanket exclusions'.

Previous research has estimated that over three quarters of people in drug and alcohol treatment have mental health problems, most commonly depression and anxiety, and that they can find it extremely difficult to access support through primary mental health services. The IAPT programme was launched by the Labour government in May 2007 to increase access to therapy – with a particular focus on cognitive behavioural therapy or CBT – to treat these conditions. The 2010 Spending Review included a commitment to expand psychological therapies, which is a core theme within the coalition Governments 2011 mental health strategy.

**The guide is available as a 'recommended download' on the IAPT website at [www.iapt.nhs.uk](http://www.iapt.nhs.uk)**

Several recommendations proposed by DrugScope have been taken up the **Sentencing Council** in its new drug offence guidelines.

Despite some media controversy, the guidelines should see custodial sentences for low level drug offences shortened, and the larger emphasis on Drug Rehabilitation Requirements as an alternative to short or moderate length custodial sentences.

The new guidelines also state that people engaged in the importation of drugs by "pressure, influence, intimidation or relatively small reward" should be treated as having a "subordinate role" and limited culpability. However, while this includes 'drug mules,' there are still concerns that despite their subordinate role, sentences may still be lengthy.

## DATE FOR THE DIARY

**The DrugScope Conference 2012** will take place on Tuesday 6 November in central London.

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weigh up the human cost and financial benefit, it did not make sense. And think of the costs to the British prison system. If you work it out, 600 women with five year sentences, at £40,000 per year in prison costs – that totals over a billion pounds. If just two percent of that had gone into raising awareness, they would have eradicated the problem".

Aided by a government grant of £110,000, a fraction of the incarceration costs, Hibiscus started an education campaign to try and dissuade women from getting involved in the drug trade.

"We started with posters and then an animation film and once they saw it, the numbers began to go down. There were always at least two carriers on every flight, sometimes eight or ten. After the campaign it dropped to almost nothing. There are only 21 in prison here now. It was important for these women to see the film, so if they continued to take the risk, they knew what the punishment would be. You cannot punish naivety."



But it wasn't just women from Jamaica. Many women from other countries were and still are coming before the courts, where there has been a lack of consistency on sentencing. "Isleworth Crown Court was reasonable, but not Croydon. When someone got seven years instead of five we didn't have to ask which court, we knew it would be Croydon. We took some judges to Holloway prison. We had a meeting with some inmates, all black women and showed them these small amounts had

only the tiniest impact on drug supply. One judge said if he had a young white European girl to sentence, he would have more empathy with her as he related to her background. Another judge said he thought the reason the woman were carrying drugs was just 'greed'."

Heaven is naturally pleased that, for the first time, sentencing guidelines will include different categories of sentence depending on how significant of the person's role was in the supply chain. However, she is concerned that inconsistency in sentencing still needs to be addressed. The charity's funding situation is equally troubling. "Last month we lost a Ministry of Justice bid for funding of £375,000, which was deeply disappointing and puzzling. We are providing a unique service in the prisons which is cost-saving. I think we have the expertise and that should be recognised."

■ **Jeremy Sare** is a freelance journalist.

# MCAT: 'worst drug I have ever seen'

That's the view of Tim Bingham of the Irish Needle Exchange Forum following publication of his field study into mephedrone injecting undertaken jointly with the Health Sciences Department of Waterford Institute of Technology.

In the UK, mephedrone is usually snorted in powder form and has been regarded as essentially a club drug, but some areas such as Romania, Slovenia and Ireland have reported injecting among established injecting drug users.

According to the study, published in the *International Journal of Drug Policy* the outcomes for these users were devastating. The researchers reported excessive binge injecting over long periods of time, intense paranoia, violent behaviour, the emergence of Parkinson-type spasm and wobbling symptoms; multiple injecting site problems caused by the general toxicity and crystallisation

of the drug. Those studied also reported increased use of heroin to offset the intense rush of mephedrone.

Bingham, who has worked in the field for 15 years says he has never seen anything like it; 'there were people in the group we talked to, all clients from the Ana Liffey Project, that were injecting fifteen or sixteen times a day. One client had been off drugs completely for a year, until she started using mephedrone and we heard reports that some users needed plastic surgery to repair the holes in their arms caused by injecting this stuff. People just didn't seem to care about anything else; they stopped looking after themselves. Those who were HIV positive weren't even picking up their medication'.

The main focus of the problem was a Dublin head shop that was open 24 hours a day and making home deliveries,

so the drug was always available. Anti-legal high legislation stripped the shops of their stocks and they closed down. The researchers followed up with users after mephedrone was banned in Ireland in May 2010 and found that nine out of the eleven original participants had stopped using mephedrone and were pleased that the head shop had been closed down. The now increased price was another factor in reducing use, prompting some users simply to switch to other still-legal stimulant-based products. And there are users who are still injecting mephedrone.

Tim Bingham admits to being ambivalent about just banning everything that comes along. 'I wanted to try and find another way legislatively to deal with the head shops but in this case, he says, 'there really was no other choice'.

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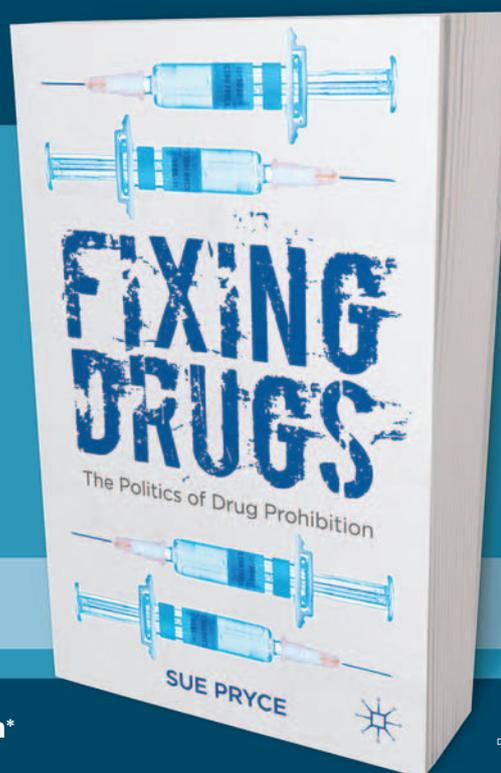
'At the end of the day, policymakers have to ameliorate the harms that both drugs and drug policy can create. They should read this to help them think about which course to steer.'

- Roger Howard, Chief Executive, UKDPC  
(UK Drug Policy Commission)

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# TROUBLE AHEAD? LET'S FACE THE MUSIC AND DANCE!



**Marcus Roberts** on the twin threats posed to drug treatment by the creation of Public Health England and the mantra of localism

It is a bright cold day in April, and the clocks are striking thirteen – not 1984 this time, but April 2013. Following the abolition of the NTA, Skipton House – the tower block in South London that served as the NTA's national headquarters – is being reduced to rubble, Berlin Wall style, by members of the Recovery Concordat and supporters of the Centre for Social Justice and Centre for Policy Studies.

Across the country, local authorities ignite bonfires of red tape and ring fences. The faces of Directors of Public Health (DoPH) are illuminated by the glow, as they dream of innovative

ways of implementing local public health priorities. Other local authority figures have left the celebrations early to reinforce or dismantle their silos, pausing only to cast a jealous glance at the DoPHs' purses, bulging with public health money. If you listen attentively you can hear the gentle sobbing of local authority Chief Executives sitting in darkened offices poring over their 2013-14 financial settlements.

At least, that is one way of picturing the scene. However it plays out, the coming months and years are likely to prove a watershed for our sector,

representing an important opportunity, but also potentially the biggest challenge for a generation. The NTA will be abolished in April 2013, with its responsibilities transferred to Public Health England (PHE) and new public health directors employed by Local Authorities. It is estimated that around £1 billion of current spend on drug and alcohol services will transfer to the public health budget – that is around a quarter of the total amount, and as much as a half of the budget allocated to DoPHs. While the public health budget will be 'ring fenced', the 'pooled

## THERE ARE ONLY A HANDFUL OF PASSING REFERENCES TO DRUGS OR ALCOHOL IN THE WHITE PAPER

treatment budget' will be discontinued, and this money absorbed into the overall public health pot.

What will a 'public health' approach to drug and alcohol services mean in practice? The Global Commission on Drug Policy declared in its 2011 Report that 'drug policies should be based on human rights and public health principles'. The Commission adopts a familiar definition of 'public health' as synonymous with harm minimisation and management. While avoiding the language of 'harm reduction', the Government has recognised its importance. However, it has been at pains to distinguish the 'recovery-orientated approach' of the 2010 Drug Strategy from 'public health' understood as harm management.

So what does it mean by 'public health'? The Department of Health website explains that 'public health is about *helping people to stay healthy and avoid getting ill*, so this includes work on a whole range of policy areas such as immunisation, nutrition, tobacco and alcohol, drugs recovery, sexual health, pregnancy and children's health. It is tempting to append 'spot the odd one out' to this list, because drug and alcohol treatment services are delivering clinical and psycho-social interventions and support for recovery in a way that other areas of public health are not – at least, not in the same way or to the same extent – and they are not primarily about 'helping people to stay healthy and avoid getting ill' as understood in a public health context.

When public health assumes responsibility for commissioning drug and alcohol services there will be a tendency for investment to flow most easily into projects and initiatives that fit with a public health paradigm and mindset – for both better and worse. It was striking that when two leading public health specialists considered the implications of these reforms at DrugScope's 2011 annual conference, one focussed on the history of needle exchanges and the other on the potential to shift more investment 'upstream' for early intervention and wider population initiatives, particularly to address harmful alcohol consumption. But this

transition is not simply about developing 'public health' approaches to drug and alcohol problems, it is about the public health service assuming responsibility for planning and commissioning entire treatment systems to deliver on the ambition for recovery-orientated services set out in the Drug Strategy 2010.

A Chief Executive of a local authority or Director of Public Health reading the Department of Health's *Healthy lives, healthy people* documents, would hardly get the impression that drug and alcohol money will comprise about half of their local budget, or that they are about to assume responsibility for a treatment system that is currently working with over 200,000 adults and around 21,000 young people annually. There are only a handful of passing references to drugs or alcohol in the White Paper, a more recent 'update and way forward' document identifies drug and alcohol treatment as one of 17 responsibilities, and the Public Health Outcomes Framework published in January includes only three drug and alcohol specific indicators out of sixty six.

The public health reforms will also mark a fundamental shift of decision-making and accountability from central to local government. Many will welcome the principle of a more localist approach, including the opportunities to cut down on 'bureaucracy', engage with communities, improve links to other services and work collaboratively. The nominal ring-fence on the pooled treatment budget has supported the expansion of services by harnessing investment to national targets. But it has not always been the sort of fence that you chat to the neighbours over, but sometimes more like the sort of fence covered by 'keep out' signs and constructed to protect a fortification. Centralisation has not always



“THE COMING MONTHS AND YEARS ARE LIKELY TO PROVE A WATERSHED FOR OUR SECTOR, ...POTENTIALLY THE BIGGEST CHALLENGE FOR A GENERATION”

THE CHALLENGE  
IS TO AVOID 'GOING  
TO EXTREMES...  
BETWEEN TRUCULENT  
OPPOSITIONISM AND  
STOICAL MUSTN'T  
GRUMBLISM



incentivised local collaboration or the activity most relevant to local need. We have all heard the stories of DATs preparing Action Plans to address crack cocaine problems, despite having little or no crack use in their local areas.

At the same time, it is hard to dispute the fact that expansion of provision in England has been driven by national targets, (nominally) ring-fenced budgets and the leadership of a special health authority within the NHS – by PSAs, the PtB and the NTA. With Local Authorities managing cuts to their budgets of an eye-watering 28 per cent over the current Spending Review period up to 2014-15, and in the absence of further safeguards, the risks of substantial disinvestment in drug and alcohol treatment are serious. Indeed, it is salutary to note that in 1998 localism was actually perceived as the problem and national leadership as the solution. 'The scope, accessibility and effectiveness of available treatments are inconsistent between localities and

generally insufficient', declared New Labour's first drug strategy, 'there is considerable insecurity about funding and disparity in provision. Consequently, there is rarely immediate access for a drug misuser to a treatment programme – given the urgency of the needs of most drug users, this is unacceptable'.

Where local authorities have control over budgets, the warning signs on disinvestment are already there. DrugScope members report cuts of up to 50% in investment in some areas of young people's treatment, and fear that worse is to come. In 2011, when asked by a DrugScope survey about the impact of the removal of the Supporting People ring fence on housing support for their clients, over half (53 per cent) of respondents said there has been a decrease in SP funding, with many reporting cuts of 25 to 50 per cent.

In addition, the high profile and comparatively large investment in drug treatment under New Labour was primarily driven by its pre-occupation (from the time Tony Blair was Shadow Home Secretary) with community safety and crime reduction combined with emerging evidence that some problem drug users commit a lot of crime. We have no experience in England of delivering drug treatment on anything like the current scale other than through a national approach with targets and nominal ring-fencing, and no experience of persuading politicians (local or national) to invest on anything like this scale except on the basis of fear (in the 1980s of HIV/Aids and from the 1990s of crime).

Perhaps for the first time – beginning under New Labour and continuing under the current government – we are organising our practice and thinking about drug and alcohol treatment increasingly around 'public health' and a concept of 'recovery' which is about hope, not fear. But when the chips are down, will playing to anxieties about crime and community safety be the most reliable way of securing investment locally?

There is nothing wrong with highlighting the contribution to reducing crime and anti-social behaviour, which impacts disproportionately on marginalised families and neighbourhoods (including service users in treatment and recovery). But it would be regrettable to miss the opportunity for a new kind of political discourse. A DrugScope/ICM public opinion poll (February 2009) found that nine out of ten respondents (88 per cent) agreed with the statement that drug treatment

should be available to anyone with an addiction to drugs who is prepared to address it. A UK Drug Policy Commission survey conducted in 2010 found that over two thirds of the public (68 per cent) think that people with drug dependence 'deserve the best possible care' (while observing that this still contrasts with 93 per cent who think the same about those with a mental health problem).

So what lies ahead? There are many uncertainties, particularly when the public health reforms are placed in a wider context. For example, how is the public health outcomes framework related to the eight 'best practice outcomes' for recovery in the Drug Strategy 2010? How exactly will Health and Wellbeing Boards work and what powers will they have? How does 'payment by results' fit in? There is a particular question mark about the relationship between public health and criminal justice. With the elections due in November (except in London where the new arrangement is in force) it is still unclear how Police and Crime Commissioners will contribute to local decision-making on drug and alcohol services. The budget for prison health care has moved from the Ministry of Justice to the Department of Health to encourage an integrated approach to offender management, but the responsibility for prison services will lie locally with offender health under the aegis of the NHS Commissioning Board, and not with public health.

Intellectually, it is important to resist the temptation to think in terms of simplistic polarities; we do not need to choose between 'centralism' and 'localism' or 'health' and 'community safety' – any more than we had to choose between 'harm reduction' and 'abstinence'. On the contrary, the challenge is to avoid 'going to extremes' and to achieve balance – including between truculent oppositionism and stoical mustn't grumblism. Strategically, we need to engage constructively without fluffing or compromising the messages on the dangers of disinvestment, which are real and present. This is a crunch time for the future of drug and alcohol services in England. If the Government keeps to its current course in April 2013 we really will be waking up to a new and transformed environment. Whether hospitable or not (and to what and whom) remains to be seen, and will crucially depend on what we say and do now.

■ **Marcus Roberts** is DrugScope's Director of Policy and Membership.

# Clare Gerada



As Chair of The Royal College of General Practitioners (RCGP), Dr Gerada's spirited opposition to the health bill has won her many plaudits. But while much of her time and energy in the last year has been ploughed into debating NHS privatisation and the 'brave new world' of GP commissioning, it is substance misuse that Dr Gerada describes as her 'passion'. *Druglink* caught up with Dr Gerada, a former DrugScope trustee, to get her take on the substance misuse sector and how she thinks it will fare under the coalition's vision for health and social care. Interview by **Andy McNicoll**

**You have described substance misuse as your passion and as RCGP chair, made it part of your priorities to reduce health inequalities for patient care in 2010 to 2013. How did you first become interested in this field?**

I remember in 1986, when HIV was such an issue, and patients were dying. I started working in a substance misuse job and realised that these patients had no care – other than a bit of specialist addictions support. I wanted desperately to help and I set up a “bare-foot” service in a needle exchange, as a psychiatrist, but providing primary care. Then I moved to general practice in 1992 and continued this. It tapped into everything I thought was right about medicine – disadvantaged health inequalities, kindness and effective treatment.

**How important an issue is substance misuse for GPs?**

It is hugely important, there's no question about that. I have been involved in this area of work for over 20 years and

have seen enormous changes for the better. I think that GPs have been part of the success of the drug strategy in this country. Personally, I love working with drug users. When treating substance misuse you can apply all parts of general practice – social, medical and psychological.

**How big a part do you feel GPs have to play in substance misuse treatment?**

We have a substantial role to play. GPs have helped transform care in this area and deliver thousands of treatment episodes per month. The quality of care is improving. The Royal College's (RCGP) work has made a great difference.

**Can you elaborate on that? How has the RCGP made a 'great difference'?**

The RCGP's introduction of the Certificate in the Management of Drug Misuse in Primary Care in 2004 did a lot to help make substance misuse a legitimate specialism for GPs. We

have trained up over 10,000 GPs in the certificate and most practices now offer substance misuse treatment. When I started in general practice, it was only about five per cent.

**What's your view of the current state of substance misuse treatment in England?**

The number of problem drug users has dropped, but this means that new contracts based on activity are losing income. It means we are losing services and losing skills. We need a core NHS offering, but much has been moved to the third sector. I should acknowledge a conflict of interest here as I do some work with Turning Point. I am worried about this and how it will affect services in the future. Who will do the training of the next generation, who will do research? Who will develop innovative services?

### What should a 'core NHS offering look like' – and what is the problem with relying on the third sector?

I am very worried that we are assuming that third sector is better – but where is the evidence? They may provide some things better, but overall I think NHS provides total care, and the third sector on the whole cannot deal as well with complicated co-morbidity problems.

### How big an impact do you feel the ten year drug strategy had?

It had a massive impact. When I started there were 3,000 drug related deaths per year and HIV was exploding. GPs were not involved in treatment and I got heckled at a conference of Local Medical Committees [bodies that represent local GPs] for suggesting that GPs had a role to play. But now it is the norm. We have problems with alcohol and new drugs emerging, so can't be complacent, but we have made progress.

### Do you feel the Health Bill will improve or harm the current situation with drug and alcohol treatment? How do you feel the removal of the 'ring fence' on drug treatment funding will impact investment?

We have repeatedly voiced our concerns that the bill will widen health inequalities. Beyond that, I am extremely worried that many of those in power think that we shouldn't fund drug services as they regard them as being for the "undeserving sick". It will be one of the areas to be cut and I am very concerned about this. I don't think the same will happen to alcohol – as the issue is so visible and most people drink.

### The RCGP priorities on substance misuse and alcohol

Action must be taken to prevent the harmful effects of alcohol and substance misuse. There should be clearer labeling on all alcoholic drinks, with graphic pictorial warnings. GPs should identify drug misuse before it becomes problematic and be able to intervene effectively.

Source: RCGP Chair Key priorities 2010 to 2013

### What about GPs as providers? Will the purchaser/provider split mean GP commissioners with a specialist interest in substance misuse are prevented from either providing or commissioning drug and alcohol provision on conflict of interest grounds?

I think that those GPs with experience and knowledge of substance misuse should be involved in planning services – it seems silly to exclude the likes of me. We need systems that address conflict of interest, but allow GPs with a specialist interest in substance misuse to be involved in commissioning and provision.

### You set up a service to support doctors with drug and alcohol problems. Why did you set it up and what treatment do you offer?

We established the Practitioner Health Programme in November 2009. I felt it was very important that doctors could get support, as we are often the last people to seek help. Since then we have treated 700 patients. We see doctors with all kinds of substance misuse issues – mainly it's alcohol but also sometimes drugs like opiates, prescription drugs, cocaine. We use a range of treatments, it is a stepped approach. Most patients will be offered detox then abstinence, but we do offer substitute medication for drug users. We use inpatient rehab earlier than the NHS might use it, but I think this is right.

### The recovery debate is central to work in the substance misuse field these days. How do you feel we should define 'recovery'?

Abstinence and the 12-step approach have their place, but it is not the only way. The doctors we work with at PHP are able to abstain, but many drug users are damaged – they have no friendship networks, no support systems. That is why substitute treatments can work. We mustn't assume that treatment has failed because patients are not abstinent.

■ **Andy McNicoll** is a freelance journalist

## CV

**1986 to 1990** – Trains as psychiatrist at Maudsley hospital in London.

**1991** – Becomes practising GP.

**1994** – Appointed GP consultant/leader of Lambeth and Southwark Community Drug and Alcohol Service.

**1998** – Appointed senior medical officer at the Department of Health's public health branch, which includes responsibility for drugs and alcohol.

**2000** – Awarded MBE for services to substance misuse and medicine. Appointed Senior Primary Care Advisor to Department of Health. Becomes member of Advisory Council on the Misuse of Drugs' prescribing subcommittee and committee to review controlled drugs post Shipman. Elected to RCGP Council and becomes lead for drugs and alcohol issues.

**2001** – Appointed Chair of RCGP National Advisory Group for Drug Misuse.

**2002** – Member of NTA working groups on heroin prescribing and education.

**2004** – RCGP launches certificate for management of substance misuse in primary care.

**2007 to 2010** – Elected vice chair of RCGP.

**2009** – Establishes Practitioner Health Programme, a service for doctors with mental health or addiction problems.

**2010** – Elected chair of RCGP.

# The year of living dangerously

Politicians can usually rely on the press to back ‘tough on drugs’ stances. But not always. By Malcolm Dean

In his evidence to the Leveson inquiry into press ethics, former Conservative minister Chris Patten criticised politicians for seeking close relationships with newspaper proprietors saying they had ‘demeaned themselves’ by ‘grovelling’ to the likes of Rupert Murdoch. Arguably, nowhere is this kow-towing more obvious than in the arena of drug policy, and explains much of the reason why most politicians refuse even to engage in the debate about reform, let alone propose changes.

Policy-making is a complex process. I watched it closely for 38 years from a Guardian desk. It’s a tangled mix, of new events, old promises, bureaucratic loyalties, party allegiances, manifesto pledges, pressure group campaigns, think tank and select committee reports, research findings, and legislative cooking time, among other factors. What surprised me during the five years it took me to write my book on the media impact on policy, was the extent of right wing tabloid influence on such emotional social issues as drugs, along with penal and immigration policy, because of the tabloids’ ability to fan public fears and prejudices.

In my recently published book *Democracy Under Attack – how the media distort policy and politics*, the drugs chapter draws a parallel between the influence the tabloid press applies to ministers and the influence Rupert Murdoch applies to his editors. Murdoch does not need to issue daily edicts because his editors know what he wants. Ditto the tabloids and ministers. They know what the tabloids want and too frequently policy is adjusted accordingly.

Just occasionally, however, the politicians get it wrong. In March 2000,

the independent Police Foundation published what became known as the Runciman report, after its Chair, Dame Ruth Runciman. It was the most comprehensive review of drugs legislation for a quarter of a century. Ministers expected the tabloids to treat the report with the vitriol and vilification they traditionally pour over progressive proposals. For once this did not happen.

Ministers were handed a copy of the report at the Home Office on Friday 25 March, three days before its publication on the following Monday. Jack Straw, who was then Home Secretary, informed Ruth Runciman that the government would be unable to introduce its proposals for political reasons. Mo Mowlam, the Drugs Minister, who was also present at the hand-over, did suggest “Don’t you think we should read it first Jack?” Undeterred, Straw and other fellow ministers moved quickly to get their retaliation in first.

There was a run of stories in the Sunday papers rejecting the proposals even before their publication. “Plea for softer drug laws will be thrown out” (*The Sunday Express*), “Drugs hard line stays” (*The Mail on Sunday*), “Government to reject drug law relaxation” (*The Independent on Sunday*). These and other similar press reports were reinforced by Charles Clarke, minister responsible for police matters, on the BBC’s Sunday morning political show, who declared there would be no weakening of penalties because that would “signal taking drugs is OK.”

Following publication, ministers were suddenly thrown onto the back foot. *The Express* noted that ministerial “knee jerk reactions won’t help the police”; *The Mirror* insisted the proposals should be “discussed intelligently and with an

open mind” as did *The Evening Standard*; while *The Daily Mail*, which placed an extract from its editorial in the middle of its front page declaring that “despite this paper’s instinctive reservations over a more relaxed approach to drugs, we believe the issue deserves mature and rational debate.” Most astonishing of all was the response of *The Telegraph*. In an extraordinary editorial, given its previously hard line approach, it proclaimed: “We are moving reluctantly to the view that Dame Runciman is asking the right questions.” In fact the paper went further than the report suggesting the government should draw up plans to legalise cannabis on an experimental basis.

What to do in the face of this unexpected burst of media liberalism? Government spin doctors changed tack, suggesting ministers were taking the report seriously. Jack Straw told *The Observer* there was “a borderline case” for softening the law on ecstasy, but in a column in the hard line *News of the World* on the same day, he declared there would be no reclassification of cannabis.

What prompted the media’s change of tone? *The Express* was not a surprise. Rosie Boycott, who in her days at *The Independent on Sunday* had campaigned for the decriminalisation of cannabis, had become *Express* Editor. *The Guardian* interviewed Charles Moore, editor of *The Daily Telegraph*, on his switch. He explained: “We are making criminals of hundreds of thousands of people even though they are not particularly wicked.” As it happened, Dame Runciman sat on the Press Complaints Commission on which Paul Dacre, editor-in-chief of the *Mail* papers was also a member. He had many opportunities to see how well



informed and intelligent she was. He is known to be influenced by the people he meets. The message went out that the report should be treated seriously. The facts that it set out clearly showed the current policy was not working. A country with some of the toughest drugs laws of any developed state had the highest proportion of drug users. The analysis was accepted, but not the proposals.

That year, the media delivered another unexpected whammy to politicians over tough talk on drugs. At the annual Conservative Party conference, Ann Widdecombe, imagining she was playing to receptive media ears, declared that people caught in possession of cannabis a second time, no matter how small an amount, should be sent to prison. There would be no cautions or “hiding places” for such people. The media quickly discovered the police had not even been asked whether this was workable. And *The Mail on Sunday* followed up with an exclusive survey revealing that seven shadow cabinet ministers had tried cannabis in their youth. *The Guardian* headline summed up the media coverage: “How Tory drug policy went up in smoke.”

However, anybody who imagined that these examples heralded a sea-change in media reporting on drugs at the dawn of the new millennium would have been sorely disappointed. Tabloid coverage of drugs is generally dire. As a special issue of *Druglink* on media coverage noted in 2006, even the General Secretary of the National Union of Journalists, Jeremy Dear, was critical: “...all too often the nature of the reporting on drug-related issues is superficial, relies on stereotypes and scare stories.” Or, as Roy Greenslade,

MOST ASTONISHING OF ALL WAS THE RESPONSE OF THE TELEGRAPH. IN AN EXTRAORDINARY EDITORIAL, ...IT PROCLAIMED: “WE ARE MOVING RELUCTANTLY TO THE VIEW THAT [DAME RUTH] RUNCIMAN IS ASKING THE RIGHT QUESTIONS.”

formerly of *The Sun*, *The Mirror* and now chief media commentator for *Guardian Online*, wrote in the same issue of *Druglink*: “what the media tend to achieve, however, is surely the opposite of their proclaimed intention. Rather than turn young people away from drugs, it entices them. Both the act of drug-taking and the fact that it is done illicitly is glamourised. Instead of turning people away from drugs and crime, it reinforces their desire to mimic the famous.”

Worse still is the degree to which in general, the media prevent a serious discussion of drugs by its eagerness to demonise the users. As the Royal Society of Arts Commission on Illegal Drugs, Communities and Public Policy, which reported in 2007, noted: “Demons are diabolical, evil spirits and are therefore to be slain. In our view, using such language and thinking in such terms is childish, if not mediaeval. It stifles national and realistic debate and makes it harder, not easier, to deal with the very serious matters at hand.”

Ironically, much media coverage runs

counter to public opinion as recorded by the polls. A survey for the Runciman commission found only 0.5% of people thought action against cannabis should be a police priority. As long ago as 1994, a MORI poll found 80 per cent of the public wanting a more relaxed approach to the control of cannabis.

It is my contention that the media is more at fault than the politicians for the failure to modernise our drug laws. True, a succession of politicians from both major parties have reverted to tough hard line rhetoric in the hope of currying favour with the electorate. True, the politicians should have been more ready to stand up to the tabloids and to recognise that the papers do not entirely reflect public opinion. The public are ready to accept more progressive policies. They do not want to see their children being given criminal records. But it is the media that has prevented a serious public debate taking place on our outdated legislation.

Runciman concluded after its exhaustive survey that the 1971 Act passed to categorise drugs by harmfulness no longer reflected modern scientific, medical or sociological evidence. Twelve years ago the media accepted this message, but then forgot about it. The fault lines set out in 2000 are still as relevant in 2012 some 41 years after the passage of the 1971 Act. It is time that *The Mail* and *The Telegraph* remembered their earlier editorials and acted on them.

■ **Malcolm Dean** spent 38 years working for *The Guardian*. His book, *Democracy Under Attack – how the media distort policy and politics* is published by the Policy Press.



# BEG TO DIFFER

After chairing a debate last year between Stanton Peele and Neil McKeganey, **Mike Ashton** concludes that the evidence-base cannot settle the harm reduction/abstinence argument.

In September 2011, a debate took place in Glasgow between two well-known and controversial personalities in the addictions field; the American psychologist Professor Stanton Peele and the Scottish sociologist Professor Neil McKeganey. The event was refreshing in many ways, but most of all in two interlinked aspects; first, the explicit

acknowledgement of the role of values in drug policy; and second, that this means the distinction between harm reduction and abstinence-oriented approaches can neither be eliminated by good intentions nor resolved by evidence; it is a matter of values – what matters most to the person making those judgements.

Rather than being complementary,

these philosophies stem from profoundly different moral positions and ways of thinking. The values which promote harm reduction above competing objectives will remain unmoved by criticisms made from an alien values base, and vice versa, the values which generate an abstinence orientation will be immune to appeals from a value base

they may not simply disagree with, but find abhorrent.

Instead of (as some formulations have it) being morally neutral, reducing harm has an obvious values base in the preservation of life and health as ultimate priorities. But even within a harm reduction context, there remains the issue of which/whose harms matter most and should be targeted. Beyond harm reduction are competing strategic and moral positions, such as freedom of the individual (even if that allows self-harm), zero tolerance of crime and illegal drug use, and recovery/abstinence agendas, within which some degree of harmful side effects might be seen as worth enduring in the service of a greater good – perhaps even an instrument in achieving that good.

Still further out is the elephant in the room of cost-benefit calculations – the fact that at least the users feel they get something of value from their substance use, something they are willing to pay for financially and in a degree of risk and some actual harm. But even if drug-taking truly did add to the sum of human pleasure, for abstinence-oriented thinkers, seeking pleasure or solace in these ways is reprehensible, while for harm reductionists, it is irrelevant except as an obstacle to harm reducing patterns of use.

Underpinning an insistence on abstinence is among some a visceral reaction to certain forms of drug use. For many people these are, as Kathy Gyngell, put it, simply “unpalatable”, a contrast to the appeal of a ‘clean’ life without drugs. Such a life for oneself and for others is worth possibly dying for: “This is what former addict Steve Spiegel and long time CEO of the ground breaking Providence Projects commented on the issue, ‘I ask myself this question, if there had been legal shooting galleries with free heroin in the UK years ago would I have ever got clean and sober? The answer to that is a categorical no’.”

The contradiction between the approaches is exemplified in the presumption that dependent substance users must hit ‘rock bottom’ (ie, experience extreme harm) before they really see the need to stop using. It legitimises strategies which at the least do not try to stop this happening (from this perspective, such efforts are denigrated as ‘enabling’), through to promoting it by imprisonment and the withdrawal of housing, employment, respect and family support.

‘Hassle’ from the uncomfortable and

risky life forced on illegal drug users by conventional enforcement is commonly cited as a reason for ‘early retirement’ and treatment entry, driving dependent users towards a possible route to stopping using. Evidence that such strategies risk harm could be met by the answer that risking harm is precisely the intention in order to promote abstinence. From this perspective, making (especially illegal) drug use safer/less harmful is questionable because it is seen as making it easier to start and stay using drugs – and using drugs is in itself ‘bad’.

## THE DISTINCTION BETWEEN HARM REDUCTION AND ABSTINENCE-ORIENTED APPROACHES CAN NEITHER BE ELIMINATED BY GOOD INTENTIONS NOR RESOLVED BY EVIDENCE

Professor McKeganey has highlighted the values issue in his analysis of research on the treatment of heroin and cocaine users at a primary care practice in Scotland, in particular in his analysis of the role of methadone maintenance – as he sees it, “one of the central planks of harm reduction oriented drug treatment”. The study found being in methadone treatment and being in it for longer associated both with saving lives and with longer injecting careers. If both are accepted as caused by and not just linked to methadone, the dilemma becomes, should we save lives by getting more people in methadone treatment for longer, or should we sacrifice some in the quest for an end to injecting drug use? Just how sharp this dilemma might be is revealed in the paper’s estimate that “for patients who do not start opiate substitution treatment (unexposed), a quarter will be dead within 25 years of their first injection compared with 6% of those with more than five cumulative years of exposure to opiate substitution treatment”.

Evidence cannot resolve such dilemmas – it comes down to what to you is most important – but it can

cast light on the degree to which they are real or imaginary. In fact the paper cannot show whether either outcome was caused by the treatment and the wider evidence base, while supportive of methadone’s lifesaving potential, either does not address the issue of whether it extends addiction careers, or finds that it does not do so; it might, but we simply do not have enough of the right kind of data to conclude securely one way or the other.

When such deep-seated values drive debate and research the reader and listener must expect some glossing over and selectivity in the facts. So in the debate Professor Peele supported his argument by asking the audience how many had overcome their dependence on tobacco on their own, but did not ask how many managed to do so through moderation rather than abstinence. The answer to the former question supported his contention that addiction can be resolved without treatment; the latter was at odds with his emphasis on moderation.

In a paper following up on the debate Professor McKeganey cited research in England to undermine one of harm reduction’s “three core assumptions”: “That there is very little prospect of recovery from dependent drug use”. It showed that even in respect of heroin, the archetypal drug of addiction, 37% of heroin dependent clients were abstinent from that drug at their last treatment review. What he does not stress is that all these patients were still in treatment and for over 80% this was opiate substitution treatment. In other words, the vast majority were being prescribed methadone or other opiate substitutes so were almost certainly still dependent on opiate-type drugs. If that was not the case, then the success he alludes to was largely success for what he sees as the leading harm reduction treatment.

Only in challenge and debate can we get the facts straight about whether A or B causes more of C or D, but no matter how straight we get them, if for one person 100 Cs is worth 1 D, or vice versa, the facts are unlikely to settle the argument about whether A or B is the preferable policy. In making this clear and dispelling the comforting illusion that “We all want the same things in the end, don’t we?” Neil McKeganey and Stanton Peele did us all a service as they crossed swords in Scotland.

■ **Mike Ashton** is the editor of Drug and Alcohol Findings

# Ten years on

Back in 2001, Colin Brewer made some predictions in *Druglink* about future developments for medical treatment. So what happened?

A decade ago, I began my article by considering vaccines that could be tailor-made to block the effects of most misused drugs. Encouraging studies of cocaine and nicotine vaccines had already been presented at conferences and it seemed reasonable to hope that something would soon be commercially available. I underestimated the time it takes to bring new compounds through animal studies and clinical trials to pharmacies and patients. Nicotine vaccines may be available soon, but cocaine vaccines, though promising, are probably several years away.

The way that anti-drug vaccines work is easy to understand. They produce antibodies that block or neutralise the drugs in question. If antibody levels are high enough, blocking effects can last for years, or even decades, as with vaccines against infectious diseases.

More interesting, in some ways, is research on vaccines to block opiates, because while cocaine and nicotine are unique substances in their class, many chemically distinct substances produce opiate effects. Heroin, methadone, codeine, buprenorphine and oxycodone are all opiates (or, technically, opioids if they are synthetic) but have different molecular structures.

So a vaccine could, for example, block all opiates/opioids except buprenorphine or methadone. This would refine maintenance treatment, so that only prescribed opiates had their normal effect while other commonly misused opiates had none. Furthermore, specialised opiates, too short-acting to interest drug users, could still be effective for emergency pain relief.

In my 2001 article, I also noted that since the mid-1990s, there had existed “crude but effective, implants of

naltrexone (NTX) which seem to provide adequate blood levels for 5-6 weeks on average.” I suggested that these “solve the problem of compliance and make supervision unnecessary”, concluding that “this means that for the first time in the history of addiction treatment, it is possible to give almost a guarantee that a patient who has been withdrawn from opiates cannot relapse to opiate use for at least a month afterwards...just when a high proportion of relapses occur.”

A SURPRISING SPIN-OFF IS THE INCREASING NUMBER OF REHABS IN THE USA (EVEN 12-STEP ONES) THAT USE NTX [FOR]... OPIATE MISUSE AND ALSO MEDICATIONS FOR ALCOHOLISM

In this area, there has been considerable progress. An implant that can block very large doses of opiates for around six months has been extensively tested. Randomised placebo-controlled trials (the ‘gold standard’ of evidence) confirm that patients do significantly better when it is added to conventional treatment programmes. These long-acting implants prevent many of the lethal heroin overdoses (often accidental rather than suicidal) that are recognised risks of conventional abstinence-based treatment, in which relapse is common. When tolerance is lost, unintentional opiate overdose is all too easy.

For mainly bureaucratic reasons

similar to those that delayed the nicotine vaccines, most NTX implants are still unlicensed, except in Russia where methadone maintenance is illegal and NTX is the only pharmacological treatment allowed. However, a depot (or longer-acting) NTX injection, Vivitrol, is now licensed for treating opiate dependence in America. It is relatively short-acting (4-5 weeks) and still rather expensive, though cheaper than even one week in the average rehab. Interest in depot and implanted NTX is increasing in the UK, now that fashion’s pendulum has swung from indefinite methadone maintenance for as many people as possible, to suggestions of time limits and more emphasis on ‘recovery’. This is often taken simply to mean abstinence, though of course, there is more to recovery than simply getting off drugs. Though addiction treatment is particularly prone to short-lived enthusiasms and ideological diktats, this partial reversal is not something I would have predicted.

Ten years ago, the British addiction establishment had only just reversed nearly two decades of anti-methadone rhetoric. GPs, having been told for years that methadone was evil and un-British, were understandably reluctant to prescribe adequate doses. Many still are. As one of the very few British clinicians who both advocated and provided methadone maintenance in the 1980s and 90s, I naturally welcomed their belated conversion. However, I also sympathise with the ‘recovery’ lobby, because far too many heroin users, especially young ones with a short history of dependence, were offered only methadone or buprenorphine by drug teams, without any real alternative choices.

Professor Neil McKeganey is right to highlight research showing that many treatment-seeking users claim to be very interested in abstinence, at least from their main drug, although one of his co-authors has subsequently suggested that such claims do not always survive more detailed questioning. Furthermore, people do not always want to be abstinent from all intoxicants, as the 12-step doctrine requires. However, our consistent experience has been that even when opiate maintenance is on the treatment menu, there is no shortage of people who genuinely want to become lastingly opiate-free. They deserve more help to reach and maintain that goal, especially opiate withdrawal programmes with good symptom-relief and much higher in-patient completion rates than the 27 per cent obliquely reported by the National Addiction Centre, whose abstinence rates one month after in-patient detox have recently been reported at an even more depressing 11 per cent. As the only British clinic that offered both methadone maintenance and NTX implant-assisted abstinence, facilitated where necessary by withdrawal under sedation, the Stapleford Centre helped many more people to come off opiates than it started on methadone or buprenorphine when it had ready access to in-patient facilities. Unfortunately, most private hospitals disliked our short (1–5 days) in-patient stays because conventional 28-day admissions make much more profit for them.

Another important development is the belated acceptance that disulfiram (DSF, Antabuse) is not only effective in alcohol treatment but more effective than alternatives, such as acamprostate. Like oral NTX, DSF needs to be supervised as part of a treatment programme but since its deterrent effects can last for several days between doses, that is not usually an insuperable problem. As with NTX in opiate abuse, the idea of adding DSF to the treatment package (out-patient or residential) is that both drugs make it more likely that patients will avoid succumbing to temptation for long enough for new, intoxicant-free habits of thought and behaviour to become routine. NTX implants make it easy to walk past your dealer without buying stuff. DSF makes it easy to walk past the pub, or stick to orange juice. Effective DSF implants would be nice but they do not exist as yet.

A surprising spin-off is the increasing number of rehabs in the USA (even 12-step ones) that use NTX during and

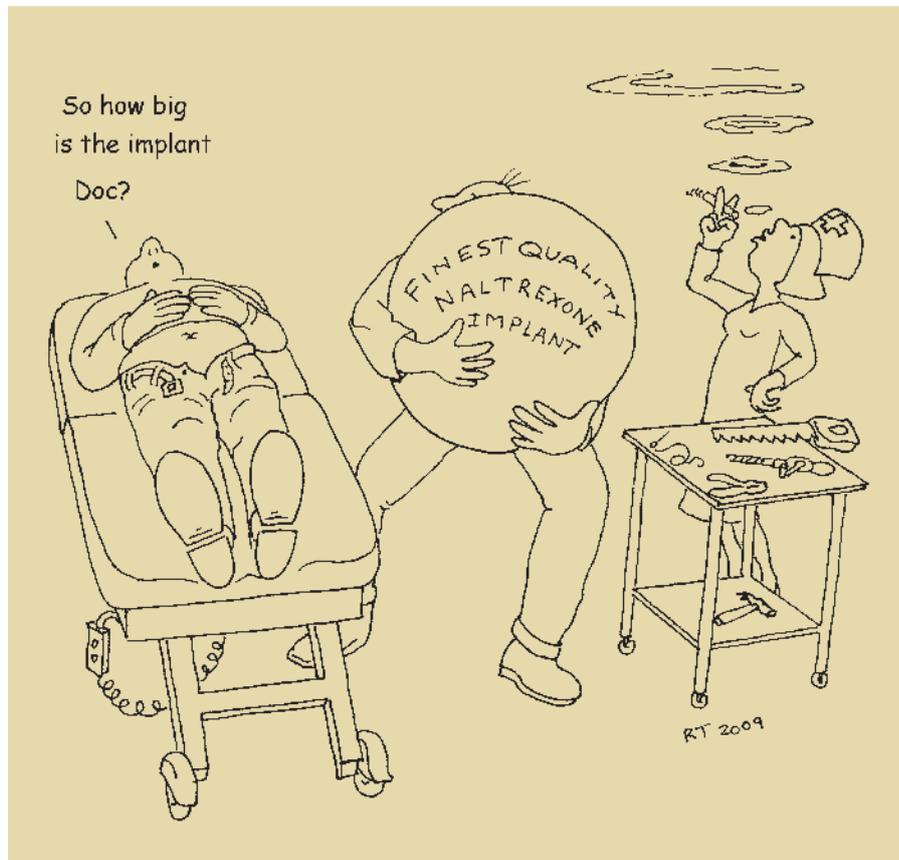


ILLUSTRATION: RON TOVEY

after residential care for opiate misuse and also medications for alcoholism. Until very recently, being 12-step meant visceral, ideological opposition to using any medication but this is clearly changing, though slowly in some quarters. Allegedly, the famous Betty Ford Clinic in California cannot yet bring itself to use Vivitrol officially, but allows residents to get unofficial injections from local physicians. Some residential rehabs even permit people to stay on long-term opiate maintenance, which seems both sensible and humane. Many users need and want the stability and discipline that good rehabs can provide, but just can't cope with prolonged withdrawal symptoms that may be determined more by their genes than their personality.

Finally, I predicted that 'Withdrawal technology will also improve...For opiates and for benzodiazepines,...conventional withdrawal programmes are lengthy and have a low success rate...It is possible that by using benzodiazepine antagonists [as with NTX for rapid opiate withdrawal] the frequently prolonged withdrawal from benzodiazepines can also be greatly shortened.' That 'possibility' is now a reality, routinely performed in at least two Australian centres and in Italy, even for patients taking fistfuls of Valium daily and with

remarkably little discomfort or insomnia.

One thing I'm glad I didn't predict was that great advances in treatment would surely result from all that clever brain research that so regularly features as lovely technicolour brain scans in the media. As Professor John Davies pointed out in a recent *Druglink* review, very little that is of relevance to the actual treatment of addiction has come of this research so far. Fortunately, explaining the effectiveness of NTX and DSF does not require the involvement of specific 'craving' or 'reward' pathways in the brain. It simply involves understanding and reinforcement of the re-educational process that the term 'recovery' implies. Many people co-exist reasonably happily with some sort of 'addiction' and by definition, they do not ask for help. However, unwanted addictions are, by the user's own definition, Bad Habits. Recovery means replacing them with Good Habits, whether spontaneously or following treatment. Unwanted pregnancy can be a disaster but though pharmaceutical treatment and prevention are very effective, it isn't a 'womb disease', any more than unwanted addiction is a 'brain disease'

■ **Dr Colin Brewer** is Research Director of the Stapleford Centre, London.



# M&S

Not just any drugs for detox, but Methadone and Subutex. New research highlights their equal effectiveness but also the need for more detox programmes in prison.

By Laura Sheard, Charlotte Tompkins and Nat Wright

Many drug users will at some point end up being sent to prison. Up to 80% of offenders who are sent to prison in the UK test positive for class A drugs on arrival, primarily heroin. Offenders are medically assessed at the start of their prison sentence and typically are offered an opiate maintenance or detoxification programme. However, since 2007, when offenders were able to carry on a maintenance script they received in the community, many have chosen to do this. The result is that detox programmes have, to some extent, become sidelined.

A variety of different detox drugs have been used to help users come off opiates, such as dihydrocodeine (DF-118), methadone, buprenorphine (Subutex), lofexidine and clonidine. But since about 2005, the main two drugs which prison doctors prescribe for detoxification from opiates are methadone and Subutex. It is the decision of the individual doctor as to which detox drug they prescribe, taking into account patient preference, but more usually the choice will depend on which drug the prison generally uses

for detox purposes. However, given the number of prison detoxes still carried out, there is surprisingly no clinical evidence showing which detox drug is most effective.

We decided to conduct a research study, the first of its kind in recent years. The randomised controlled trial was called LEEDS (Leeds Evaluation of Efficacy of Detoxification Study). Three category B prisons, all in the North of England took part in providing a total of 289 prisoners for the study. To be involved in the trial, prisoners had to be using street opiates; want to detoxify and remain abstinent; give informed consent and be expecting to remain in prison custody for at least 28 days. The patients, doctors and the prisoners' drugs workers all knew which detox drug the patient had been randomised to and there were no placebos. The detox was usually twenty days long, with drug doses each day being the same as any other detox in the prison outside the study.

We wanted to know if prisoners were

drug free after receiving their prescribed detox and importantly, which of the two drugs appeared to be better at helping prisoners get drug free. The main test was whether prisoners had got off heroin eight days after they had stopped taking their detox medication. We confirmed this by asking them to provide a urine sample for drug testing. If prisoners had been released and we weren't able to get a urine sample from them, we had been given their permission to look at their medical notes at local drugs services to see if they were drug free. We were also interested in whether prisoners who took part in the trial were abstinent from heroin at one, three and six months after they had finished the prison detox and we recorded the outcome of this, where possible. We also recorded details about people's previous everyday drug use such as how much money they spent on drugs, how long they had been using or previously abstinent and whether they smoked or injected.

So what did we find? There was no difference between the effectiveness

of methadone and Subutex at any of the time intervals we collected data for. Instead, we found that being drug free was associated with whether or not the participant was still in prison and whether the participant was abstinent earlier in the trial monitoring period. At eight days after the detox, those still in prison were 15 times more likely to be abstinent than those who had been released. We also found that one month after the detox had ended, prisoners who were abstinent at eight days were 4.5 times more likely to remain abstinent than those who were not. So what are the implications for practice?

Firstly, we know from research that some prisoners prescribed Subutex for detox will swap or sell their tablets with other inmates for street drugs or cash. Although methadone is traded in prison, this is less likely to happen than with Subutex, so in prisons where Subutex diversion is a problem, we would recommend that methadone is prescribed instead.

Secondly, the key factor in achieving abstinence is residence in prison. We recommend that prison healthcare staff are supported to offer detox programmes to users who want to get off drugs. Such programmes should be offered with support to prevent relapse and the user should be informed that release from prison is a significant time for relapse.

Also the chances that a prisoner will stay abstinent for any considerable

## DETOX SHOULD ONLY BE UNDERTAKEN WHEN PRISONERS' CARE CAN BE HANDED OVER TO COMMUNITY SERVICES UPON RELEASE TO ENSURE CONTINUITY OF TREATMENT

length of time are strongly associated with whether they managed to become drug free earlier in the monitoring period. If they were drug free at eight days after detox, they were much more likely to be clear of drugs at one month compared to other prisoners who had relapsed. We recommend that drug users should receive intensive support during their period of detox and the period following this, in order to optimise their chances of achieving lasting abstinence.

None of the details regarding prisoners' previous drug use were related to whether people were abstinent or not. Whether people smoked or injected, spent a little or a lot of money on heroin each day and whether they had previously managed to get off drugs for any considerable length of time or had never been able to, none of these factors increased or decreased their chances of becoming abstinent. So finally we also

recommend that patients should not be discouraged from entering a detox based on current or past drug history or previous detox success. Our results show that historical detox success was not related to current detox success in the prison.

There has recently been widespread introduction of opiate maintenance programmes into UK prisons to achieve equivalence with drug treatment standards in the community. While this is important, prisoners who express preference for detox should be supported in their choice, where possible. However, detox should only be undertaken when prisoners' care can be handed over to community services upon release to ensure continuity of treatment. The period immediately after release is a high risk time for drug users to relapse and there is a high risk of death for prisoners who have undergone detox in prison and then used street drugs upon release. To minimise this, there needs to be strong co-working between prison and community drug treatment services. People who have achieved abstinence should be put in contact with community services who provide support to prevent relapse.

**The results of this study were first published in the *British Journal of General Practice*. For further details of the study contact Laura Sheard at [laura.sheard@york.ac.uk](mailto:laura.sheard@york.ac.uk).**

### CASE STUDY ONE

'John' was 34 and had been using heroin for 10 years, smoking £50 worth of the drug every day. When he came into the prison, he tested positive for heroin, cocaine and benzodiazepines. He had never had a detox previously and had never managed to get off drugs. John was prescribed Subutex. He finished the detox and gave a urine sample. His urine was negative for opiates – John had got off heroin. However, his sample tested positive for Subutex and benzodiazepines, received from other inmates. One month after the detox, John was still in prison. This time, his urine sample was positive for opiates. John had started using heroin again sometime in the previous three weeks. He was also still using Subutex that wasn't prescribed to him. John was released shortly afterwards. From this point onwards, the researchers weren't able to record any more information about him. Over the next

three years, he never accessed any community drug services or the Drug Intervention Programme (DIP) in the area he lived or came back into the same prison where he entered the trial.

### CASE STUDY TWO

'Jamie' was 37. When he came into prison, he tested positive for heroin, cocaine and benzodiazepines. He had tried to detox in prison before with methadone but this had not worked. He had been using heroin for 15 years and was smoking £80 worth of the drug every day. Jamie was randomised to methadone. His urine sample was positive for heroin and cocaine after his detox had finished. He had not managed to get off drugs. One month later, his urine sample showed that he was still using heroin although the test came back negative for cocaine. The test was repeated three months later and showed the same result. Jamie was released shortly after but returned

to prison towards the end of 2008. A researcher asked him if he had been drug free or was still using, around the date of his six month follow up (June 2008). Jamie was still using heroin at that point in time. He had not managed to get off drugs during the six months he was involved in the trial.

### CASE STUDY THREE

'Ian', aged 25, had been using heroin for 10 years and was injecting £70 worth of the drug every day. Previously, he'd had a Subutex detox in the community but hadn't managed to get off drugs. The longest period that he'd been drug free was six months. Ian was randomised to methadone. After the detox, his urine sample was negative for all drugs. Ian was in the prison throughout the whole of the trial and he provided urine samples at one, three and six months after the detox. They were all negative for opiates – he had stayed off heroin over that time.



# Moroccan 'roll

There are official claims that Morocco's days as a leading exporter of hashish are over. But do such claims stand up to scrutiny? By Adrian Gattou

LAURENT LANIÉL

In recent years Casablanca, Morocco's heaving commercial capital, has taken on a new buzz – with exclusive boutiques, shops and cafes springing up. In 2008, an inquisitive US embassy official was in conversation with one of his sources. How is all this funded, he asked? “We have dirty money,” the source told Douglas Greene, “The problem is we don't know how much.”

In a secret cable, Greene cited the State Department's own International Narcotics Control Strategy Report (INCSR): “Morocco is the world's biggest producer of cannabis resin (hashish) and is consistently ranked among the world's largest producers of cannabis.” Might this be an explanation for Casa's new-found glow?

The report put Morocco's annual drug trade, mostly to Europe, at \$13bn: more than twice Morocco's earnings from tourism. Greene observed that some of these drug profits poured into Casablanca where they got blown on

“jewellery, cars, houses and other items”, or “laundered”, he added. Sure, there was a lot of legitimate wealth, but also “some tough-to-track, but significant, negative elements such as drug-trafficking”. One finance professional Greene was acquainted with joked that indeed “money laundering creates a nice café culture in Casablanca”.

Greene's cable of 23 May 2008 highlights a question about Morocco: has it got to grips with its drug trade or not? Since 2003 the government has been waging a war on kif, a campaign known as *el hamla* (“the raid”). There are signs it is working, but agencies like the United Nations Office on Drugs and Crime (UNODC) are waiting for definitive proof.

Two hundred miles north of Casa in the Rif Mountains, near Morocco's northern tip, is the frontline in this largely unreported war. In these mountains, most farmers growing the crops only scratch out a living, while traffickers make the real money.

29 June 2010 is a black day the villagers of Beni Ahmed Charquia won't forget. One farmer, ‘Zakaria’, woke up to a deafening noise. He rushed out and saw a helicopter buzzing up and down his valley “nose diving” the crops, and spraying a white powder. He collapsed in shock. “Green gold” withered under the effects of the chemical powder, and with it so did the livelihoods of many otherwise hard-up locals. The incident is a striking testament to the war on drugs: one local captured it on video camera and posted it on YouTube.

Helicopters rain down herbicide from the sky. Meanwhile, fanning out across the Rif below are ‘destruction brigades’, men harnessed with heavy portable tanks squirting a dark green herbicide called Gramoxon. Often old-fashioned methods will do: sickles, chainsaws and tractors hack down the Rif's abundant cannabis fields.

By September 2010 the province of Larache was declared officially “hash

free". So the government set to work in nearby Taounate (the second of five Rif cannabis provinces in their sights).

Perhaps the moment when Morocco's cannabis farmers were doomed was in 2003, when staff from the UNODC in Vienna arrived in the kingdom and set up their office in Rabat (sanctioned by the Moroccan authorities). A mix of highly-accomplished agronomists and satellite imagery specialists set to work, employing commercial spy satellites, like SPOT 5 and IKONOS orbiting 500 miles above the Rif, and combined with staff working on the ground, they built up a comprehensive picture of Morocco's cannabis trade.

The UNODC's Morocco Cannabis Survey of December 2003 was the result, a landmark report that for the first time offered indisputable, officially gathered evidence of the scale of Morocco's cannabis production. Its conclusions were astonishing: an area the size of Los Angeles, 135,000 hectares, was under cannabis cultivation.

Now Antonio Maria Costa, the UNODC's boss spelled out the problem: "A quarter of the agricultural land in the Rif region is now occupied by an expanding cannabis cultivation"; "two-thirds" of the rural population were dependent on cannabis (or 800,000 people). He feared an environmental and, in the long term, social disaster. Informed observers say that the Moroccan government never expected the UNODC to publish figures on this scale. Hitherto the kingdom had played down the scale of the growing zone. This posed a problem.

In the 1990s, Morocco's King Hassan II had launched crackdowns on the hash trade, yet each year only brought bigger harvests. But 9/11 was the game-changer. The War on Terror had spotlighted the links between the drugs trade and terrorism: Casablanca was hit by suicide bombers in 2003; when 191 people died in the Madrid train bombings of 2004, the gang of Moroccan bombers had financed the job from profits from their hashish racket.

The *el hamla* crackdown began. In 2006 Abdelaziz Izzou, the high-ranking security chief in the royal palace itself, was arrested, according to press reports and US cables monitoring the operation. In September 2009, a former MP, Mohammed Jouahi, "considered to be among the biggest and most powerful of the drug barons" was arrested. Traffickers fell like toy soldiers: in January 2009

## 'WHATEVER CLAIMS MOROCCO IS MAKING ABOUT ERADICATION, SEIZURE STATISTICS TELL ANOTHER STORY'

Nador speedboat operator Mohammed Lghani, was arrested and his confession led, in a few days, to 80 more arrests, including officers from the Royal Navy, gendarmerie and army. Hundreds of speedboats were seized, even a plane. In 2009, 27,226 individuals were arrested for drug related offences.

The US State Department seemed impressed. Morocco was "serious". The government wanted to change its "negative image as the world's largest producer of hashish," reported a February 2009 cable (later disclosed by Wikileaks).

Another US cable, from October 2009, revealed just how optimistic Moroccan officials were about *el hamla*: "The Moroccan Ministry of Interior (MOI) has the goal to reduce cannabis cultivation to 12,000 ha by 2012. If this goal is accomplished, it will mean that Morocco will have reduced cannabis cultivation by 91% since it first started serious eradication efforts in 2003, according to the GOM." In 2009 the government reported to the UNODC a drop in cannabis production to 52,000 ha. Compare these figures to the 2003 findings of the UNODC. In this version, Morocco, clearly, was no Colombia in terms of having an intractable problem.

But given this apparently extraordinary progress, there is an abiding mystery that puzzles experts. Why won't Morocco allow the UNODC to return to the country to verify this incredible success story?

UNODC was last involved in survey work in 2005, when Coen Bussink, a specialist on 'remote sensing', worked in Morocco updating the 2003 report. He told *Druglink*: "In 2005 there was a severe drought which affected the area cultivated and the yields, and yes this [fall] was dramatic." Cultivation dropped 40% to 72,500 hectares, thus getting closer to Morocco's 2009 figure.

Dr Kenza Afsahi, who did her PhD on the Moroccan kif industry and worked on the 2003 UNODC report, did fieldwork in Morocco as recently as 2010. According to a 2011 paper she wrote, eradication has been "fierce" and cannabis faces the stark possibility of being "brutally

eliminated". She paints 2003 as an historic peak in production, a "golden age" that is now gone.

But her informal observations await formal confirmation by a new UNODC report. "The Moroccan Government says that they used satellite images and ground information to come to these [2009] figures," says Coen Bussink. "However, UNODC hasn't received any technical report on the method and the results, so we cannot say whether it is true or not."

Bussink added that the UNODC wants to go back: "But the Moroccan Government has never come to a real commitment to conduct another survey." There are not even discussions, he added.

The UNODC's frustration is reflected in the 2010 International Narcotics Control Board's (INCB) report, which noted Morocco's lack of co-operation with "regret" and urged it to conduct a fresh survey "as soon as possible".

Whatever claims Morocco is making about eradication, seizure statistics tell another story: "Seizures data suggests that Morocco continues to be a major producer of cannabis resin, since the majority of countries still mention Morocco as a source," says Coen Bussink. "Data on seizures and prices in Europe suggest that the supply of cannabis resin from Morocco has remained the same or slightly decreased."

Dr Gary Potter of London South Bank University, editor of the recent book *World Wide Weed*, which covers Morocco, says: "Morocco still remains the key provider of hashish to Western Europe – but with more and more of the cannabis market in many of these countries being taken over by domestic cultivation, there has been a decline in demand for Moroccan hash." A 2008 paper by Dr Potter suggested that as much as 60% of the UK's cannabis could be homegrown.

It seems that whatever the outcome of Morocco's drugs war, the market has moved on. "The UN claims that cannabis cultivation reduction efforts in Morocco have been moderately successful," adds Dr Potter. "More likely, cultivation in Morocco has declined in reflection to the changing market in Western Europe."

And as one former senior SOCA officer warned *Druglink*, cocaine imported mostly via West Africa and snaking its way up north in routes that include Morocco is now the real worry.

■ **Adrian Gatton** is a freelance journalist.

# THE ACID KING

Without the little-known éminence grise of LSD, Owsley Stanley III, 'the sixties' might never have happened. By Andy Roberts

On March 12, 2011, a 76-year old man drove his car into a ditch, in a remote part of Queensland, Australia, killing himself and injuring his wife. In the years leading up to his death, Owsley Stanley had become a reclusive, semi-mythical figure, refusing to give interviews and rarely photographed. Why the media interest? Because Owsley Stanley was the world's first underground chemist, the first person to produce LSD outside the laboratory and the man who dosed the psychedelic revolution.

Despite a prestigious background – his grandfather was Kentucky State Governor and a Democratic senator, his father a lawyer – Owsley's family life was troubled. He responded by being completely unmanageable at school, while displaying intelligence way beyond his years. He was expelled from military prep school for getting his mates drunk. Even so, the headmaster later remembered him as a 'brainchild, a wunderkind, tremendously interested in science'.

Owsley's early career was eclectic. After a short spell at the University of Virginia, a stint in the United States Air Force and a period in which he studied Russian and French, and worked as a professional ballet dancer, he enrolled at the University of California where, in April 1964, he first tried LSD. He was impressed, "I remember the first time I took acid and walked outside. The cars were kissing the parking meters."

Until then, LSD had only been available to those undertaking serious medical research and all the early psychonauts like Ken Kesey and Allen

Ginsberg took the drug as part of a federally funded volunteer programme. But it was never clear what drug they were being given or at what dosages.

I WOUND UP DOING  
TIME FOR SOMETHING  
I SHOULD HAVE BEEN  
REWARDED FOR.  
WHAT I DID WAS A  
COMMUNITY SERVICE,  
THE WAY I LOOK AT IT

Owsley decided the only way to ensure the quality of what he took was to make it himself. At that time, LSD was still legal in America. Owsley was able to find a formula in the university library. He teamed up with Melissa Cargill, a chemistry student, and they went into production. By May 1965, Owsley had created his first batch of LSD, of a reasonably consistent dose of 2-300 micrograms, more than enough for a full blown psychedelic experience. Owsley's housemate, Charles Perry commented that the batch was, "devastatingly strong in an almost heavy-handed way that recalled Owsley's own insistent manner". This comment echoed Owsley's belief that the state of mind of an LSD chemist affected the quality of the product and the consequent experience of the LSD user. At crucial stages of later LSD production runs, Owsley often phoned a radio DJ friend and asked for certain music to be played to help him get in the appropriate mood. Owsley believed

that LSD chemistry was nearer to acid alchemy.

Owsley's fame spread and he met up with author and Merry Prankster Ken Kesey and began supplying Kesey's notorious Acid Tests, LSD consumed in orange juice, famously chronicled by Tom Wolfe. But while Kesey and his cohorts wanted to be as stoned as possible on high dose LSD, Owsley knew they were playing a dangerous game. Equating the acid trip with the altered states of consciousness associated with magical rituals, he said to Kesey, "you guys are fucking around with something people have known about forever...All the occult literature about ceremonial magic warns about being very careful when you start exploring these areas of the mind." He recalled later that they had simply laughed at him.

It was at one of these gatherings in 1965 that Owsley, also known as 'The Bear' because of his inordinately hairy chest, met The Grateful Dead and began using his LSD profits to further the band's career. He offered them accommodation, helped devise their famous 'skull and lightning bolt' logo and used his array of technical skills to build them a state of the art sound system for live performances that was the envy of every major rock band on the touring circuit.

That same year, he had his first run-in with the law. To help subsidise the costs of the raw chemicals for LSD, he had also been making bath-tub methamphetamine and his lab was raided. Fortunately for Owsley, what was seized turned out to be LSD, legal at the time, so his lawyer, the vice mayor of

Berkeley, successfully sued for the return of all Owsley's lab equipment.

LSD was outlawed in October 1966, by which time, Owsley's name became synonymous with cheap, high quality LSD. He produced 300,000 doses of what he called 'White Lightning' acid for the San Francisco Human Be-In event in January 1967 and in June, 'Monterey Purple' was consumed in some quantity backstage at the Monterey Pop Festival by the likes of Jimi Hendrix, Brian Jones and Pete Townsend. Owsley recalls: "Brian Jones had a photographer in his entourage who brought a telephoto lens which had been gutted. He took it back filled with Monterey Purple. I asked Brian to share the stash between his Stones and the Beatles. So far as I am aware he did so." John Lennon was so impressed that he allegedly bought a lifetime's supply of LSD from Owsley.

But the high life couldn't last. Owsley was arrested in late 1967, eventually serving three years in custody. On his release, he kept a low profile, touring with the Grateful Dead and helping perfect their Wall of Sound concert system.

No-one, least of all Owsley, knows how much LSD he made. A reasonable estimate would be over 1.25 million doses. The USA and Britain in the 1950s and early 1960s was a world of beige conformity as a generation craved peace and stability in the post-War period. The cultural revolution of the mid 1960s was an explosion of primary colours made possible by an elite group of musicians, artists, writers, photographers and fashion designers inspired by the impact of their own LSD experiences. Whatever one's view of the sixties, its political, social and cultural impact rumbles on. To that extent, the influence of Owsley Stanley is hard to exaggerate. Perhaps Owsley's cultural significance is suggested by the fact that he has entries in both the Encyclopaedia Britannica and the Oxford English Dictionary, where he is enshrined as: *Owsley, noun, An extremely potent, high quality type of LSD.* His wry comment when he heard of this was, "Isn't that sort of surprising? I am like... 'Kleenex'!"

Owsley downplayed his influence, telling *Rolling Stone* magazine, "I just wanted to know the dose and purity of what I took into my own body. Almost before I realized what was happening, the whole affair had gotten completely out of hand. I was riding a magic stallion. A Pegasus, I was not responsible for his wings, but they did carry me to all kinds of places."

In 1980, Owsley moved to Australia,



ILLUSTRATION: JODY HOWGILL

driven by his belief that a new ice age was to engulf the northern hemisphere. He settled in the bush country near Cairns in Queensland, eventually becoming a naturalised Australian citizen. There he exercised his artistic talents, making and selling beautiful enamel jewellery and sculpture, a skill learnt in prison. The arrival of the internet enabled him to create a web site which allowed him to market his wares more widely and to publically espouse his unusual beliefs, producing essays on diet (he was a lifelong carnivore), exercise, war and drug prohibition, to name but a few.

While he was only too aware of the potential dangers of hallucinogenic drugs – he once produced a batch of

cosmically powerful STP from a recipe obtained from Alexander Shulgin – nonetheless he was unrepentant over his life as the peoples' chemist. In a rare interview given to the *San Francisco Chronicle* in 2007, he said; 'I wound up doing time for something I should have been rewarded for. What I did was a community service, the way I look at it. I was punished for political reasons. Absolutely meaningless. Was I a criminal? No, I was a good member of society. Only my society, and the one making the laws, are different'.

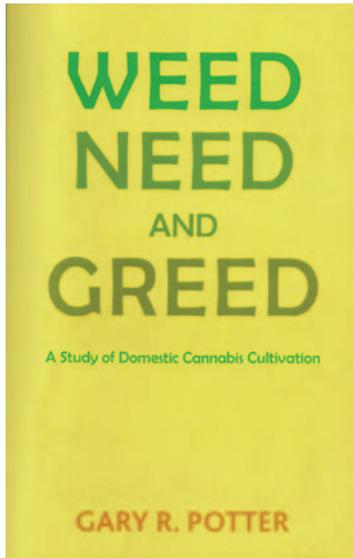
■ **Andy Roberts** is the author of *Albion dreaming: a popular history of LSD in Britain* published by Marshall Cavendish.

# Growth industry

Two recent books examine the issues surrounding cannabis cultivation in the UK and worldwide.

## Reviews

■ **Matthew Atha** is Director of the Independent Drug Monitoring Unit and expert witness in drugs cases, particularly cases involving cannabis cultivation.



### WEED NEED AND GREED

Garry Potter  
Free Association Books  
ISBN 978-1-8534-2033  
Paperback  
276 pages  
£ 17.95  
Date of publication  
June 2010

Potter's title takes an in-depth look at cannabis cultivation in the UK, ranging from outdoor 'guerilla growers' motivated by ideology, and with no expectation of a harvest (or prospect of arrest), to large-scale commercial cultivators in industrial or agricultural premises. He briefly describes the history and different methods of cannabis growing in the UK, but his primary focus is on the people involved in growing cannabis and their motivations, drawing from academic, official and subcultural, sources. Potter's emphasis is on personal interactions with growers, using informal interviews with varying degrees of structure, as well as participation in grower forums on the internet, with case histories illustrating different grower types.

Growers are divided into three broad categories, as per the title of his book:

**Weed** – ideological users, including guerilla growers (in the wild or e.g. outside police stations), hobby growers of particular exotic strains – including growers entering competitions such as the Cannabis Cup, and growers for whom cannabis use or cultivation remains a political statement.

**Need** – growers whose primary purpose is to provide cannabis for their own use, medical or recreational, and growers providing medicinal cannabis for others in need.

**Greed** – growers whose motive is partly or primarily commercial, including growers for personal use who sell any surplus production up to large scale producers growing exclusively for financial gain.

The main criticism would be that much of the evidence and sources indicate the book was mainly written several years before publication in 2010. For example he quotes

statistics from IDMU surveys of drug users, but only to 2003, although he does update parts of the book with official statistics from 2008-09.

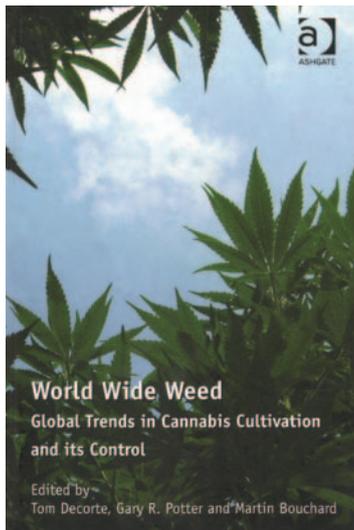
In chapter three Potter states: "Cannabis growing is quite easy. Cannabis is an adaptable and versatile plant and it is sometimes called 'weed' – perhaps for the good reason that it grows very successfully as a weed in many countries. The challenge lies in growing it well." Potter's grower sample would appear to over-represent those experienced growers

involved with internet forums who do 'grow it well'. Typical yields of several ounces per plant were quoted by some of his subjects; these yields significantly exceed those normally found (more typically 1/2oz-2oz).

In my 20 years experience of investigating cannabis cultivation cases for the courts, the longer term trend has been away from hydroponic systems with numerous small plants yielding 5-15g per plant towards systems with smaller numbers of much larger plants grown in large pots or tubs, and typically yielding 1oz-3oz (25-90g) per plant, with an average yield of 25g per plant.

Potter focuses on the growers, whereas in legal casework our focus is on the system and the plants in order to establish yield and production capacity over time, and whether or not the production capacity significantly exceeds the capacity of the grower to consume it. Since the police practice of destroying the bulk of plants and only retaining a small sample became widespread among police forces around 5-6 years ago, the average yields reported by forensic agencies have risen sharply. The Forensic Science Service used to quote figures of 10-15g per plant, but now quote an average of 40g, with other forensic labs having quoted average yields between 37g and 57g. Where we have encountered cases where the bulk of plants has (often inadvertently) been retained, the average yield of the bulk plants has been far lower than the sample plants submitted for analysis. IDMU have recommended basic safeguards – including retention of a 'B-sample' of plants, to act as a check on the temptation for police officers to simply select the largest plants in systems seized. In any event, the new sentencing guidelines for cannabis production offences set limits of 9 and 28 plants respectively for the two lowest categories of 'seriousness' of the offence, thus yields in future are only likely to be considered relevant for commercial-scale systems.

Potter's book is a good read with valuable insights into the world of UK cannabis cultivation. He has an easy narrative style, conveying the concepts clearly in a form accessible to the general reader but with enough 'meat' to satisfy the specialist. The book is highly recommended, especially for those dealing with cannabis growers within the criminal justice system.



**WORLD WIDE WEED: GLOBAL TRENDS IN CANNABIS CULTIVATION AND ITS CONTROL**

Tom Decorte, Garry Potter, Martin Bouchard: Editors  
Ashgate  
ISBN  
978-1-4094-1780-4  
Paperback  
314 pages  
£ 60.00  
Date of publication  
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*World Wide Weed* is a collection of essays on cannabis use and cultivation by commentators from the developing (Caribbean, Morocco) and developed world (Europe, North America, Australasia). Each chapter stands alone as a study of cannabis cultivation within the countries involved, and as reference material for students of cannabis markets and production, with each providing a springboard for further study via their numerous citations.

The first section deals with traditional producer nations in the developing world; how traditional cultivation was overtaken by commercial growing in the 1970s; and the importance for the respective economies, both national and local, of the profits generated from cannabis, particularly when 'legitimate' markets (e.g. bananas in the Caribbean) suffer a downturn. Klein charts the ethnographic history of the Caribbean and the cultural mix from Africa and Asia which led to the 'ganja' culture, the growth of commercial outdoor cultivation in the 1970s and the failure of US-sponsored attempts at eradication. In Morocco, Afsahi comments on the improvement of the position of women in society via the roles they play in cultivation of cannabis and processing into hashish; and how Western cannabis users influenced hashish production methods in the light of practices in the Middle East and Indian sub-continent.

The second section looks at cannabis cultivation in the developed world, specifically the development of indoor cultivation techniques and high-potency strains. Dahl and Frank look at medicinal users in Denmark, although as they only refer to growing in passing, their chapter seems out of place in a book dealing with cultivation. Decorte notes the motivation of some Belgian growers to produce cannabis lower in THC than that found in Dutch coffee-shops which they consider too strong. Bouchard and Nguyen suggest a matrix between skills and commitment to cannabis cultivation, distinguishing amateur (low-skill, low commitment) from professional growers (high-skill high-commitment) and stages in between (e.g. career criminals (low skill, high commitment) and pro-am growers (high skill but low commitment, e.g. experienced growers who downsize from commercial to domestic level production). In

Canada, Malm and colleagues investigate the development of co-offending networks among growers over a period of time. South of the border, Weisheit examines the history of marijuana cultivation in the USA, particularly in the light of state legislation legalizing the medicinal use and cultivation of cannabis, including the open supply of cannabis in California and the questionable conditions used by some as a justification for their usage. Finally, Arana and Sanchez describe the growth of cannabis cooperatives or clubs in Spain, with users pooling their 'personal allowances' to the collective, which exists solely to supply the needs of its members in a semi-legal market.

The final section looks at official responses to the development of cannabis cultivation in the developed world. Korf examines the 'back door' Dutch cannabis market supplying the demand from coffee shops, from small-scale domestic producers to large scale systems controlled by organized crime and law-enforcement practices targeting commercial producers. Lenton considers the policy in Western Australia, imposing civil penalties for small scale possession and cultivation. Kalacska and colleagues investigate potential agents for biological control, concluding that none are effective without risks of spreading to legitimate crops or the wider environment; and stressing the high tolerance of cannabis for harsh environments, while Wilkins and Sweetsur describe eradication efforts against outdoor and indoor growers in New Zealand. Finally Potter examines enforcement policies in the UK with large-scale growers tending to minimize risk by for example, splitting grows between a number of sites so all is not lost if one is detected.

A number of common themes emerge from these titles, notably adaptive responses to law enforcement efforts and unforeseen negative consequences from eradication activity, such as growers expanding cultivation to new areas at greater environmental impact, the development of high-potency strains, greater efforts at concealment and cultivation practices more likely to attract lesser sentences if detected.

*World Wide Weed* is a book for the specialist reader, more academic in tone than *Weed Need & Greed*, and a valuable resource with a wealth of information and sources for the serious researcher. However, the book is still accessible enough for the more general reader with an interest in the practices and policy issues involved in cannabis cultivation around the world.

## In this issue, Findings editor Mike Ashton looks at the evidence base for residential rehabilitation. Is it the high road to recovery?

*"I would like to ... try to provide – difficult though it will be given the shortage of money we have been left – more residential treatment programmes. In the end, the way you get drug addicts clean is by getting them off drugs altogether, challenging their addiction rather than just replacing one opiate with another."*

These comments made by the Prime Minister in August 2010 promised to embed in policy the recent stress on treatment which explicitly aims for recovery, reintegration and abstinence, a trend which in turn has focused attention on what has traditionally been seen as the best route to all three – residential rehabilitation. Add the claim that these services have been sidelined in the pursuit of 'manage the problem' objectives, and the fact that they are among the most expensive options at a time of financial cutbacks, and you indeed have a combustible mixture.

The search offered at the digital version of this column at <http://findings.org.uk/DL/DL2.php> will give you one-click access to relevant research analysed by Drug and Alcohol Findings – but beware that no conclusive answer to the residential v. non-residential question can be found. Non-randomised studies are generally confounded by differences between clients who find their way to residential services, and those who do not, while randomised studies can only ethically include people who will accept and can safely be allocated to either. Not surprisingly, they also tend to do equally well in either. Our reading of the research is that while non-residential care is sufficient for many clients, residential care has particular benefits for the minority who are most severely affected.

### RESIDENTIAL REHABILITATION: A SELECTION OF STUDIES FROM THE EFFECTIVENESS BANK

Key issues in these studies include who needs this level of care and whether it really does do more than other modalities to promote recovery from addiction.

For the full stories with links visit <http://findings.org.uk/DL/DL2.php>

### Rehabs promote abstinence in Scotland

The study in Scotland which seemed to establish that residential rehabilitation enabled many more people to be sustain long-term abstinence than other services. However, the findings have been widely misinterpreted and misunderstood, most starkly in an apples v. pears comparison which contrasted a meagre 3% long-term abstinence rate after methadone treatment in Scotland with 25% in England.

Source: McKeganey N. et al. "Abstinence and drug abuse treatment: results from the Drug Outcome Research in Scotland study." *Drugs: Education, Prevention & Policy*: 2006, 13(6), p. 537–550.

### Is the therapeutic community an evidence-based treatment?

By reviewing prominent North American trials and meta-analyses, a leading researcher tries to settle the issue of whether therapeutic communities effectively treat addiction, so research can move on to from *whether* they work to *how* to make them work better.

Source: De Leon G. "Is the therapeutic community an evidence-based treatment? What the evidence says." *Therapeutic Communities*: 2010, 31(2), p. 104–128.

### Needy clients do as well in day hospital as in residential care

By selecting clients at the very edge of ethically requiring referral to residential care, this US study confirmed that unless there are pressing contraindications, intensive non-residential options deliver equivalent outcomes. Of course, often there are pressing contraindications.

Source: Witbrodt J., Bond J., Kaskutas L.A. et al. "Day hospital and residential addiction treatment: randomized and nonrandomized managed care clients." *Journal of Consulting and Clinical Psychology*: 2007, 75(6), p. 947–959.

### Methadone patients benefit from therapeutic communities as much as other residents

Are therapeutic communities incompatible with methadone maintenance? Not when staff have been prepared to accept and work with methadone patients and programmes adapted to accommodate them. Then patients stay as long and sustain abstinence from illegal drug use just as well as other residents.

Source: Sorensen J.L., Andrews S, Delucchi K.L. et al. "Methadone patients in the therapeutic community: a test of equivalency." *Drug and Alcohol Dependence*: 2009, 100, p. 100–106.

To access the digital version of this search, go to:  
<http://findings.org.uk/DL/DL2.bhp>



## Methoxetamine (MXE, MKET, Special K)

This is an edited version of the Factsheet produced by Crew 2000.  
For the full text go to: [www.crew2000.org.uk](http://www.crew2000.org.uk)

### What is it?

Methoxetamine is chemically similar to ketamine. Some sources suggest it was initially synthesised by an underground chemist for treatment of chronic pain, but it has been present on the designer drug market since 2010 and use has increased in 2011.

### What does it look like?

Often found in white or off white crystalline powder form and as pellets.

### How is it taken?

Powder form most commonly sniffed, but can be swallowed in a cigarette paper ('bombed'). Other routes, such as rectal ingestion or injecting appear rare in the UK.

### How much does it cost?

Around £25 per gram although sold in smaller amounts. The cost for pellet form is around £6 per pellet.

### What is the average dosage?

The dosage range for methoxetamine, is lower than ketamine due to its higher potency. For the most common route – sniffing – it might range from 10-20mg (light) to 50-90mg (strong) and the effects would be felt between 10-30 minutes after ingestion.

### How long do the effects last?

Generally up to 2 – 4 hours with the main peak of effects lasting approx 1 ½ – 2 hours. Some reports suggest that re-dosing even small amounts whilst experiencing after effects can trigger an intensity similar to that of the original peak. Most people report that methoxetamine is longer lasting than ketamine with after effects lasting a further 1-2 hours and effects gradually lessening in intensity.

Some user reports suggest there is less 'hangover' with methoxetamine although many suggest methoxetamine is longer lasting than ketamine. User reports also suggest that tolerance can build quickly. Where someone has repeatedly dosed, effects are likely to be much more prolonged and returning to baseline has been described as "long and arduous".

### What are the patterns of use?

It seems common for users to re-dose every 1½ – 2 hours. Dosing before this time is thought to have potential to induce negative side effects. There have been several reports of a compulsion to re-dose, referred to as "fiending". Methoxetamine has the potential for addiction and dependency.

### What are the physical effects?

- Central Nervous System (CNS) depression
- Unconsciousness
- Dizziness
- Double vision
- Impaired coordination
- Sweating
- Muscle relaxation
- Insomnia
- Body load (tactile sensations in body)
- Nausea

### What about the psychological effects?

- Feelings of stimulation
- Mild euphoria
- Hallucinogenic effects
- Dissociation
- Anti depressant effects
- Feeling of floating
- Time dilation
- Connection with music
- Loss of inhibition
- Cravings to re-dose
- Disorientation
- Mental confusion
- Agitation
- Amnesia
- Delirium
- Paranoia
- Anxiety

The list above is some of the main effects and side effects that have been reported, not all these effects will be experienced by all users and the more serious effects tend to be reported in cases of higher dosages. Similar to ketamine, some users describe the more intense experiences as an 'MXE hole' however, anecdotal reports on drugs-forum suggest that methoxetamine is mentally a 'cleaner' dissociative than ketamine, and less physically impairing as well.

There have been drug related deaths involving ketamine so this could be a risk for methoxetamine. Death could be due to a reaction to the drug itself, a combination of the drug mixed with other substances or from an accident that occurred whilst under the influence. As methoxetamine is a dissociative drug, it affects your inhibitions and coordination so accidents are more likely to occur. Similar to ketamine, it is possible there may be a risk of psychosis.

### What about longer-terms effects?

Similar to ketamine, there may be risks of bladder problems and kidney damage with prolonged use of the substance. Some sources claim that methoxetamine has less risks to urinary system and online vendors have marketed MXE as a "bladder friendly ketamine" but more research needs to be done in this area to establish the accuracy of this claim.

### Is it legal?

MXE will be subject to a Temporary Banning Order under the Misuse of Drugs Act. The Medicines Act would apply to supply if a vendor was selling and making a medicinal claim about the product.

# Headspace

...drugs from the left field

● Marcus Roberts

is DrugScope's Director of Policy and Membership

## Time to end the 'war on drugs'?

On 24 January, the Home Affairs Select Committee (HASC) inquiry on drug policy, after considering evidence from Virgin boss Richard Branson, heard from Dame Ruth Runciman and Roger Howard of the UK Drug Policy Commission. 'Has the war on drugs been lost?', began HASC chair Keith Vaz. 'I don't think in those terms at all', Ruth Runciman replied, 'the polarities between the war on drugs and legalisation seem to pit sides against each other in terms of "lose", when there are many nuances that we need to consider very carefully'. And Keith Vaz's next question? 'Is the war on drugs successful?', to which Roger Howard replied 'as Dame Ruth said, in the UK we don't think we have had a war on drugs. We have had some pretty sensible drug policies over the last few years'.

For me, this exchange perfectly illustrates the tensions between attention-grabbing campaigning and detailed policy analysis and formulation. The increasingly indiscriminate use of the concept of a 'war on drugs' has certainly grabbed the attention of politicians, media and an assortment of celebrities, but is it actually helpful as a way of framing and facilitating the policy discussion we need to have?

If a 'war on drugs' is understood to refer – roughly speaking – to an approach which looks to enforcement to eliminate (or substantially reduce) the availability and use of drugs, and rejects harm management approaches, then, yes, it has certainly failed. But this has little to do with contemporary drug policy as it is practiced in many parts of the world. As Roger Howard argued, it is misleading to describe UK policy (the primary focus of the HASC) as 'a war on drugs'; consider, for example, the development of needle exchanges in the 1980s, massive expansion of drug treatment in the 1990s and the current interest in social



**The blanket use of 'war on drugs' does more to conceal than expose the worst abuses that are committed in its name internationally**

reintegration and recovery.

Of course, there are genuine concerns about key aspects of law enforcement in the UK – including the numbers of vulnerable women in prison for drug offences committed in contexts of intimidation and exploitation (including drug mules) and the still high numbers of drug-related stop and searches.

But let's be honest – to end up in the courts (let alone prison) for a possession offence in the UK – unlike, say, the USA – you generally have to be very unlucky or very incautious or both. Roger Howard and Ruth Runciman went so far as to suggest that, on cannabis, 'we

are seeing a gradual decriminalisation in this country' (particularly with use of warnings and penalty notices).

Nor is it helpful during a period of spending cuts and far-reaching policy change to tell parliament that drug policy has been a 'failure' – it hasn't. In fact, overall drug use has fallen significantly, at least according to the British Crime Survey. Recent treatment figures suggest there has been a reduction in the numbers of people developing serious problems with heroin. Treatment services are hugely improved and are working better with many more people. Yes, there is still a lot to do (my list would include hepatitis, overdose prevention, prison treatment, family support, stigma and attitudes and access to housing, work and meaningful activity). And, yes, a proper review of the Misuse of Drugs Act is overdue and would be welcome (but don't hold your breath). But describing UK policy as a 'failed war on drugs' is neither balanced or illuminating.

Finally, I think the blanket use of 'war on drugs' does more to conceal than to expose the worst abuses that are committed in its name internationally. Back in the early 1930s, the Communist International coined the term 'social fascism' to reflect its belief that there was no significant difference between social democracy and fascism, because both shared a corporatist economic model and stood in the way of full-blooded communism. As a result, it resisted the emergence of popular fronts against fascism until the mid-1930s. Something not dissimilar happens when the 'war on drugs' is used as an antonym for legalisation. It is important never to forget that there is a world of difference between a drug rehabilitation requirement and a death sentence and between NICE approved drug treatment and being chained to a bed.

# drugworld DIARIES



**SUE GOODLIFFE**

**Adfam Family  
Support Worker**

**HMP Peterborough**

Adfam is the national umbrella organisation working to improve the quality of life for families affected by drugs and alcohol. Alongside its work in developing and supporting work with families around the country, it also runs direct support services in some prisons, including HMP Peterborough.

There are about 1,000 inmates here, split between the male and female halves of the prison; my colleague Laura Elener and I make up the Family Support Team. We have around 300 family 'contacts' per month, anything from taking and making phone calls to face to face work with families in the visitors' centre, or accompanying them on visits into the prison.

The work is as varied as the families are. In terms of everyday tasks, we always go to see the prisoners on the detox wing, where we work to maintain positive family links and ensure prisoners are aware of the impact of their behaviour on their families outside. The induction list tells us which prisoners came in the day before. The first morning is obviously a difficult time, so we make sure they're aware of the support available not just for them, but for their families too. We also look at the background checks to make sure that our work is safe for the offender, the family and us. Then we're back out to our office in the visitors' centre. In the afternoons, we see families in the special family consultation room that's recently been built. It's been designed to be a really relaxing environment in which to offer support.

Some of what we do is relatively

simple, but no less valuable for it – the provision of practical information on how to get to the prison, booking visits and the procedures you have to go through, what forms of identification they need to bring, and so on. Families often feel stigmatised and threatened when they come on visits, so it's important to take them through what will happen and why, and explain how it helps keep the prison safe.

## FOR EFFECTIVE WORK INSIDE THE PRISON, YOU HAVE TO THINK OUTSIDE THE WALLS

We also do much more gradual, long-term work. Of course not all families are raring to go when it comes to visiting. Family breakdown is a big issue and problems in relationships often predate the sentencing itself. Not all families automatically can – or want to – play a supportive role, and it can be a challenge to work with a prisoner who is keen to make changes but whose family are not fully supportive. Providing support in the early stages of a long-term sentence can be hard too, as families can't really see an endpoint.

But wherever we can, we work to help prisoners rebuild their relationships. If things are difficult, we start by helping get them to the letter-writing stage, then onto phone calls and gradually introduce them to more contact, supporting them through

the whole process. I think going on this journey is the most rewarding part of my work – it might start off with families who haven't spoken in years, but we help them find common ground. By the end, we're with them when they come on visits. That's really special.

Though many prisoners have their own problems with addiction, some are there due to involvement in trafficking and can be from abroad. Their families might not even know they're involved with drugs, let alone that they've been caught and imprisoned in a foreign country. Enforced separation is a big issue for any family, but especially when families are in different countries.

I've been with Adfam for about six years now. I've noticed changes, particularly in people's attitudes. There used to be a 'done the crime, doing the time' culture, and a reluctance to support prisoners and their families; now, thanks to the leadership of the governor, we're part of the induction and training programme for all new staff at the prison, and our links with other prison services are really positive.

There is a team of two here. Obviously it would be ideal to have a similar structure in all prisons, but it isn't the case. Even with a broader consensus about the influence of family relationships on reoffending and resettlement, it's hard to make funding demands in the current climate, especially for a group often seen as 'undeserving'. For effective work inside the prison, you have to think outside the walls.

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