VOL 29 | ISSUE 3 | **MAY/JUNE 2014**

Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

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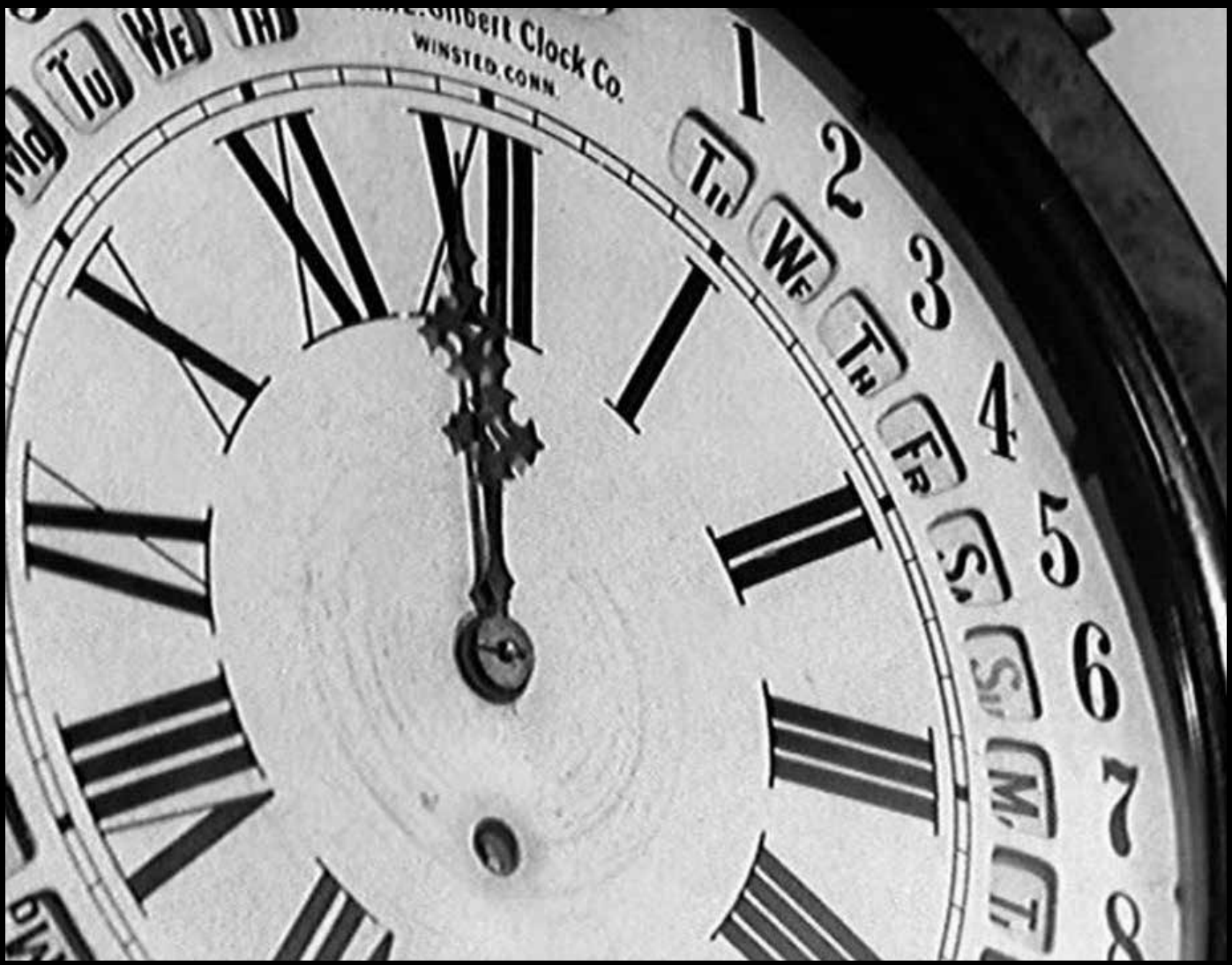
High noon for prohibition?



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Druglink

Fewer bricks in the wall?

The idea that global drug prohibition is going to crumble any time soon like the Berlin Wall is to wildly overstate the international situation as it stands. There are still substantial parts of the word – Africa, The Middle East, Asia and the Far East and Russia, where prohibition is not only a matter of tough drug laws – including the death penalty – but when drug enforcement is virtually the only element in the national drug strategy.

Even so, cracks are beginning to appear. Most obviously, this is in the decision of Washington States and Colorado to legalise cannabis. Already several US state allow for the medical use of cannabis, but this is widely acknowledged to be just an administrative veneer over legalisation – and other states look like they might go down the legalisation route anyway. And this at a time when the 'drugs war' has, since 9/11, undoubtedly slipped down the US foreign policy agenda. Uruguay has become the first country to legalise cannabis, while New Zealand is pursuing a strategy allowing for the legal sale of new psychoactive drugs. All of these experiments will be watched with keen interest.

But much could be done too, simply by a reallocation of resources; American researchers have calculated that enforcement activity in the USA could be reduced by as much as 50 per cent without appreciable increases in drug use. Imagine how much money would be freed up across the world for desperately needed drug-related public health interventions, if enforcement was scaled back to that degree.

Harry Shapiro
Editor and Director of Communications and Information

DrugScope

DrugScope
Asra House
1 Long Lane
London SE1 4PG
Telephone
020 7234 9730
Email
info@drugscope.org.uk
Web
www.drugscope.org.uk
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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DRUGLINK STAFF
Editor Harry Shapiro
Editorial Assistant
Ruth Goldsmith
Online Jackie Buckle
Book Reviews Editor
Blaine Stothard
Director of Communications and Information
Harry Shapiro
ADVERTISEMENTS
Email:
harrys@drugscope.org.uk
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Design
Helen Joubert Design
www.helenjoubertdesign.com

Cover illustration
Luke Waller,
www.lukewaller.co.uk
CONTRIBUTIONS
Druglink welcomes letters and other contributions. Send direct or contact Harry Shapiro
Email:
harrys@drugscope.org.uk
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News

Features

Regulars

Brighton rejects consumption rooms

A proposal to look at the feasibility of opening what would have been the UK's first drug consumption room (DCR) has been rejected by Brighton City Council.

The recommendation came from the Independent Drugs Commission for Brighton and Hove, which was set up in 2012 to look at the problems for the city associated with local drug markets and drug use. Last year, it submitted a report to the Council with 19 recommendations, one of which was the idea of examining the DCR idea in more detail. Not surprisingly, the idea received both local and national media coverage.

The Council and Sussex Police set up a working group to take the matter further and concluded that to set up such a facility would be costly without sufficient evidence that it would reduce the high level of drug-related deaths in Brighton. The Council preferred to invest limited budgets in this area on

naloxone distribution (which would have an impact on deaths) and training GPs around benzodiazepine diversion. Additionally, Brighton does not have a significant problem with drug litter, nor (unlike cites such as Copenhagen, Zurich and Vancouver) does it have a visible drug market concentrated in one area.

Behind the scenes though, it was the legal consideration that probably carried most clout, making the Council nervous about going ahead. At the time of the recommendation being submitted the Chief Constable was reportedly quite supportive. However, he has since retired and his successor was decidedly not. And that was significant, because although the Home Office was unequivocal in telling the Council that such a move would be illegal, Chief Constables have the discretion to turn a blind eye, as has happened in the past when drug paraphernalia has been distributed by drug agencies ahead of the item being exempted under Section 9A (the section relating to drug paraphernalia) of the Misuse of Drugs Act. So a combination of hostility from local police and central government sealed the fate of the DCR proposal. A similar proposal put to Birmingham City Council has also been rejected.

Meanwhile in Denmark…

Copenhagen's mobile consumption room, Fixelance, operated outside the law when it first took to the streets in September 2011. With the law change of June 2012, Copenhagen City Council took over its operation. Now replaced by a purpose-built vehicle, the redundant pioneer has entered a new phase in its history. At an April 15 event, Fixelance was formally initiated into the permanent collection at Denmark's National Museum. It will be used by the contemporary history department to contribute to exhibitions and displays on social history, urban development and, later this year if all goes to plan, drug use.

Photo and words: Blaine Stothard.

New opiate/ crack figures

Latest data from Liverpool John Moores University reveals that England has a total of just under 300,000 heroin and crack users with just under 90,000 of those being drug injectors. The figures cover the period 2011/12 and the researchers say that while there has been a decrease in users from 2010/11, overall this is not statistically significant. However, there has been a statistically significant fall in those injecting drugs and use among both the 15-24 and 25-34 age ranges with increases in the 35-64 age group. This confirms the trend that England has an increasingly ageing heroin population.

In terms of regional differences, Yorkshire and Humber region has the highest prevalence of use per thousand population, followed closely by the North West and North East with the East of England registering the lowest level of use. Most drug injecting was to be found in the North East.

‘Housing First’ project success

A project to put housing ahead of treatment and rehabilitation for a group of Scottish homeless substance misusers has been hailed as a success. Ninety per cent of the pilot group retained their tenancy over three years and nobody was evicted.

The 22 users from Glasgow were part of an EU pilot scheme involving ten countries and based on a US model. Perceived wisdom has always been that those with serious drug and alcohol problems living on the streets need to address their substance problem before they can cope with issues such as housing. An American housing experiment turned that on its head by providing housing first. This gave users the stability they needed to progress in treatment.

The project was run by Turning Point who moved clients into flats alongside ordinary tenants in six housing associations. Once installed, they received intensive support from six full-time staff. There was little change in levels of drug or alcohol use, although criminality was reduced. However, the researchers from Heriot Watt University who conducted the evaluation reported that the group was more receptive to support than before.

To read the Heriot Watt project evaluation, click here: https://pureapps2.hw.ac.uk/portal/files/4154648/Glasgow_HFE_Local_Evaluation_1_.pdf

Drugs and prostitution to aid recovery

The UK Office for National Statistics have been ordered by the European statistical agency, Eurostat, to calculate the benefit to the UK economy of the income derived from the sale of illegal drugs and sex work.

The EU has declared that illegal activities need to be included in national accounts so that comparisons can be made between countries. Given that the EU budget is based on the size of a country’s economy measured by GDP, the EU wants to ensure that all counties are measuring in the same way.

In 2013, the EU published a report prepared by the Dutch Trimbos Institute, RAND and the Institute for Criminal Policy Research entitled *Further insights into aspects of the EU illicit drug market*. One paper considered the size of the English heroin market. The researchers were using data from 2006, but using official data, their estimate for the number of heroin users was 255,000, not markedly different from the figure of 256,000 cited in recent PHE figures (see page 2) and prices have not changed significantly over the past eight years either. An estimate was made that heroin users in England consume between 32-47 grams of pure heroin a year. This translates to between 8-12 tons of heroin annually generating an annual income for the illicit market of around £2.5bn.

Drones weed out cannabis farms

Criminal gangs in Shropshire are reportedly using unmanned drones with heat-seeking cameras to hunt for cannabis farms so they can extort drugs and money from the growers.

One gang member told the *Halesowen News* that the cannabis growers were ‘fair game’. “I am just after drugs to steal and sell. If you break the law then you enter me and my drone’s world”. He added that many of the growers were not gangsters, just ordinary people who were easy targets and also who were more likely to live in suburbs as opposed to inner cities, so the chance of drones being spotted was reduced.

Studies show benefits of mutual aid

A brief literature review by Richard Phillips, CEO of SMART Recovery points **to a number** of benefits for longer-term recovery outcomes associated with mutual aid. The author points out that most of the studies surveyed are from the USA and based on AA, but feels that **there is every chance** that the findings can be generalised to the UK and cover all forms of mutual aid, not just AA. The report concludes that there is strong evidence showing that:

- **Greater levels of participation** equating with better outcomes;
- ‘**Abstinence supportive**’ social networks are critical to recovery;
- **Treatment agencies engaging** more effectively with mutual aid networks;
- **Mutual aid on its own** is not an effective replacement for treatment for those approaching services – a combination of the two is best;
- **Coercive mutual aid is invariably** counter-productive.

A range of recommendations for treatment services and commissioners is included while significant deficits in the evidence base are also noted.

To read the whole report go to: http://cdn.smartrecovery.org.uk/doc/Addictions-Mutual-Aid-Overview-of-Evidence-for-the-UK.pdf

NZ backtrack on NPS

The New Zealand government has changed its mind about a temporary licensing scheme for synthetic cannabinoids after intense media and political pressure in the run-up to the General Election.

Last year, the government enacted the Psychoactive Substances Act, which required all products, retailers, manufacturers, wholesalers and researchers to be licensed. This in effect put the onus of proof of 'low risk' on those who make and sell NPS and led to a reduction of retail outlets from around 4000 down to 150 as about 200 products were immediately banned.

However, the Act also allowed for the continued sale of those NPS already on the market as part of a transitional regulatory scheme. Forty seven synthetic cannabinoids, deemed by health officials to be 'low risk', remained on sale. A key reason for delaying the introduction of the full scheme was concern at Cabinet level that testing NPS to obtain licenses would entail experimenting on animals. The government has already made clear that safety assurances based on animal studies either conducted in New Zealand or overseas would not be accepted. In fact, although the New Zealand licensing scheme is seen as radical, in effect it is hard to imagine any product passing the 'low risk' test. Prime Minister John Key was quoted as saying, "There will be a process that manufacturers will be able to go through, that will be a long and very expensive process and, if you want my view, I hope none of the products actually make it."

Middle East meth

For a country so steeped in the tradition of opium and heroin, it is strange to report that, according to the Tehran correspondent of *The Guardian* (13 May) crystal meth or shisheh has became Tehran's drug of choice. In 2013-14, the authorities seized 3.5 tons of the drug and closed nearly 400 production labs. So how has this happened?

The analysis suggests that as the country has modernised, the pace of life has quickened and a new generation of westernised middle class young adults has emerged, so drug habits have changed. For this new more sophisticated group of urbanites into raves, computer games and a level of liberation unheard of in Iran's recent past, the opiates are now associated with both an out of date vision of the country and 'low rent' working class use. Instead stimulants like MDMA and meth are more in keeping with a 21st century aspirant lifestyle. But inevitably, life in the fast lane comes at a price. Some Iranian academic research yet to be peer reviewed claims that 50% of those admitted to mental hospitals are there due to complications arising from their use of crystal meth.

Poppies for pyramids

The dramatic fall in tourism in Egypt has led to an increase in poppy cultivation as tour guides have seen their income collapse. Political unrest and violence following the overthrow of the Muslim Brotherhood and President Morsi in July 2013 has kept the tourists away in droves, a 90 per cent fall since last September. Sinai's Red Sea coast has been particularly affected after a tourist bus was attacked close to the Israeli border in February. The UK had advised against all travel in the Sinai region apart from the resort of Sharm-el-Sheikh. And it is in this region where a tradition of opium growing going back thousands of years is being intensified. A Bedouin tour guide told *The Sunday Times* that his field produced 340 ounces of opium last year which he sold on to dealers at £27 an ounce, and now he is earning three times his income as a tour guide.

The Brixton experiment revisited

Researchers from University College, London have been studying the impact of the experiment in cannabis law enforcement conducted by Commander Brian Paddick when he was in charge of Lambeth Police. They concluded that there was a real fall in crime in Lambeth as police resources were reallocated; that, not surprisingly, cannabis possession offences rose significantly and continued to rise after the experiment ended and that the most noticeable downside for local residents was a fall in house prices during the period of the experiment in 2001-02. They also looked at the possible impact of rolling out such a policy across the whole of London and believe that some of the less attractive aspects of the policy like drug tourism would be mitigated while the overall reductions in crime would benefit the wider community. **http://www.ucl.ac.uk/~uctpimr/research/depenalization.pdf**

CHILDREN AT RISK

Adfam, the national charity for families affected by drugs and alcohol, have published a new report that shines a light on one of the murkier corners of addiction treatment. *Medications in drug treatment: tackling the risks to children* addresses the dangers presented to children when they ingest medications meant to help treat their parents' addiction.

The report discusses the findings of the twenty relevant Serious Case Reviews (SCR) in England and Wales from the 10 years following the 2003 publication of the *Hidden Harm* report, before highlighting the issues raised by 11 interviews, two focus groups and a roundtable discussion group they conducted.

The report finds that over 60,000 people in the UK who care for children are prescribed substitute medications, mostly methadone and buprenorphine. Between 2003 and 2013, twenty SCR were conducted after incidents were reported; 19 involved methadone, which lead to the deaths of 15 very young children. Buprenorphine also caused the death of a child in this period, and 17 deaths were reported in total; the children who were involved in serious cases were on average only two years old. While it was often not known how the children came to ingest their parents' medicines, in at least five cases they were deliberately administered by their parents in attempts to soothe or pacify them.

Adfam strongly emphasise that their report must not be read as an attack on the use of methadone or other opiate substitute treatment drugs and make it clear that problems are very much the exception and not the rule. Nonetheless the problem is real, as Vivienne Evans, Adfam Chief Executive, notes: "Just one of these cases would be one case too many, but this research shows that they have happened with depressing regularity over the last decade… We've already seen these cases happen from Bradford to Bridgend, and many towns and cities elsewhere. The cases are frequent and similar enough that we should be much louder and more honest about the risks of methadone to children, including the rare but real instances of parents using it to try and soothe babies and toddlers."

JUST ONE OF THESE CASES WOULD BE ONE CASE TOO MANY, BUT THIS RESEARCH SHOWS THAT THEY HAVE HAPPENED WITH DEPRESSING REGULARITY OVER THE LAST DECADE

The report does not simply identify the problem but also makes a number of detailed recommendations. It concludes that the blame does not lie with the use of these medications to treat addiction, but with the insufficiency of safeguards that could protect children from their parents' and carers' medicines. While the National Institute for Health and Care Excellence (NICE) do mention the dangers to children from such medicines in their guidelines, there are not currently any details about how to put safeguards in place and how to take potential dangers into consideration when making decisions about prescribing. The report calls for this to change, along with a number of other practical steps, starting with improving awareness on the issue through national data collection on the number of parents prescribed substitute medications, and the number of children admitted to hospital after consuming them. Improved advice about storing medicines safely should be given, and people prescribed medications for addiction to take home should be given lockable storage boxes and agree safety plans. Adfam also want the issue addressed at all levels, with improved training for everyone from drug treatment workers and pharmacists to GPs and social workers, while they recommend that addiction treatment agencies should have mandatory representation on local Safeguarding Children boards.

Adfam's aim with the report is simple but powerful; through better information and education, they believe children's lives can be saved. As Vivienne Evans writes in the Foreword, it's about refusing to accept the status quo: "We can't just accept that 'these things happen' and we must be louder and more challenging. We think it is possible to make these incidents less likely."

BUY ONE – GET ONE FREE

In this second part of her two-part feature on commissioning, **Sara McGrail** offers a personal view on the growing supermarket model of service provision and how changes in commissioning have impacted on service users in England.

The scale of substance misuse contracts, coupled with a cumbersome and expensive approach to procurement, inevitably favours larger organisations. The expansion of the super-charities and mega-trusts happens at the expense of smaller local providers or local NHS services. It also happens at the expense of our workforce, with salaries paid by the larger providers being pegged, volunteers replacing paid staff and safety being compromised to enable them to deliver the cost reductions without impacting on central management structures. Fundamentally it happens at the expense of people who use and benefit from services.

For example, in the area I discussed in my last article, the new contract has made dramatic reductions in the level of clinical support available for blood-borne virus (BBV) and harm reduction work. In an area that has a large, very diverse, transient at risk population, specialist services will no longer provide basic interventions like liver function tests, infection and wound care and cancer surveillance for people with viral hepatitis or cirrhosis. Nor will they provide emergency sexual health interventions (critical for a group who often sell sex), undertake TB screening or undertake supplementary prescribing (for example, for initiation of naltrexone, acamprosate and disulfrim, which help GPs deliver sustained recovery in the community).

Concerns have been raised by the Clinical Commissioning Group about the very narrow focus within the service, which seems at odds with NHS England priorities to reduce deaths through hepatitis C-related cirrhosis and liver cancer by joining up service responses for vulnerable groups. This is essential healthcare for a very vulnerable population – many of whom have little or no contact with primary care, who are unlikely to consistently access specialist care and who have in many cases a profound suspicion of mainstream services. The cost of delivering sub-optimal care to this group will far exceed any savings in this single contract – with increasing hospital admissions and deaths, and a likely increase in the number of new transmission of BBVs.

Across the country, service users and communities are finding choice restricted, as more contracts are left to those large agencies with the resources to bid for them. Local areas, used to a plurality of provision, are finding themselves with a one-size-fits-all treatment option and, in this conservative climate, a mandated approach to recovery that leaves many people prematurely detoxed, inappropriately supported or simply out on their ear.

The National Council for Voluntary Organisations (NCVO) identified bundling as a significant problem to the UK voluntary sector in its response to the proposals to amend European legislation saying:

"One of the main barriers facing VCSE organisations in public procurement is the increased use of large scale contracts. This is leading to a diminution of local knowledge and expertise to the detriment of public services and the people that use them."

The urge to bundle has a number of drivers. While budgets for substance use services may seem to have plateaued, many have experienced substantial cuts. Partly due to the inclusion of alcohol in main contracts and partly due to pressure on mainstream budgets, substance misuse commissioners are being expected to buy much more for substantially less.

The absence of coherent central guidance on substance use commissioning – a national service framework, the inclusion of the right to treatment for drug and alcohol problems under the NHS constitution and the inclusion of substance misuse under the auspices of healthcare regulator Monitor – reinforces the difficulties of austerity.

Commissioning the larger organisations may mean that commissioners kill off their own local voluntary sector, but when there is an unwritten consensus among your peers that 'best practice' commissioning equals buying services from super charities or mega trusts, this provides a sense of security for pressurised commissioners.

The shift from a central to a local focus for service commissioning was predictable – and predicted – from the early part of this century. In our sector, however, the approach of localism was identified as a distant threat, not an opportunity. Rather than working to build relationships that would enable local ownership of drug and alcohol issues, we became more inward looking – our agenda so obscure and complex that only 'experts' could understand it. We reduced the power of local partnerships in favour of an all powerful central dictatorship. This left us hopelessly ill-prepared for both localism and austerity.

Today in many areas, local partnerships no longer commission services collectively. Drug Action Teams (DATs) and Joint Commissioning Groups (JCGs) have fallen by the wayside, subsumed by sub-groups of sub-groups of Community Safety Partnerships, or sludged up in the labyrinthine bowels of the largely dysfunctional Health and Wellbeing Boards. By losing these partnerships, we have lost our local strategic focus and the scrutiny of commissioning and service provision.

IRONICALLY IT IS THE SUPPOSED CENTRALISTS OF THE EUROPEAN UNION WHO ARE DOING MOST TO ENSURE WE CAN KEEP OUR SERVICES SMALL, LOCAL, AND RESPONSIVE

Another rationale offered for commissioning treatment services in single lot contracts is that it supports integration. Of course having a single provider can support integration – but it is by no means bound to, nor is it the only option for achieving this. What it does do, however, is enable the service provider to commission and operate the care pathways. This once again limits scrutiny of the treatment system and restricts the opportunities for commissioners to intervene in failing systems. As the smaller local agencies close down or are allowed to act as "sub-contractors", the local market is irreparably damaged. Choice is restricted, leaving communities, individuals – and ultimately commissioners to "take what they're given".

The range of substances available in our communities has probably never been higher and the range of ways in which people use them is expanding. Would we ever have considered, 20 years ago, that we would have people injecting tanning agents or using undetectable cannabis substitutes in prisons? Or, indeed, that our high streets would be spawning pubs on a pound-shop model? Given this, the demand for substance use interventions is likely to increase over the next few years – despite what we understand about trends in heroin and crack cocaine use. We have not yet even partly accurately anticipated the demand for alcohol services, but it is likely to be massive.

So what are we going to do to ensure our practice is nimble and effective and a market can provide the services that we're going to need?

The Social Value Act was much heralded by many in the government and voluntary sector as the means with which we could "level the playing field" for smaller local charities. Unfortunately, as many have observed, it lacks teeth. It allows commissioners to consider a wider range of social benefits in commissioning a particular provider – including the impact on local businesses and the local economy. However commissioners are not bound to do this, and in the face of pressures on costs and time, may opt to consider the state of the local voluntary sector – and then forget it.

Ironically it is the supposed centralists of the European Union who are doing most to ensure we can keep our services small, local, and responsive. With national legislation due in the summer for implementation within the next two years we cannot be sure how much of the liberalising agenda the government will adopt. However, the new Public Sector Directive can potentially lift the barriers that prevent small organisations bidding for and winning tenders.

With the new EU directive, the government could require public services to split contracts into smaller lots to encourage small local charities, social enterprises and mutuals to bid for services. It will simplify the resource intensity of the procurement process itself, meaning it will cost small charities less to take part in bidding. It will allow public bodies to reserve certain areas of work to charities, social enterprises and mutuals. It could give some teeth to the Social Value Act meaning that those procuring public services will consider more than the price when looking at economic value. We will know more when the government places its draft legislation before parliament this summer. But there is more we need to do to ensure that the drug and alcohol sector is capable of delivering the services people need.

We need to protect our sector and those who benefit from it from the worst vicissitudes of the free market. Contrary to current political doctrine, the market does not protect the consumer. Left to

its own devices, the market exploits the consumer to enable the service provider to profit. For a market-driven approach to any kind of health or social care to be effective, we need to put in place robust safeguards of quality and choice. This has been recognised in every other area of market-focused healthcare provision. Drug and alcohol services should be no exception.

We should – as has been agreed and mandated in other areas of healthcare and as is regulated by Monitor – restrict the bundling of services within procurement to those circumstances in which it is directly beneficial to the person using those services. Where bundling does support integration, we should be able to use it. But where it is just about cutting corners and costs and making the world a brighter place for lazy commissioners, it should be prevented.

Drug and alcohol treatment needs to be included in the NHS constitution. Those who benefit from it should be able to challenge and engage with treatment as recipients of NHS services. We need a new national framework for substance use – one that places the individual at its heart, that impels us to operate not on the basis of what substance people use, but that uses **what we know works** in a way that is safe, cost effective and individualised. A well-conceived framework for the provision of NHS drug and alcohol services would enable commissioners to act confidently to provide services that work, responding to the articulated needs of service users.

We also need to work within the spirit of the Public Health Outcomes Framework – protecting people from ill health, helping them achieve better health, tackling the determinants of poor health and doing so in a way that reduces inequalities in life expectancy. Tacking moral and political imperatives onto public investment in people's health can only end in disaster.

But it is not just government who can change things. As a sector we can mobilise around some critical commitments to preserve quality and choice. Firstly, the large providers need to take some responsibility for growth strategies that advance their own position but are lethal for smaller locally based charities. As well as better recognising the impact of their

WE NEED TO PROTECT OUR SECTOR AND THOSE WHO BENEFIT FROM IT FROM THE WORST VICISSITUDES OF THE FREE MARKET

approaches on smaller providers, they have both the weight and influence to support local charities' challenges to poor commissioning practice – and could provide muscle and expertise to build a sustainable and diverse sector.

Commissioners can and should explore the impact of market-limiting practices on their local communities and, where appropriate, handicap larger charities and foundation trusts within procurement processes – an approach likely to become a statutory duty if the government deploys the full force of the new regulations.

Service users need to make their voices heard, not just to advise commissioners on service specifications, but to campaign and lobby for effective local providers. In return, those providers should offer genuine engagement and involvement in service provision.

Smaller providers need to strike out too. It is hard to fight back when your only contract is with the Local Authority. But simply kowtowing to your commissioner will no more preserve your service than your sanity. Challenge commissioners' actions. Mobilise your service users. Engage local communities – and open up what you do to scrutiny. Establishing outcome monitoring systems is expensive, but by working closely with other small providers, you can improve management infrastructure and compete better.

Local areas need to look at how they strategically manage drug and alcohol issues – and how and where they integrate that strategy with other health and social care issues. If these issues lack priority at the Health and Wellbeing Board table, you will find them making themselves a priority before long. The day of the DAT may be long gone, but right now we need joined up local thinking more than ever.

As for commissioners – well, you have my sympathy. There has never been a worse time to be commissioning local services. It's hard, it's often depressing and financially it is set to become more challenging. But do yourself a favour. The next time you go out to tender and one of the big boys comes up and promises you the earth, consider the other implications of bringing them in. Ask them what they understand about your area, what local contacts and networks they have access to, how they will ensure management is local and responsive. And then ask someone else who has commissioned them – in their references – if any of it is true. Marketing is clever stuff. Finally, ask yourself a question – if you commission them and your local providers shut down, and your commissioning process effectively devolves to them, if it all goes pear-shaped – who will you turn to next?

This is a great field. It was built to meet people's needs through innovation and investment in local communities and has become the envy of the international drug and alcohol community. Let's keep it that way by managing our markets – and not letting them manage us.

Sara McGrail has worked as a commissioner, service director and was the chief adviser to the National Audit Office on the evaluation of the Value for Money of the previous drug strategy. Latterly, she has developed proposals and specifications on behalf of organisations across the UK.

First notice

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Higher education

The public perception of the drug dealer is either a seedy street corner ne'er do well or a bling-laden 'kingpin'. But **Max Daly** sheds light on a different world of dealing.

A university campus is a drug dealer's dream. Thousands of young people living together like sardines in a tin, eager for new experiences, in an environment largely cocooned from the attentions of police and hardened criminals.

It is no wonder then, that drug markets in universities are lively, lucrative and attract young dealers who would not normally get involved in a crime that could end with them spending the rest of their degree behind bars. The student drug market is so sought after that dealers have been known to enroll at colleges specifically to take out student loans and sell drugs on campus.

Gaining independence, being surrounded by their peers and living away from parents for the first time gives many students the opportunity and the motive for starting, or upping their drug use. Nearly three quarters of Britain's 2.5 million university students – a far higher proportion than the general population – have taken an illegal drug.

Some drugs are highly identifiable with student life. Ketamine, for example, is five times more popular among students than it is among non-students of the same age.

So, with halls of residence largely out of bounds for outsiders, it is not surprising that universities are cultivating a small army of academic mini-entrepreneurs, eager to subsidise their own use, gain social currency or make a healthy profit, by selling drugs to this most captive of populations.

A 2012 survey by *Varsity*, the student newspaper for the University of Cambridge, found that one in seven students who used drugs also admitted to selling them for profit.

In March one student wrote anonymously in the Guardian about how some of his fellow students had turned to selling drugs because of the high cost of degree courses and rent. He described the moment police raided his student shared flat, close to the local university, to arrest a flat mate for Class A drug supply. He said he knew of three fellow students, none of whom are "violent criminals on the fringes of society", on bail for selling drugs.

But university drugs markets, and the rise of student dealers from their more caring, sharing hippy predecessors in the 1960s and 1970s, are a vastly under-researched subject, especially in the UK.

The most referenced text is from the US. *Dorm Room Dealers: Drugs and the Privileges of Race and Class*, written by two US sociologists, Rafik Mohamed and Erik Fritsvold, who had gained access to a group of mainly middle class white sellers at a private college in San Diego, California, was published in 2010.

ONE STUDENT WROTE ANONYMOUSLY IN THE GUARDIAN ABOUT HOW SOME OF HIS FELLOW STUDENTS HAD TURNED TO SELLING DRUGS BECAUSE OF THE HIGH COST OF DEGREE COURSES AND RENT

The sociologists described how upwardly mobile college kids smuggled pills across the Mexican border and sold a mixture of weed, cocaine, valium and oxycontin with near impunity across the college campus. The message of their study was, as its title suggested, that selling drugs was just a phase that the future city brokers and newspaper editors of the future went through, and police were perfectly willing to turn a blind eye to offences that would end in prison for other US citizens.

Meanwhile in the UK, Judith Aldridge, a senior lecturer in the School of Law at the University of Manchester, has studied how a group of university students in the city responded to the rapid rise in popularity of the then legal drug mephedrone by virtually setting up shop in the halls of residence, marketing and selling the drug to fellow students via social media and mobile phones.

What interested researchers at Plymouth University's Drug and Alcohol Research Unit (DARU) was the notion of 'social supply' – an elastic term, which aims to differentiate professional drug sellers from those who pass drugs onto a friends and acquaintances for minimal monetary reward. It had previously been documented, in several studies over the 2000s, both within the UK clubbing scene and among young cannabis users.

So the Plymouth team undertook a piece of research, carried out last year, into the student drug dealing scene at their university. Aiming to compare social supply within this arena to 'drug dealing proper', researchers conducted in-depth interviews with 30 student dealers who had recently been selling drugs at the university.

It found most student sellers enrolled there were 'social dealers' rather than professionals. Many described what they charged their friends as a "hassle tax" – a small financial reward for the "inconvenience, risk and hard work" sometimes involved in sourcing drugs.

However, three of the 30 current and former student dealers interviewed were profit-motivated dealers with a wider circle of customers, who dealt to finance their way through university. Some had quickly realised on arriving at university that, because of economies of scale, buying in bulk was an increasingly attractive option, particularly if they spent a lot on drugs for their own use.

The study found that universities provided a "microsite of transition" for

both drug users and sellers. Loosened social controls at universities meant students were more likely to use drugs. And because of the high demand from such a captive, interconnected population, particularly in halls of residence, drug users were more likely to become drug dealers.

"Findings from our study suggest that universities act as an environment in which many drug-using students progress to small-scale social supply roles," says Dr Leah Moyle, a research fellow at Plymouth University, who conducted the interviews.

The university drug dealing scene, the researchers found, had altered significantly since the 1960s and 1970s. Where once drug distribution was all about 'sharing and spreading the love,' now it is more financially focused with an emphasis on a wider variety and higher volume of drugs.

"We spoke to students who had been involved in selling relatively large quantities of class-A substances, but who had no previous experience of commercial drug supply. The prospect of making a relatively good income in a short space of time often outweighed the risk of undertaking 'one off' periods of drug dealing activity," said Moyle.

The 'normalisation' of drug use and drug dealing at the university made 'drifting' into supply easier to do. Interviewees said they started selling drugs as a consequence of using them rather than the need to make money. Nearly all the social dealers rejected being associated with normal drug dealers.

"In the university context, these students felt relatively protected from law enforcement, and often had access to a ready-made customer base of friends and acquaintances, through which drugs could easily and discreetly be distributed," says Moyle.

"Our findings also indicate that, in the university environment, engaging in a supply role on behalf of the wider social group can act as a kind of social cement, and that our respondents often wanted to 'do their bit' for the group by accessing drugs for less well connected friends."

It identified different types of social suppliers at the university: stash user suppliers (heavy drug users who fund their habit through selling to friends), designated buyers (who buy on behalf of the group), party buyers (who buy large amounts on special occasions) and entrepreneurs (who buy in bulk when the opportunity arises to sell for profit).

The study found that social supply differed from normal dealing because it was more fluid and less hierarchical. As a result, most social suppliers at the university generally avoided contact with professional drug sellers and provided their fellow students with convenient access to drugs without the risk, while at the same time "cushioning" themselves from the wider drug market.

Of the student dealers interviewed, eight in ten had used an illegal drug in the last month (mainly cocaine, MDMA and cannabis), spending a average of £70 a month on drugs for themselves. More than three quarters of them had sold drugs in the last six months and the average age they started selling drugs was 17 years old.

One student drug dealer studying in a northern city university, who now earns £500 to £1,000 a week from selling drugs to students from his rented flat in the area's student district, told me: "I don't think of myself as a drug dealer in the popular sense of the word," he says. "It's more like a hobby that pays for drugs, going out, rent and holidays.

"Selling drugs in halls was too easy, because it all took place in a bubble. Students knocked on the window if they needed anything. There were no police or locals to worry about, just a couple of security officers looking after 3,000 students who all wanted to get high. I knew if I hadn't taken advantage of the situation I would have regretted it."

Although the Plymouth University study revealed only 10 per cent of student dealers had become out and out profiteers, there's a catalogue of cases around the country where student dealers have ended up in front of a judge.

In September last year, Salford students Cara Donnison and Daniel Campbell, both 20, were locked up for two years each after being caught with £2,500 worth of ecstasy, cannabis and ketamine, alongside plastic snap bags and weighing scales, at their halls of residence.

In January of this year, Michael Thompson, 22 – a final year History student at Sheffield University – was sentenced to three years after police intercepted a package addressed to him from Holland that contained £600 worth of ecstasy pills. A raid on his flat, close to the university campus, found 46 bags of ecstasy tablets, cannabis resin, weed, ketamine, Valium and LSD.

In conclusion, and in order to ensure social dealers are not punished by courts in the same way as professional dealers, the Plymouth study recommends that a new definition of social suppler – someone who offers minimally commercial supply – as a good way of removing non-commercial drug dealing from the ambit of conventional drug supply offences.

"A conceptual shift towards 'minimally commercial supply' offers a more realistic and inclusive means of conceptualising both social supply and user-dealing activity," the study said. "Possible ways forward therefore include the implementation of this term as a distinct offence that focuses on intent, thereby presenting a more proportionate approach than current policy responses for these groups allow."

Max Daly is a freelance journalist

What student dealers told the researchers

'I mean I've bought for ten people before so that would be over £100, so that would be over 100 pills it might be even 200 pills or something...it sounds stupid to say it out loud. I mean, that's a serious amount of drugs! But yeah if you're going to a festival or something and you've got 10-15 people...' *Jacob, 23*

'It's kind of using your business sense really... So you think I might as well go and do this so instead of £40 for one [gram] you pay £400 for 28 [grams] so that means I've only got to sell 10 and then...it's free. So yeah, but then you are aware that you're taking a bit of a risk... You never push it on people you don't know but you know at uni you've got so many friends that do it and it's just easy really...you don't really think of the consequences.' *Tom, 22*

'I didn't have a part time job as I have done for the last couple of years and one day it just occurred to me it would be so easy with all the contacts I've got that I just thought I'll give it a go, see how I get on, buy a 'work' phone and kind of take it quite seriously and the money started to come... It's not ridiculous money, but for a student it's quite nice.' *Dan, 22*

Money talks

How successful are attempts to incentivise service users towards better health? By **Max Daly**

The use of incentives to reward people for taking positive action, in the field of public health, is a relatively new and untested development in the UK.

One of the first trials took place in Tayside in Scotland in 2007. In an attempt to reduce the high numbers of pregnant smokers, the local NHS board offered women weekly grocery vouchers in return for stopping smoking. It was a success. Of the 450 women who took part in the scheme, a fifth had remained non-smokers throughout their pregnancy – twice the success rate of normal stop smoking services.

Since then, the use of financial incentives as part of a behavioural intervention to encourage people to positively change their behaviour, sometimes referred to as 'contingency management' (CM) or 'positive reinforcement', has been recommended by the National Institute for Health and Care Excellence (NICE) for use in addiction services. There have also been positive results from studies in the US where drug users have been offered rewards in return for abstaining from using opiates.

Now, a number of areas in the UK are running incentive-based programmes. Most have been set up to encourage drug users into services for addiction counselling and vital health treatment, such as potentially life-saving hepatitis B (HBV) vaccinations.

Becoming infected with HBV, as with other potentially damaging and potentially fatal viruses, is a serious risk factor for injecting drug users. The virus, which attacks the liver and can cause cirrhosis and cancer, affects 22 per cent of this population. An effective vaccination exists and is routinely offered to drug users who enter into drug treatment services.

To be fully protected against HBV, individuals need to complete their full course of at least 3 vaccinations. However, the less ordered lives of injecting drug users means that many do not complete the vaccination course and some become infected and seriously ill as a result. The 2010 Drug Strategy highlighted the treatment and prevention of blood borne viruses as a priority issue.

This appeared to be an ideal physical healthcare intervention in which to test whether financial incentives as part of a behavioural intervention might be effective in improving benefit.

A team of researchers and clinicians from King's College London, Imperial College London and University College London conducted a study, funded by the National Institute for Health Research, to assess whether financial incentives might improve completion of HBV vaccinations among drug users in treatment compared to no incentives. The results were published in *The Lancet* in April.

Twelve NHS drug clinics took part and were randomly allocated to one of three groups to provide either – HBV vaccinations with small fixed value financial incentives in the form of a £10 supermarket voucher, at each of the three vaccination appointments; HBV vaccinations with small escalating value financial incentives in the form of a £5 supermarket voucher at the first vaccination appointment, £10 at the next and £15 at the third; or HBV vaccinations with no financial incentive.

The vouchers were only given to people attending vaccination appointments on time and complying with the vaccination schedule.

"The study found remarkable improvements in completion of vaccination," Nicola Metrebian, joint lead author of the study and senior research fellow in the Addictions Department at King's College London, told the *New Scientist*.

While only nine per cent of those not getting incentives completed their vaccinations, 45 per cent of those getting the fixed-value voucher incentive and 49 per cent of those receiving the escalating-value voucher incentive completed their course of vaccinations. Furthermore, 80 per cent of those receiving vouchers who attended appointments, attended on time. This suggests financial incentives can improve healthcare efficiency by reducing missed appointments.

"Thirty pounds of vouchers (plus £90 vaccination costs) is a small sum when weighed against the healthcare costs of liver disease," said Metrebian. "Antiviral treatment for chronic hepatitis costs £3,000 to £10,000 a year and a liver transplant exceeds £50,000. Then there's the cost to the NHS of missed appointments."

Nicola Metrebian adds: "We have shown that financial incentives really can help encourage completion of HBV vaccination and we hope this intervention will be taken up routinely by service providers."

Metrebian says a separate, ongoing study conducted by the team is looking at whether giving a £10 shopping voucher to opiate addicts in treatment, each time they provide a clean urine sample, will have a similarly positive effect.

Eliot Albers, executive director of the International Network of People who Use Drugs (INPUD) said: "I am broadly in support of incentives in the context of HBV vaccinations. But as regarding clean urine – absolutely not. As we object to urine testing on principle, we can't support incentives in that context."

Erin O'Mara, editor of drug user magazine *Black Poppy*, says incentives can work "as long as drug users are viewed as people with the same need to have a good life as the rest of us".

O'Mara says that offering incentives for HBV vaccines are at the more "palatable end of the spectrum" in terms of selling the idea of incentives for drug users to the UK public. However, she adds: "Before injectors get abused for wasting public money, one would be wise to remember that incentives have

been around for years; for smokers, the obese, the young with STDs, and they are certainly worth further investigation and trials."

She says that experiments in the US whereby crack users were offered goods or money to make positive decisions appeared to work. "The US research did seem to have quite surprising results. It became clear that even entrenched addicts were able to make considered decisions and respond to incentives.

"It showed, of course, human nature. That when you have nothing to strive for, when your world seems empty or meaningless, a practical and immediate offer of support to get a foot back on the ladder with no judgments and no lengthy strings attached, can be most welcome. A positive moment for some in an often harrowing week of loss upon loss."

Indeed, the evidence from the US on the success of incentive programmes, with rewards ranging from methadone to shopping vouchers and lottery prize, is compelling.

"The scientific community in the US has been investigating the effectiveness of incentives in promoting therapeutic behavior change for many years," says Kenneth Silverman, Professor of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine in Baltimore, Maryland. "Much of that research has focused on the use of incentives to promote abstinence from drugs in people who have long histories of drug addiction. Incentive interventions are among the most effective approaches to treating drug addiction of all the methods that have been studied."

THERE'S SUBSTANTIAL EVIDENCE TO SHOW THAT IT WORKS WELL – MUCH MORE EVIDENCE THAN WE HAVE FOR PRETTY WELL ANYTHING ASIDE FROM METHADONE MAINTENANCE

Silverman says the evidence shows that the bigger the incentives are, and the longer they are provided, the more effective they are in promoting long-term abstinence and preventing relapse.

His team has developed an incentive programme based on getting problem drug users into employment. Under the 'therapeutic workplace' programme, recovering drug users are employed and paid to work but are required to provide drug-free urine samples or take addiction medications to maintain maximum pay.

It's a no-brainer, according to Peter McDermott, a former drug user who sits on the steering committee for the HBV study. "There's substantial evidence to show that it works well – much more evidence than we have for pretty well anything aside from methadone maintenance. It's insane not to use it. Why would you spend a fortune paying outreach workers salaries to locate the hard-to-reach when you can have the same people beating down your door for a tenner a pop?"

Mike Ashton, in his *Findings* analysis of the evidence from a series of incentive studies, concludes that it can be effective, but there is a tendency for drug users to go back to their old habits once the studies have finished and the rewards have ended. He says that the best results come from the use of incentives in conjunction with counselling and the ability of people to be able to 'own' their decision-making.

"It would be a surprise indeed if offering often destitute patients housing, employment, money or goods, and the more despised among our population recognition and rewards, did not have powerful effects, at least while the contingencies are in place," points out Ashton. "Realising and making the most of this potential, while avoiding unintended consequences, is the task facing the researchers and clinicians who devise the programmes."

The economic reality, says O'Mara, is that the NHS has to constantly find new and innovative ways to save money and 'incentive' culture can only become more widespread, as you are spending small amounts in the short term to save much larger amounts further down the line.

"Quite frankly if anything backed by the evidence helps to encourage people to avoid ill health – and it is preventative medicine that will save us all in the end – then we should applaud it," says O'Mara.

"Health and healthcare is not a moral issue. It is about saving lives first and foremost and hopefully to educate as well. And if the bean counters and researchers can meet in the middle to provide new ideas to keep us aware and proactive about our health, then well done, we all win."

■ **Max Daly** is a freelance journalist

DRUG & ALCOHOL FINDINGS

Research, with teeth

David Ader takes a bite into an unprecedented and expansive database on drug and alcohol treatment

It's been a year since the publication of the 'drug and alcohol matrices', the world's first database of the most significant research evidence underpinning the work of the substance misuse treatment sector. The two Matrices map out the different territories of the sector. For each one they answer the question: 'What are the major documents practitioners should read even if they read nothing else?'

Developed by Drug and Alcohol Findings with the close collaboration and support of the Substance Misuse Skills Consortium, the drug and alcohol matrices are each comprised of a 5x5 grid, totalling 25 cells.

The five columns separate research into five different aspects of treatment: the intervention itself – techniques, programmes, equipment, therapies or medications and the practitioners delivering it; staff attributes, training, skills, qualifications, and competencies; the management and supervision that oversees it – selecting, training and managing staff and interventions; organisational functioning – how the organisation itself fosters effectiveness; and the treatment system – creating an appropriate mix and quality of services across an area.

The five rows that intersect the columns are organised by the different kinds of intervention: covering harm reduction (for drugs); screening and brief interventions (for alcohol); generic and cross-cutting treatment issues; medical treatments, psychosocial or 'talking' therapies; and treatment that aims to safeguard the community.

Once you've picked the level and type of treatment you're interested in, each cell contains the major historical and contemporary research landmarks in that territory, as well as systematic reviews and expert guidance. Commissioners can use this selection to learn what services and treatment systems accord with the best evidence of 'what works', managers can use them to help new staff understand the basis for addiction treatment or existing staff with continuing professional development, and practitioners themselves can appreciate the foundations of their work and how to build on them.

The value of the matrices doesn't stop at the grids themselves, nor the documents within them. This selection of the most important treatment research, evidence and guidance, all mapped according to the level and type of intervention, presents a unique opportunity for an introductory course that does not just direct readers to the documents, but also explains and analyses them – individually and as a whole – and sets them in their context. The matrix bites build on that opportunity, forming weekly cell-by-cell introductions to the matrices, which cumulate to a year-long foundation course on the treatment evidence base.

The Alcohol Matrix Bites course has now been completed – although don't worry, they remain on the website and can be viewed any time – and we can now look back at the highlights. To see the bites for each cell, visit the Alcohol Treatment Matrix, click on the cell you want to see, then underneath the studies, reviews and guidance, click Matrix Bite to unfold the commentary. There are also summaries for each row; click the row title to see these.

The first row of the Alcohol Treatment Matrix, and the first five matching bites, deals with screening and brief interventions. This key public health strategy is intended to be a relatively simple and quick way to identify people who are drinking at levels that may harm their health, when they have contact with their GP, at A&Es, or in other contexts not focusing specifically on alcohol. They are then given brief advice about their drinking that encourages them to cut down.

THE RELATIONSHIP BETWEEN THERAPIST AND PATIENT IS EVERYTHING – BUT NOT ALWAYS SOMETHING THAT CAN BE TAUGHT. IT SEEMS EMPATHY, AUTHENTICITY AND RESPECT ARE KEY, WHILST FORMAL TRAINING, MANUALS AND GUIDEBOOKS ARE LESS INFLUENTIAL.

The first cell of the row looks at the landmark Screening and Intervention Programme for Sensible drinking (SIPS) trials, examines the strength of evidence for these interventions, and asks why it was sometimes patchy, whilst the second cell underlines the crucial importance of the behaviour of the practitioners delivering them.

The main message here is the variation in success from different practitioners, which is not just about skills, experience or qualifications. Instead the evidence points to the importance of the interpersonal style of the practitioner (the more confrontational, the more their clients later drank).

A key study from a Swiss emergency department showed that five counsellors with similar qualifications and experience and identical training, ended up with huge differences between their clients' change in drinking. The best led to an average reduction of nine UK units a week, whilst the worst led to an increase of 18 units. Have a look

at the full matrix bite in cell B1 to find out what made the difference.

The rest of the row zooms out from the interventions themselves and the practitioners delivering them, to discuss the effect of different management styles, organisational influences and commissioning systems. Issues include whether to insist on screening and brief interventions being integrated into practice, or letting staff and patients decide their priorities, whether there is a single universally applicable method for implementing these interventions, and the evaluation of a Scottish national commissioning programme that aimed to hit a minimum number of brief interventions.

The second row aims at the heart of alcohol treatment, and asks how we should conceive of treatment – who and what it should be for. Do the interventions even work, or is it the case that people who make the choice to come into treatment have already done 90 per cent of the work?

If treatment is to work, the lessons from cell B2's bite is that the relationship between therapist and patient is everything – but not always something that can be taught. It seems empathy, authenticity and respect are key, whilst formal training, manuals and guidebooks are less influential. This theme carried through into cell D2, where we discovered from a 2009 study in association with the National Treatment Agency that clients did best when the whole organisation was imbued with the same qualities that patients should experience, meaning staff must be treated with respect, understanding and support.

Treating alcohol dependence in a medical setting was explored in the third row. Because no medications are a 'cure' for alcoholism, although they may be aids to recovery, often at issue was not simply the drugs themselves but how they are delivered. Again, interpersonal factors were key. Cell B3 led us to appreciate that the 'bedside manner' of the clinician is not just a conduit for treatment, it actually is a large part of the treatment. Other cells discussed the importance of recruitment and how to identify the right staff, the value of implementing new evidence-based interventions versus the harm caused by frequent upheaval, and how commissioners can recognise a good quality service.

Moving on from medical treatments, the fourth row of the matrix and corresponding bites looked at psychosocial therapies, asking what are really the key ingredients of therapy, and whether 'breaking the rules' can actually be a good thing, especially if being genuine requires it.

The role of matrices and bites in not just identifying the best evidence – but also gaps in the evidence base – came to the fore here, when in cell E4 we saw the surprising lack of evidence for the core key working and care coordination functions. Despite being explicitly called for in the National Institute for Health and Care Excellence (NICE) guidelines, there is little research that backs up the idea of having someone to guide a patient through their alcohol treatment journey, arranging treatment and aftercare, monitoring progress and liaising with other agencies. Of course, lack of evidence doesn't mean that key working is definitely ineffective; perhaps it is hard to evaluate, or so obviously useful that it requires no further evidence.

The fifth row addresses a particularly difficult area of alcohol treatment, which has to marry aims to improve the health and quality of life of the patient with safeguarding their family and protecting the wider community from crime. Is it really possible to deliver an effective alcohol intervention in a prison, given what we've learned from the other bites about the importance of empathy, respect, and genuineness? Can treatment be productive even when it is forced on prisoners by the same authorities that have taken away their liberty?

Other cells look at possibly the most difficult management task in the addictions field – managing a 'wet centre' for street drinkers. They discuss whether smaller organisations are better able to deliver effective treatment for offenders, and ask whether our society's mix of criminal justice and health ingredients has the right balance, noting that drinking is at least partly responsible for sending thousands of people to prison. However once they get there, programmes to address their drinking are mostly characterised by their absence.

The Alcohol Treatment Matrix Bites course has been a fascinating, comprehensive and controversial cross-section of alcohol addiction treatment, and will remain available to view for free online. The Drug Treatment Matrix Bite course is about to begin, with support from the Society for the Study of Addiction. Sign up online to receive the weekly update service and get each bite sent to you as soon as it's written.

David Ader is Assistant Editor of Findings and also Communications Officer at DrugScope

Find the Alcohol Treatment Matrix and Matrix Bites at http://findings.org.uk/docs/amatrix.htm
Find the Drug Treatment Matrix at http://findings.org.uk/docs/dmatrix.htm

To sign up for Drug and Alcohol Findings Effectiveness Bank Alerts, including the forthcoming Drug Treatment Matrix Bites course, go to http://findings.org.uk/e-bank.htm#signUp

What they say about Matrix Bites

"A godsend for practitioners and commissioners. Dip in and take a look – the links are all there for you to benefit from the largest live drug and alcohol library in Britain."
Claire Brown, Editor of *Drink and Drugs News* (DDN), UK

"The Drug and Alcohol Matrices are just awesome. Teaching just those could qualify many in the substance use field."
Shaun Shelly, Substance Use Program Manager, Hope House Counselling Centre, South Africa

"I have found this resource incredibly useful. It is thought-provoking, the matrices are well laid out and offer easily accessible and comprehensive information, and the email service allows me to keep up with the most up to date research. It's great for my PREP requirement."
Jenny Willmott, Addictions Nurse (RGN) with Glasgow Addiction Services

THE ACID TEST

Psychedelic drugs such as LSD, MDMA and ketamine show promise in the treatment of mental health problems. By **David Ader**

HOWTOFASCINATE.COM

The crossover between illicit drugs and medicines is nothing new. Opiates like heroin and morphine can be our most effective medical painkillers, yet cause immense harm to individuals and society.

Some drugs that are currently illicit were originally invented or discovered for use in medicine. Conversely, some medicines have been developed from drugs that have become illegal – cannabis had been used for thousands of years, and made widely illegal, before the medicine Sativex was recently derived from it to treat multiple sclerosis.

Perhaps surprisingly, this crossover has so far mostly been limited to painkillers, tranquilisers and stimulants. The family of psychedelic and hallucinogenic drugs that include some of our most powerful and popular mind-altering illegal drugs, including MDMA, LSD and magic mushrooms containing psilocybin, have mostly not been mined for medical benefits.

In the UK, these three drugs are all not only Class A, but also Schedule 1, meaning that – unlike heroin, for example – they are not authorised for medical use and cannot legally be prescribed by doctors. The reasoning is they are judged by the Home Office to have no therapeutic value. Even so, ketamine is used widely as an anaesthetic, and there are a few other exceptions too. The over-the-counter cough suppressant dextromethorphan (DXM) is a powerful dissociative hallucinogen when used in quantities way above the stated dose. However, on the whole, this class of drugs are not permitted for use as medicines, and none are used in the treatment of mental illnesses.

Yet a growing number of voices are calling for just that to happen – and they are not only from people who are in favour of a more liberal approach to drugs.

More and more serious scientists, publishing in venerable academic journals, are highlighting the potential effectiveness of LSD, ketamine, MDMA, psilocybin and compounds derived from cannabis for a variety of mental illnesses. People suffering from common, difficult and debilitating illnesses including alcoholism, depression, post-traumatic stress disorder (PTSD), anxiety disorders and schizophrenia might have their condition alleviated by these new psychedelic medicines. But only if some or all of the promising early research findings translate into proven benefits, and the necessary regulatory and legal barriers are crossed. It's a big if. The trialling of new medicines is lengthy even when the drugs appear to be innocuous and have few side effects, and the legal and political barriers are real.

Professor David Nutt, former Chair of the Advisory Council on the Misuse of Drugs, certainly thinks that the legal obstacles are significant, and he speaks with a moralistic fervour on the issue, saying in 2012: "Regulations, which are arbitrary, actually make it virtually impossible to research these drugs. The effect these laws have had on research is greater than the effects that [George] Bush stopping stem cell research has had because it's been going on since the 1960s."

It's hard to support this comparison though. Even Schedule 1 drugs in the UK can be used for research purposes, although a Home Office licence is needed. For its part, the Home Office insists that bona fide institutions are perfectly able to conduct research into illegal drugs, and only necessary safeguards are in place. Given the difficulties and enormous expense involved in researching and bringing any drug to market, one extra level of delay and cost caused by having to obtain a licence should be relatively insignificant. And in any case, the amount of research that is going on in these areas belies Professor Nutt's claims; it only takes a second on Google Scholar to find many recent trials involving Schedule 1 drugs.

On the effectiveness of some of today's recreational drugs in the treatment of mental health problems, there are a few combinations in particular that crop up repeatedly in the literature, and for which the findings are especially positive. The longest-established link must be between LSD and alcoholism.

As long ago as 1958, American scientists were writing reviews of the existing research into LSD for a variety

of psychotherapy treatments – most notably for alcoholism – and individual studies date back to at least 1950.

The mechanism by which it might work is theorised to involve many of the same emotional states described by recreational users – the feeling of greater connection on a closer interpersonal level with the therapist, reduced inhibition, defensiveness, guilt and resistance to repressed memories – which enable the patient to discuss problems and issues that they would not usually be able to or feel comfortable doing.

The experience appears to have been felt by some to have been so powerful that a single dose had a lasting effect. Bill Wilson, the co-founder of Alcoholics Anonymous, was apparently convinced of the benefits, which he thought owed to LSD's ability to provoke the 'spiritual awakening' that he believed was an essential part of the process of recovery.

Perhaps unsurprisingly, the number of studies involving LSD seems to increase exponentially in the 1960s but then mostly tail off by about 1970, presumably as the drug became harder to obtain. The statistical power and methodologies of the many studies conducted might not stand up to modern scientific standards – these were often very small studies which dealt with the use of LSD for a very wide variety of mental illnesses. In 2012 Norwegian researchers extracted the data from all these studies, focusing exclusively on alcoholism, and conducted a systematic review and meta-analysis, concluding that a single dose of LSD as part of an alcohol treatment program was indeed associated with a lasting decrease in alcohol use.

A similar mechanism is purported to be behind promising results reported by several studies when seeking to treat PTSD and other similar anxiety disorders using MDMA. The strong sense of empathy with the therapist, feelings of happiness, serenity and warmth, a detachment from unpleasant memories and an increased introspective ability may help the patient to feel safe and in control, while the therapist and patient together address the causes of anxiety. First patented by Merck in 1912, MDMA was originally intended to be a medicine, and if the level of current scientific interest is any indication, it may end up being one again soon.

Perhaps the area with the most striking recent finding is the potential for ketamine to help alleviate the symptoms of severe depression. Widely reported in the press, a trial by researchers at Oxford University and Oxford NHS Foundation Trust found promising results.

The treatment, a much lower dose than is typically used recreationally and hugely lower than when used as an anaesthetic, was given to 28 people whose depression or bipolar disorder was so severe and treatment-resistant that they were in a clinic that usually performs electroconvulsive therapy (ECT, or electric shock therapy). The patients were given one or two small dose injections of ketamine a week, for three weeks. Almost one third of them reported that their depression was reduced by at least 50 per cent within two weeks of starting the treatment. This reduction lasted from just under a month to almost half a year.

PERHAPS THE AREA WITH THE MOST STRIKING RECENT FINDING IS THE POTENTIAL FOR KETAMINE TO HELP ALLEVIATE THE SYMPTOMS OF SEVERE DEPRESSION

Oxford psychiatrist Dr Rupert MacShane praised the "dramatic effect" of the ketamine treatment on people "whose lives are blighted by chronic severe depression". The side effects – some people experienced nausea, anxiety, confusion and altered perceptions – seem unimportant compared to the serious memory loss that ECT provokes.

The list by no means ends there. Psilocybin is reported to have some similar effects to MDMA for anxiety and PTSD, and cannabidiol (CBD), the second most important psychoactive compound found in cannabis after THC, may be as effective as antipsychotic drugs at treating schizophrenia, but with fewer side effects and an improved effect on the most negative aspects of the condition.

It is important to note again that these studies are coming from highly respected peer-reviewed scientific journals, not from the cannabis legalisation movement. The CBD for schizophrenia result was termed an "exciting finding [that] should stimulate a great deal of research" by Dr. John Krystal, the Chair of Psychiatry at Yale University School of Medicine.

For many of these drugs, though, the potential problems are well known. As the psychiatrist Dr Ben Sessa points out, it is important not to let justified wonder at the sometimes seemingly benign power of these drugs obscure their potential for harm. "The subject of psychedelic psychotherapy in the past collapsed – in part – because it was not only the pop-stars and poets who were preaching about the wonders of LSD, but also some clinicians who allowed themselves to become biased and blinded to the potential dangers of the drug," says Dr Sessa.

As well as worrying about harms, it must also be recognised that the scientific evidence on all the treatments mentioned so far remains promising rather than proven. The science for all these treatments is at a very early stage, and there will need to be many more trials, and many more positive results, before the Department of Health beseech the Home Office to allow therapeutic use of these drugs. It is of course hugely important that the bar is set high and that new medicines (or old medicines repurposed) are comprehensively tested for efficacy and safety. Nonetheless, the mental illnesses in question, for which some psychedelic drugs seem to offer a glimmer of hope, can have lifelong and hugely negative impacts on people's quality of life.

The recent Academy Award-winning film *Dallas Buyers Club*, although perhaps rightly criticised as a poor representation of the development of medicines for HIV/AIDS, did provoke discussion and may still provoke legislation that points in an interesting direction.

Set during the scramble to develop drugs for HIV/AIDS, before any effective medicines existed, the film explores whether people with terminal illnesses should have the 'right to try' anything that might help them, despite the new drugs not having been proven effective or safe.

Depression, anxiety and addiction are of course not terminal illnesses, but then LSD, psilocybin, ketamine and MDMA are not unknown quantities either, and much has been made – notably of course by Professor Nutt again – of the relatively low toxicity of these drugs.

If people with serious mental illnesses demand the 'right to try' these drugs as treatments for their conditions, it is not difficult to imagine a future where the psychedelics join painkillers, tranquilisers and stimulants as both illicit drugs and essential medicines.

David Ader is Communications Officer at DrugScope and also Assistant Editor of Findings

John Collins

John Collins coordinates the international drug policy project at LSE IDEAS. He is the editor of the latest report to call for an end to the drugs war, but the analysis from this expert group of economists points to a more realistic, incremental approach than sweeping legislative change. Interview by **Harry Shapiro**

So why another report about the failed drug war?

This report is slightly different, in that we are not saying that the war on drugs has failed. There is a cacophony of voices saying that. We are not saying we have a silver bullet solution to fix global drug policy. What we are saying is that there are specific things that we can now do towards de-escalating the drugs war, towards reallocating resources, towards making sure that in a few years time, we don't get a new generation of politicians coming in at the international level saying, 'let's push harder, let's have another drug war, this time we can actually do it, all we need is more political resolve and see it through to its conclusion'. This is all about drawing a baseline above the war on drugs and starting thinking about a post-war drugs framework.

The core focus is reallocation of resources. Rhetoric has changed at the UN level; if resources now follow that change in rhetoric, we could see a shift in institutional inertia. We have got to start taking money out of things that shouldn't be funded to the level they are and putting money into things that should be scaled up in funding. And looking further ahead, it's a matter of seeing what happens in Washington State and Colorado and Uruguay and learning from those situations. We can't extrapolate much further than that, but we can see what happens, and then decide our next steps. So that's why this report is slightly different.

There is a wearying level of simplicity in the public debate – get tough or sweep it all away. Do you see a way of pushing past this to something more sophisticated and nuanced?

The debate does tend to be very country specific. In the UK, there isn't much low hanging fruit in terms of drug policy. We can drastically improve cannabis enforcement which is essentially a means to control minority youth in poor neighbourhoods. And that is probably it in terms of low hanging fruit; harm reduction is well established and integrated into the NHS. You could move into more heroin-assisted treatment, but there are large cost questions around that. So the end of the drug war in UK drug policy terms is far more problematic as to what that actually means because policy isn't that extreme.

But when you get into the world of international drug cooperation, there is really low hanging fruit here. We can't even use the term 'harm reduction' at the UN in a consensual way. At the CND conference in Vienna this year, Japan stood up and criticised nations for implementing needle exchange – the equivalent of going to an AIDS conference and saying that condoms were contributing to the spread of HIV.

The UK should not be gearing all its cooperation at the international level on enforcement, because it is a total fantasy that it will have anything other than a marginal impact. In the US, everybody is talking about ending the war on drugs, but have budgets really shifted? There is de-incarceration because there is less money at the state level to pay for prisons. But the DEA is still stuck in this drug war mindset: somebody has to break that institutional inertia. Why? Because when the reform narrative begins to lose momentum, which is very possible because lots of reports say 'end the war on drugs' but how do you actually do it – the DEA will still be doing what it's doing and somebody has to challenge that, to say we are not giving you the money to pursue this policy the way that you were.

So do you really think the reform narrative could lose momentum?

I think eventually we'll see a new equilibrium reached in the policy discussions, where the reformers will find it harder to get airtime for their case. A useful way of thinking about the evolution of the international control system is 'punctuated equilibria'. Periods of stability are broken by periods of upheaval, before a new period of stability is reached. We're clearly in a period of upheaval and the reform narrative is winning at the international level. It won't continue indefinitely, so one of the ways to ensure specific change is to change how money is spent. Otherwise, when the discussion dies down, we'll find that institutions are still operating in the same ways they did before.

To what extent then has the drug war become unaffordable in an era of global austerity?

Well, I have some sympathy for the notion that what nations actually spend on executing the drug war is not enormous. For example, if you look at the international aid budget, the global drug war budget is far smaller. Something like Plan Colombia was a counter-insurgency budget – it was framed in drug war rhetoric and there was a huge drug policy component, but it wasn't specifically a drug policy intervention. But whatever money is allocated at the international level, put those resources into more effective interventions and you will see more effective outcomes. I don't think that the money spent on international level drug policy is breaking budgets; internationally, the USA spends about 5% of its total drug policy spend. At the national level, of course the picture is quite different for some countries. The US spends a fortune implementing its national drug war and this is something which is being scaled back by austerity. Further, the social costs (in many ways unquantifiable) are not captured by these kinds of figures. So although the international drug war budget isn't enormous, the social costs of bad policies – think increased murder rate in Latin America – are extreme, yet not liable to fall victim to austerity.

It is an interesting report in that, despite the title, it does give a role for prohibition.

We can only extrapolate so far – this is an economic report and so it has to be evidence-based and the evidence base around the impact of enforcement is pretty minimal; what will happen under a regulated market is largely conjecture. We can make extrapolations based on economic modelling. The best of this I have seen is that prohibition in and of itself raises prices significantly. If we take it that drug use responds to price, then it makes sense that if prohibition is raising prices, it is probably also reducing consumption. But can the damages that prohibition causes be sufficiently managed so that the costs of prohibition to society can be reduced to the point where it makes sense?

Spending huge amounts of money chasing everybody around who might be dealing or selling in that commodity has no proven value. Peter Reuter and Jonathan Caulkins calculate that you could roll back enforcement in the US by 50% and not see any significant increase in drug use. So the outcomes remain the same, but the social and economic costs are drastically reduced. We have to see if we can set limits on prohibition, see if

there is a workable model of prohibition. Personally, I am highly skeptical, but we are not going to get to a post-prohibition world immediately. And in any case, we don't want to run too quickly in the other direction; just because the drug war has been such a disaster, you don't run towards complete legalisation and commercialisation. As Mark Kleiman says in his chapter, then you will get an industry with lobbyists trying to sell more cannabis. So that's why we need to take an incremental approach.

Can you expand on the idea of the UN consensus breaking down?

Particularly after 9/11, the US became marginalised in a number of multi-lateral institutions. Russia quietly strengthened its hand in a lot of these, like the UN. The US has been scaling back on its global commitment to the drugs war since Obama took office; he said the US was not going to spend vast amounts of bi-lateral political capital enforcing its interpretation of the prohibitionist regime. The consensus began to beak down and you could see the fracturing. Russia sort of stepped in, in some ways took control of UNODC, but now you have the Ukranian crisis – so there is now a diplomatic freeze against Russia. That's having a huge impact on the degree to which Russia can control the narrative of international drug policy. In Vienna this year, the Russian foreign minister didn't show up. The Russian drug czar is not allowed into the US because he's on the sanction list. So the only other nation that could take a leadership role in the years ahead is China. But the Chinese are not going to expend political capital on this at an international level because Chinese policy is non-interventionist. So there is a power vacuum at the UN level.

So where should the UN be heading?

On the drugs issue, the questions should be – are we doing the right things to help prevent the spread of HIV and hepatitis? Are we protecting human rights? Are we preventing the blanket criminalisation of people who use drugs? We are doing all the wrong things at the international level, looking at all the wrong indicators.

Currently none of these things are enshrined at the UN strategic level apart from some grudging acceptance of a balanced approach. But the effort is still toward shrinking markets, shrinking demand and supply. What I hope to see in 2016 is a focus on public health and population security – and an acceptance that some states will experiment with cannabis legalisation and others won't. This will represent an important shift in the strategic trajectory away from the 'drug free world' mentality.

And where do the UN Conventions sit in this evolving landscape?

Far too much is made of the Conventions. They were written in a purposely vague manner. Going by the letter of the law, you would say that states can't legalise cannabis, but states have always interpreted the Conventions in relation to other international commitments, for example around human rights. The only part of the international system that the UN should say states adhere to is the control of the licit global market in opiates, because if they don't, the whole thing falls apart. But as far as national policies are concerned, if a country wants to legalise cannabis, so long as they are not exporting it, then in my view, it is debatable whether they are in contravention of the 1961 UN Convention. The US and Uruguay have claimed they are not in contravention and I have an awful lot of sympathy for that view. Overall, the point is that the Conventions are what states decide to make of them. They should never be seen as a barrier to states improving international drug policy, even if that goes against previously held interpretations.

You are quite critical of the role of the INCB in your report.

States are the executors of the treaties. There is some bizarre notion that INCB is the executor of the treaties. INCB was created as a technocratic body to receive from states the numbers relating to the amount of licit opiates they require. INCB looks at those numbers and then determines what the supply is on the international market and they report back to the Commission on Narcotic Drugs. The idea that INCB are somehow 'the guardians of the Conventions' is a purely political creation – not mandated under any international agreement.

Do you think we have reached any sort of tipping point in relation to the execution of international drug policy?

I think 'the revolution will not be televised' is the way it will happen. It is a quiet evolutionary process; the rhetoric has changed dramatically in just a few years. The Russian head of UNODC said that he doesn't understand how Uruguay can say they are not in breach of the Convention, he doesn't understand the logic, but accepts it because they are a member state. This is the kind of shift we are seeing at the UN; Yuri Fedotov is acknowledging that all he is, is a functionary – a lot of UN rhetoric was paper tiger stuff; it pretended it could enforce the system.

With UNODC resource allocation, I think we have to see a democratisation of the budget. It's not sustainable that the most conservative states fund UNODC. It results in an international focus on the wrong kinds of policies – all those efforts to reduce supply. There is no evidence that they work at the margins and there is a large body of evidence highlighting the damage they cause and the destabilisation, yet enormous efforts and resources are directed towards them.

To read the full report, go to: http://www.lse.ac.uk/IDEAS/publications/reports/pdf/LSE-IDEAS-DRUGS-REPORT-FINAL-WEB01.pdf


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Smack is back… but not here

The recent death of Phillip Seymour Hoffman has shed light on what appears to be a new heroin epidemic in America. **Max Daly** investigates.

Heroin use is on the wane in Britain. The battle against a drug that blighted many impoverished areas in the 1980s and 1990s appears to be won. To a large extent young people have turned their back on a substance that so visibly damaged the previous generation. In the UK's narcotic marketplace, low quality heroin is struggling to compete against an array of cheap, illicit market prescription medicines and bargain basement alcohol. But across the Atlantic, heroin is making a comeback.

In the US, the media and politicians have declared a nationwide heroin 'epidemic' which is finding fertile ground among America's middle classes.

The heroin-related deaths within the last 10 months of two well-loved actors, Phillip Seymour Hoffman and Corey Monteith, nailed the "scourge" to the very heart of America. Scores of towns, cities and states across the US have declared themselves 'heroin capitals'.

In January, Peter Shumlin, Governor of the east coast state of Vermont, one of the worst affected states in the US, devoted his entire annual 'State of the State' address to the heroin problem. He pointed out that nearly twice as many people in the state had died from heroin overdoses as the year before.

Since 2000, he said, Vermont, the second least populated state in the country with 626,000 residents, has seen an increase of more than 770 per cent in people seeking treatment for opiate addictions, up to 4,300 people in 2012.

"In every corner of our state, heroin and opiate-drug addiction threatens us," warned Shumlin. "The time has come for us to stop quietly averting our eyes from the growing heroin addiction in our front yards."

In Massachusetts, another New England state that has been shocked by the rising presence of heroin among its citizens, Senator Edward Markey described a "meteoric rise in addiction to heroin." Similar warnings have been heard across the country, from Ohio to Louisiana and from Colorado back to the east coast, where sharp rises in heroin deaths have been reported from New Jersey up to Maine.

FOUR OUT OF EVERY FIVE HEROIN USERS IN THE US HAS FORMERLY ABUSED PAINKILLERS

"We're seeing a resurgence of heroin," Gil Kerlikowske, director of the Office of National Drug Control Policy, said. "It cuts across all demographic groups. We used to think of heroin as an inner city problem, but it's now a problem we're seeing across the nation among all populations and all ages."

What has made the rise in heroin use so difficult to swallow for the US is that it is a phenomenon that to a large extent has been driven by Big Pharma, rather than the usual suspects – foreign drug cartels. The scattergun prescription and widespread illicit diversion of opiate painkillers such as OxyContin over the last decade appears to have inadvertently created a fresh and sizeable US market for street heroin.

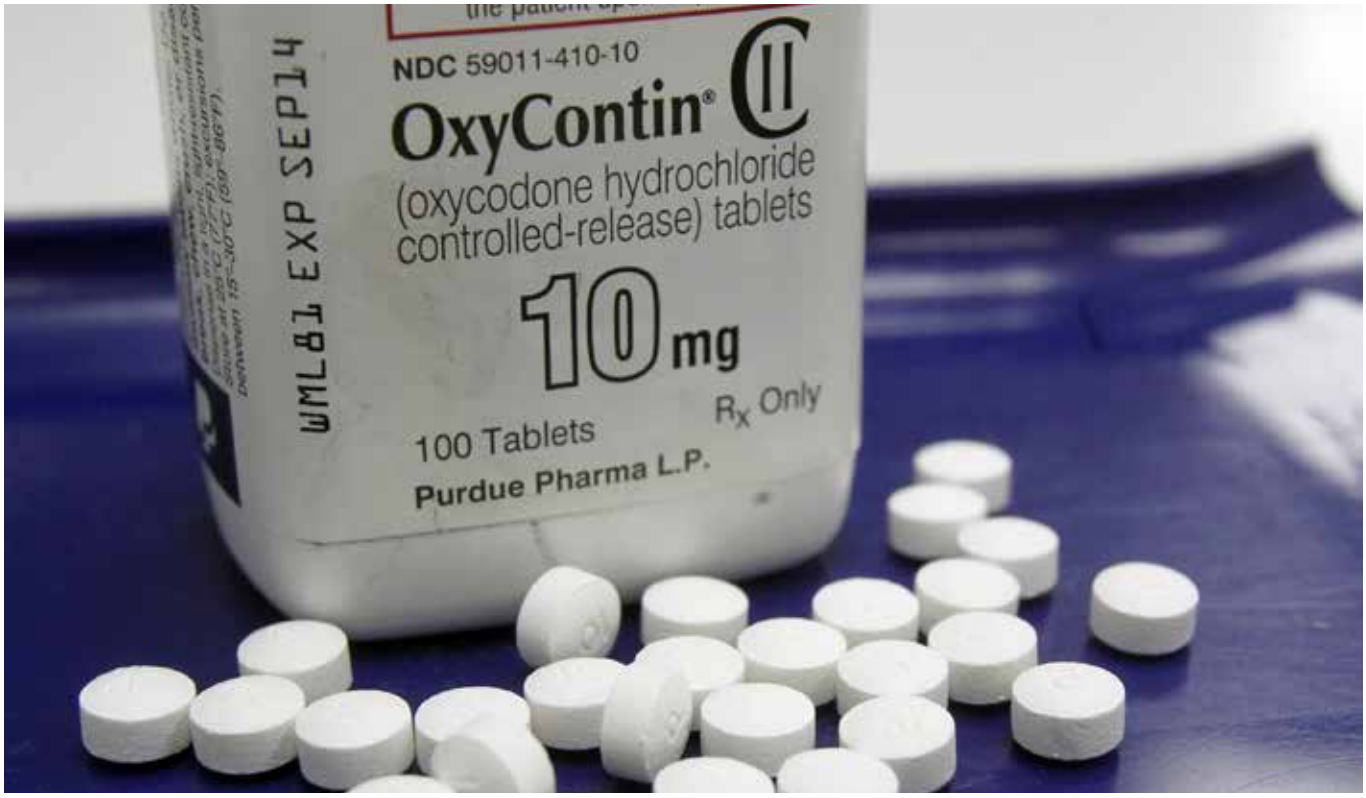
Whether what is going on in America can or should be described as a heroin epidemic is highly debatable, but all the indications show that, unlike the UK, the US has certainly witnessed a rise in heroin use over the last decade.

The National Survey on Drug Use and Health (NSDUH), a door-knocking survey of homeowners similar to the annual Crime Survey for England and Wales (CSEW), found the total number of monthly heroin users in the US had jumped from 239,000 in 2010 to 335,000 in 2012, doubling since 2002. Around 0.3 per cent of the country's 314 million citizens had used the drug in the last year, compared to 0.2 per cent in 2002. Based on these figures, declaring a heroin 'epidemic' seems a little dramatic.

However, as research into heroin prevalence in the UK has shown, nationwide drug use surveys, as their authors admit themselves, are notoriously inefficient at head counting heroin users.

For example, the latest CSEW estimated there were 56,000 last year opiate users in England and Wales. However, more detailed research carried out for the Department of Health found this figure was five times higher – at 261,792 regular opiate users.

In an attempt to drill down to get a truer picture of the US heroin figures, researchers from the RAND Corporation used data from the Arrestee Drug Abuse Monitoring Program and then converted the statistics into nationally representative figures. Their conclusion was that rather than the US having



60,000 daily heroin users, as the national drug use statistics had found, the true figure was closer to one million.

Americans have not had to look far to find the root cause of this phenomenon.

In 2009, 257 million prescriptions for opioid painkillers such as OxyContin, the first drug of its kind to have a time-release mechanism that spaces out its effects over a longer period of time, were dispensed from retail pharmacies, a 48 percent increase from 2000.

The flood of relatively easy to get painkillers, especially in more rural areas where some doctors turned to painkillers as a cure for all, created a huge number of recreational users of these pills, which is why OxyContin is also known as 'hillbilly heroin'.

Unlike heroin use in America, the use of opioid painkillers has reached epidemic levels over the last 15 years. Since 1999 there has been a near four-fold increase in deaths from opioid painkillers, from 4,030 to 16,651 in 2010. During this time heroin deaths climbed from 1,960 to 3,036.

The net soon started closing in on OxyContin's manufacturer, Purdue Pharma. In 2007, the firm and three of its top executives were fined $600 million after pleading guilty to misleading the health industry about the drug's risk of addiction.

Cowed by this, in 2010, Purdue caved in to pressure from the government to reformulate the pills in order to make them harder to crush and snort.

It is this forced, but well-intentioned move that observers say switched thousands of addicted prescription pill users onto cheaper, more easily available heroin.

Figures from NSDUH support this theory. While the number of Americans abusing OxyContin fell from 566,000 in 2010 to 358,000 in 2012, the number of heroin users escalated. Four out of every five heroin users in the US has formerly abused painkillers: the direct opposite of what is going on in the UK.

Heroin dealing gangs from big cities such as New York and Boston were in the perfect position to provide the goods to all the out of town pill crushers who suddenly found themselves needing an opiate fix.

Dealers travelled up to New England and made a healthy profit. A $5 bag was worth $10 to $30 up the coast – and was still less than an opiate pill. Former prescription painkiller users were able to return to an opiate hit that was relatively cheap and as it was beforehand, readily available.

In 'Effect of Abuse-Deterrent Formulation of OxyContin', a report which analysed the impact of the changes made to OxyContin pills, published in the *New England Journal of Medicine* in 2012, researchers concluded:

"Our data show that an abuse-deterrent formulation successfully reduced abuse of a specific drug but also generated an unanticipated outcome: replacement of the abuse-deterrent formulation with alternative opioid medications and heroin, a drug that may pose a much greater overall risk to public health than OxyContin. Thus, abuse-deterrent formulations may not be the "magic bullets" that many hoped they would be in solving the growing problem of opioid abuse."

A study into US national drug overdoses following the introduction of the new pill, published last year in the journal, *Pharmacoepidemiology and Drug Safety*, found the change prompted a 36 per cent fall in OxyContin overdoses, but a 42 per cent increase in heroin overdoses.

The dishing out of opiate painkillers by American doctors, often on the behest of the manufacturers, sowed the seeds of this upturn in heroin use, by grooming a nation of opiate addicts.

As Wilson Compton, deputy director of the National Institute on Drug Abuse says: "When heroin users weren't able to obtain heroin, they'd use pills as a secondary substance," Compton says. "But what has been emerging is the trajectory from pill to heroin use."

Max Daly is a freelance journalist

WRONG ARM OF THE LAW

The evidence from abroad, especially Portugal, suggests that scaling back on criminalising drug users in the UK could be a smart move, says **Jessica Magson**.

Despite major advances in drug treatment support over the past 20 years, punitive approaches to tackling illicit drug use remain a central feature of UK policy. Current sentencing guidelines still impose a maxmium penalty of seven years in prison for drug possession offences, and figures from 2010 suggest 43,406 individuals were found guilty of drug possession in the courts that year, primarily in relation to cannabis.

While numbers have stabilised over the past two years, we have witnessed decades of increases in the incarceration of drug offenders, with the total in 2011 166 per cent higher than in 1993, according to Ministry of Justice figures.

I recently returned from visiting Portugal, the Czech Republic and Uruguay as part of a Winston Churchill Memorial Trust Fellowship. Drawing on meetings with politicians, state officials and frontline staff in the three countries, my aim was to understand how other states have conceptualised and implemented a shift away from criminal sanctions and towards health-based support for problematic users.

During my visits, I found that a move to civil rather than criminal possession penalties was fairly simple to enact, could generate a range of efficiencies for the criminal justice system and allowed for the more effective targeting and prioritisation of treatment and social support.

My final report argues that, in what is a fast shifting international environment, the UK urgently needs to iron out the contradictions in its current policy approach and to objectively consider the arguments for reform set out by practitioners across the health, welfare and criminal justice sectors.

Over recent decades, two strands of closely related UK policy have developed at divergent tangents. On the one hand, a growth in police capacity, resourcing and legal powers has helped to fuel a substantial rise in the numbers prosecuted and incarcerated for drug possession in the UK. Sentences for all drug offences have risen to an average of 31.3 months in jail, followed by mandatory supervision and a criminal record that will hinder your chances of legitimate employment in the future.

For individuals lucky enough to have their addiction identified by staff in the health and social services however, the story can be very different.

The UK has developed a well-functioning system of drug treatment support that is internationally renowned and used as a model in other countries. There are options for residential or community support, substitution therapy, needle exchange and social services stretching into housing, employment, education and debt management. Financial constraints may be putting pressure on these resources and we know that many more individuals remain in need of help. But, in the main, service provision for drug users is strong in the UK when compared to many other countries.

The fact that some of these treatment facilities are made available to offenders within the criminal justice system misses the point. Why is one strand of the state punishing individuals which another part of government would be working to treat and support?

Both the Home Office and the Department of Health are looking to reduce the demand for and damage caused by drugs, but these contradictory approaches are arguably working to undermine common objectives.

Enforcement is meanwhile generating tensions between the police and local communities and putting unsustainable pressure on a criminal justice system undergoing major cuts. In the UK we don't see the levels of chronic prison overcrowding or court backlog that encumber many other administrations, but the concept of 'overcriminalisation' remains pertinent. We may have sufficient capacity to be able to process and incarcerate a large number of people, but the cost to the taxpayer is vast.

Growing numbers within the justice system itself are arguing that the criminalisation of users is undermining rehabilitation and generating significant barriers for individual recovery. Leading experts from a wide variety of fields are adding their voices to groups like the Home Affairs Committee, UK Drug Policy Commission and National Association of Probation Officers, in calling for reform.

With this context in mind I wanted to analyse and compare countries where a process of decriminalisation has been designed and implemented. Portugal and the Czech Republic have mutually shifted to civil rather than criminal penalties for drug possession offences, while the authorities in Uruguay revised their possession laws in 1979 and are now on the cusp of implementing a regulatory model for cannabis supply.

The Portuguese strategy was premised around the principle of the drug addict as a diseased citizen with a constitutional right to health and a recognition of the limitations of rehabilitation within the custodial estate. The Czech administration also

sought to refocus attention towards harm reduction and, as in Portugal, appointed a health expert to oversee policy development and delivery. In Uruguay treatment provision remains under-resourced and it is hoped that the regulation of cannabis will cut the link between cannabis users and the suppliers of stronger illicit substances and lead to stronger support for problematic users funded through taxation revenues.

In each of these countries, I interviewed staff working in policy, enforcement and frontline service provision to understand what the impact of legislative changes had meant for them and the individuals they work to support.

Each administration is tackling nuanced domestic problems and their approaches to drug abuse vary, but there are common lessons which can be drawn from their experiences. And while there are examples of good practice in both the Czech Republic and Uruguay, it is the Portuguese dissuasion commissions that really stand out as a potential model for the UK.

CONTRARY TO THE VIEWS OF SOME COMMENTATORS, THE NEED FOR REFORM IN THE UK REMAINS ACUTE. DECRIMINALISATION IN OTHER STATES MAY SOON MAKE A PROHIBITIONIST UK POSITION UNSUSTAINABLE

These quasi-judicial bodies blend the authority of the courts with a focus on individual rehabilitation and treatment support. The commission panels combine judicial, health and social service expertise, to work with individuals referred by the police, identifying any problems early and directing users to a National Network of Harm and Risk Reduction, a body set up alongside changes to the law.

A number of sanctions are available to the commissions but the focus lies in supporting the individual away from problematic use. Tens of thousands of people have attended these sessions and officials point to a variety of successes including a rapid decline in public concern around drug abuse, identified in Eurobarometer surveys.

While many of those interviewed in Portugal have noted how the judicial system continues to suffer from resourcing and capacity constraints, nobody was in favour of returning to a prohibitionist model. There was consensus that their innovative reforms, built on the back of expert evidence, have been central to helping them overcome a severe HIV epidemic in the late 1990s and widespread intravenous heroin use.

Their policies were targeted to address the specific problems of the Portuguese context, but it is nonethless clear that conceptualising drug abuse in a framework of disease and addiction gives space to policy development that is more firmly rooted in applying the evidence of what works for long-term recovery.

We can also now prove that decriminalisation policies do not need to result in a surge in drug consumption rates or acquisitive crime. Contrary to the expectations of critics, initial rises in use in the immediate aftermath of reform quickly calm down again. Over time the benefits of enhanced trust between individuals and state authorities has filtered down, creating a more open environment where individuals are better supported and untainted by a criminal record.

Each section of the justice system is likely to see efficiencies. Police processing time can be substantially cut, allowing them to concentrate more on the investigation of other crimes. Referral tools provide officers with the ability to help the addicts they encounter, while probation officers and charity workers in Portugal and the Czech Republic noted how they are able to have a more honest dialogue with clients who are no longer fearful of the consequences of admitting an addiction.

If a country like Portugal, with limited economic resources, is able to set up an effective diversion model to deal with possession only offenders, could the UK follow suit?

A final report, accessible here http://goo.gl/KUDNT9 argues that the piloting of comparable schemes is both feasible and necessary. The idea fits well with UK principles of rehabilitation and community policing and there already exists a strong network of practitioners available to provide support. The formation of dissuasion commissions, tailored to the UK context, could generate a range of benefits, particularly at a time when resentment towards police stop and search techniques is mounting.

Ultimately, these changes have worked best elsewhere when they are framed in a broader strategic shift at the executive level, giving precedence to health-based solutions for overcoming addiction and applying this to decisions in relation to oversight and resource allocation.

Contrary to the views of some commentators, the need for reform in the UK remains acute. Decriminalisation in other states may soon make a prohibitionist UK position unsustainable.

When domestic public services continue to document the wide-ranging social and individual harms arising from drug addiction we cannot complacently point to a slight downward shift in consumption patterns as testimony to an effective policy approach. Instead we should consider the thousands who continue to die from overdose each year, the rise in untested new substances and sustained numbers seeking treatment support as signs of a continued failure to adequately prioritise health and welfare provision over the partial by-product of drug abuse which is, sometimes, crime.

Before starting the Churchill Fellowship Jessica Magson worked at the International Directorate of the UK Ministry of Justice for five years, analysing the effectiveness of criminal justice systems in other countries and managing projects to support the development of court, prison and probation services abroad.

Further information about the fellowship can be found at jmagson2013wcmt.wordpress.com

49 factsheet

DrugWatch

MPA

Produced in association with UK DrugWatch. UK DrugWatch is an informal online professional information network established by a group of professionals working in the UK drugs sector. The aim of the group is to raise/establish standards for drug information, alerts and warnings. It is currently an unfunded, bottom-up initiative that works in the spirit of mutual co-operation. Details of current members can be found online: www.drugscope.org.uk/partnersandprojects/DrugWatch

Drug overview

MPA (Methiopropamine) is a new psychoactive substance (NPS), a stimulant drug, sold on its own or within a wide range of branded products.

Background

MPA was originally discovered in 1942. It is an analogue of methamphetamine. However its effects are very different to those of methamphetamine. MPA began to be seen in the UK towards the end of 2010.

Appearance

MPA is an off-white powder, slightly clumpy in appearance with a bitter taste. It has a recognisable smell that has been described by some as having a "slight odour of aniseed".

Marketing

MPA is often sold as a combination drug and is one of the ingredients of a wide range of branded products, among them: Ammo, Barry White, Blue Genie, Bomb, Bullet, Charlie Sheen, China White, Dragon, Dusk Till Dawn, Flake Red Eye, Fury, Fury Xtreme, Gogaine, Green Beans, Pink Panthers, Poke, Posh, Purple Bombs, RPM1P, Synthacaine and White MM.

The contents of these branded products can fluctuate and it is often unclear which compounds they contain. For example, Pink Panthers have been marketed as containing a combination of MPA and MDAI, however some contained just MPA, others are marketed as pure MDAI, and others still a blend of MDAI, 5-iAi and 2Ai 14.

The reasoning behind MPA being sold in combination with other compounds is widely discussed on user forums. For example, there are many user posts describing a synergistic relationship between MPA and MDAI, in which combining these two drugs in a certain ratio creates an effect stronger than the sum of its parts. While MPA on its own is usually sold in powder form, the branded products containing MPA are available in both powder or pellet forms.

Cost

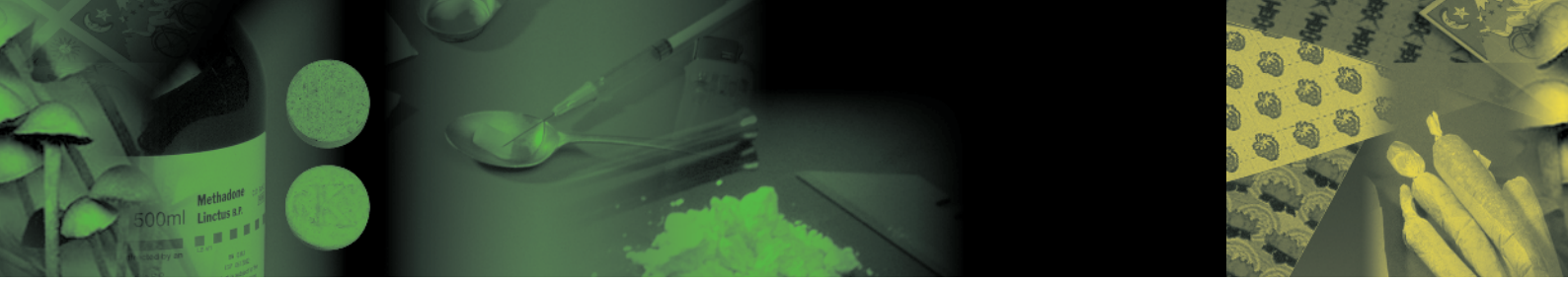
MPA 1g approx £14, 10g approx £80, 100g approx £550. Branded products containing MPA cost approximately £15 per gram (online) or £20-£30 per gram (in retail outlets).

Route of administration

MPA is typically sniffed or vaporised (heated and inhaled). Rectal administration is discussed on forums, but only limited data on intravenous use or oral use.

Typical effects and side effects

MPA is described by many users as a "functional stimulant". It is compared to drugs such as caffeine or methylphenidate (Ritalin), and users state that they find it helpful when studying or working late. Another positive factor mentioned by users is that as MPA induces very little euphoria, it is often harder to tell when someone has taken the drug as there are less "tell-tale signs." After effects/comedown: Users report the comedown from MPA to be minimal or significantly less pronounced than for other stimulant drugs, perhaps due to its lack of activity on the brain's reward mechanism. Effects noted by users include tiredness, low mood, headaches and irritability.



Dosages, onset and duration

Due to the scarcity of either published research or user reports about MPA, these dosages are rough guidelines only. Effects and times of the drug vary; reported duration times for example range from 30 mins to 4 hours depending on user, dose and route of administration. Please note that the amounts and times below will not apply to everyone who takes the drug.

Sniffed

Threshold	5 mg (approx)	Total duration 1-4 hours
Light	5-20 mg	Onset 5-10 mins
Common	30-50 mg	Coming up 5-10 mins
Strong	60+ mg	Plateau 30-120 mins
		Coming down 60-120 mins

Vaporised (heated and inhaled)

Threshold	5 mg (approx)	Total duration 30-60 mins
Light	5-15 mg	Onset <1 min
Common	15-30 mg	Coming up 1-10 mins
Strong	20-40+ mg	Plateau 60-120 mins
		Coming down 60-120 mins

Emergency situations

Serotonin toxicity: When MPA is combined with certain other drugs (for example aminoindanes such as MDAI or 5-iAi) the user is placed at risk of serotonin toxicity. This can be fatal if not recognised and dealt with both quickly and effectively. Symptoms include hyperthermia (overheating), hyperreflexia (over responsive reflexes), clonus (involuntary muscular contractions and relaxations), hypertension (high blood pressure), dysphoria (mental distress) and mydriasis (dilated pupils). Due to muscle tension being triggered by the condition, there is a potential of developing rhabdomyolysis (muscle tissue breakdown) which can cause severe kidney damage and can be fatal. It is therefore dangerous to restrain individuals, as increased agitation will lead to increased muscle tension trying to break free from restraints. Treatment can include cooled IV fluids, benzodiazepines to control agitation, rapid cooling via ice packs, oral cyproheptadine (antihistamine with anti-serotonergenic properties) and anti-psychotic medication in severe cases Perceptual effects of serotonin toxicity can last up to 24 hours; there is also the possibility of 'rebound effects' more than 12 hours after initial symptoms.

Patterns of use

Some users claim that there is little urge to re-dose, however a number of other users report continued use during episodes of taking MPA. Re-dosing appears more prevalent among users who inject intravenously, sniff or vaporise, and this increases the likelihood of negative effects such as anxiety, irritability, jitteriness and insomnia. There are user reports of compulsive 'binge' sessions lasting for several days[16]; as with other stimulant drugs there is a risk of developing psychological dependency.

Long term effects/known harms

MPA is a relatively new compound and as such there is little information available on the harms associated with long-term use. Extended periods of use of any stimulant drug are likely to result in symptoms such as tiredness, weight loss and an increased risk of mental health issues such as paranoia, mood swings and low mood.

Legal Status

MPA is currently not controlled under the Misuse of Drugs Act.

Harm reduction

All drugs have the potential to cause harms and some of these can be very serious and rarely, life threatening. The lack of knowledge about the toxicity and effects of new psychoactive substances may mean harm reduction options are not always clear. New psychoactive substances have not been tested in clinical trials and the short-, medium-, and long-term effects are not known. A lack of consistency in the active content of individual products over time may put users at risk of misusing the substance, or of overdosing, and the combination of substances within individual products creates a potential risk of problematic drug interactions

This information has been collated from a variety of sources including expert users and information from users via relevant websites and drug forums. This information sheet is to be used as a rough guide only; there is little scientific or medical evidence available on the substance and much of the information has been obtained from service users' reports.

The key to the highway

An ambitious and wide-ranging introductory text impresses **David MacKintosh**.

Reviews

KEY CONCEPTS IN DRUGS AND SOCIETY

Ross Coomber, Karen McElrath, Fiona Measham and Karenza Moore.
Sage 2013

BUY NOW

The ambition of this book is considerable, seeking to bridge the gaps that exist between many existing introductory texts on drug issues while addressing the multiple issues linked to drugs and drug policy. In essence it seeks to provide impressive breadth with a degree of depth. It's a tall order, but one which the authors prove capable of matching – I wish I had had a copy years ago.

The book is divided into three sections, looking at types of drugs and patterns of use; the effects of drugs; and then drug policy, treatment and perception of the drug problem. It's further broken down into 41 headings – everything from "Why do people take drugs" through to "Crop eradication, crop substitution and legal cultivation". Each heading is further broken down into bite-sized elements. A potential criticism of this approach is that complex issues are often mentioned or hinted at without being fully explored, which is totally understandable in keeping the book to a manageable and accessible size. However, in mitigation each section ends with a list of references allowing the reader to follow their interests and go deeper into the subject matter where required. This alone makes *Key Concepts in Drugs and Society* a valuable addition to the canon of drug literature.

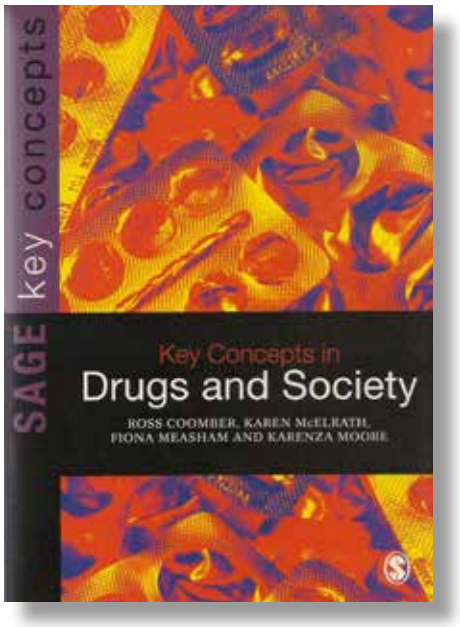
In fact, the discipline exercised by the authors in addressing each heading within four pages (and most in two) is the standout attraction of this book. There is a calm and authorative style to tackling issues such as "Drugs and Crime" which sets out the competing perspectives and theories in a way which is helpful and illuminating. The section which looks at the current very live issues around recovery (titled here the New Recovery Approach) provides some very helpful context and certainly reminded me of the issues in providing care and responses for individuals, which is much broader than just treatment, when delivery is set within population level approaches.

Clearly aimed at the academic market (it would make an excellent pass-notes revision aid) I hope that many working in the drugs field, or even those with a passing interest in the subject, will make use of this work. Personally I would hope it finds its way onto a number of politicians', special advisers', civil servants' and media commentators' reading lists. It could certainly aid many of those who constantly confuse chalk with cheese: reading section 40 on Decriminalisation, Legalisation and Legal Regulation should be required reading for all those seeking to pontificate on those particular issues.

While its structure lends itself to dipping in and providing a veneer of understanding and insight into some of the thorny issues which surround drugs, it is also very readable, and the links between various headings are clearly flagged. By following these, the reader rapidly builds up a considerable degree of knowledge. You could also do far worse than pick it up and read it from cover to cover. I don't expect everyone to agree with all of its conclusions or nuances but it provides a great deal of information and clarity, and provides an excellent basis for common understanding and meaningful debate. We could all benefit from more of that.

David MacKintosh is the Policy Adviser for the London Drug and Alcohol Policy Forum. He writes here in a personal capacity.

I WOULD HOPE IT FINDS ITS WAY ONTO A NUMBER OF POLITICIANS', SPECIAL ADVISERS', CIVIL SERVANTS' AND MEDIA COMMENTATORS' READING LISTS



United States of Alcohol

An anthropological approach to alcohol and its place in American culture makes for interesting reading, **John Foster** finds.

Reviews

Dr John Foster: Reader Alcohol Policy and Mental Health Studies, University of Greenwich, London.

Dr Chrzan is based at the University of Pennsylvania and received her PhD in Nutritional Anthropology in 2008. Part of the Routledge Series of Creative Teaching and Learning Anthropology, edited by Richard Robbins, States University of New York, her book is aimed at anthropology/sociology undergraduate students. Professor Robbins provides a foreword which situates alcohol within this series and "provides students with an opportunity to re-think their culture-bound notions of drink and to engage in a process of placing their own beliefs and behaviours in a cultural and historical perspective."

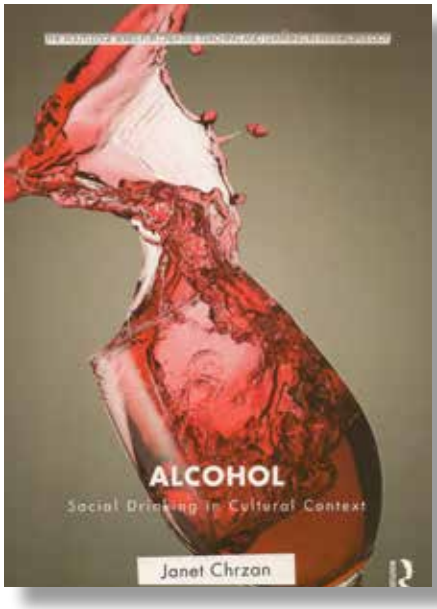
DR CHRZAN SUCCESSFULLY CONVEYS THE IMPORTANCE OF ALCOHOL IN NEGOTIATING THE TRANSITION BETWEEN BEING A YOUNG PERSON TO AN ADULT WITH RESPONSIBILITIES

This is a course textbook which also at times promotes drinking within a harm reduction context. Whilst I endorse this approach, the promotion of harm reduction can be a little clunky. However, despite being largely aimed at US readers it has much to appeal to a UK and indeed European readership.

The first chapter places student drinking within the setting of being an illegal act taking place when the student is making a transition to adulthood. The focus is upon risk and experimentation within the context of frequent binge drinking, but also with an understanding that these are important developmental process.

One of the aims of the book is to present alcohol within a historical context. This is admirably achieved in the first part of the book, which traces alcohol use in Greek, Roman, Celtic and other ancient societies. The influence of MacAndrew and Edgerton is clear, as is how drunkenness was tolerated by ancient societies at some times and not others. Other notable themes that have present day resonance is that drunkenness on the part of the powerful is tolerated and encouraged whilst in the peasant classes it is often seen as a threat. However, drinking in the peasant classes in those times was largely unproblematic and was often part of a daily diet (both wine and beer), albeit the alcohol content was weak compared to what is sold today.

America is a society that was originally comprised of European immigrants and the next part of the book provides a brief history of American drinking and contextualises the rise of the temperance movement. The themes are too extensive to do justice to here but the myth that original settlers were puritan in the way we understand the term is exploded – many were heavy drinkers. The rise of the temperance movement is seen in the context of the movement providing a role for influential, predominantly middle and upper class women, in protecting the family unit from drunkenness, invariably associated with danger and violence. This part of the book concludes with prohibition and I found this a little disappointing.



ALCOHOL: SOCIAL DRINKING IN CULTURAL CONTEXT:
Janet Chrzan
Routledge 2013
200 pages

BUY NOW

The cliché of prohibition being a disaster is once more re-hashed uncritically: US per capita drinking levels have never returned to pre-prohibition rates. (See Edwards (2000)[1] for a brilliant description that deserves a far wider audience.)

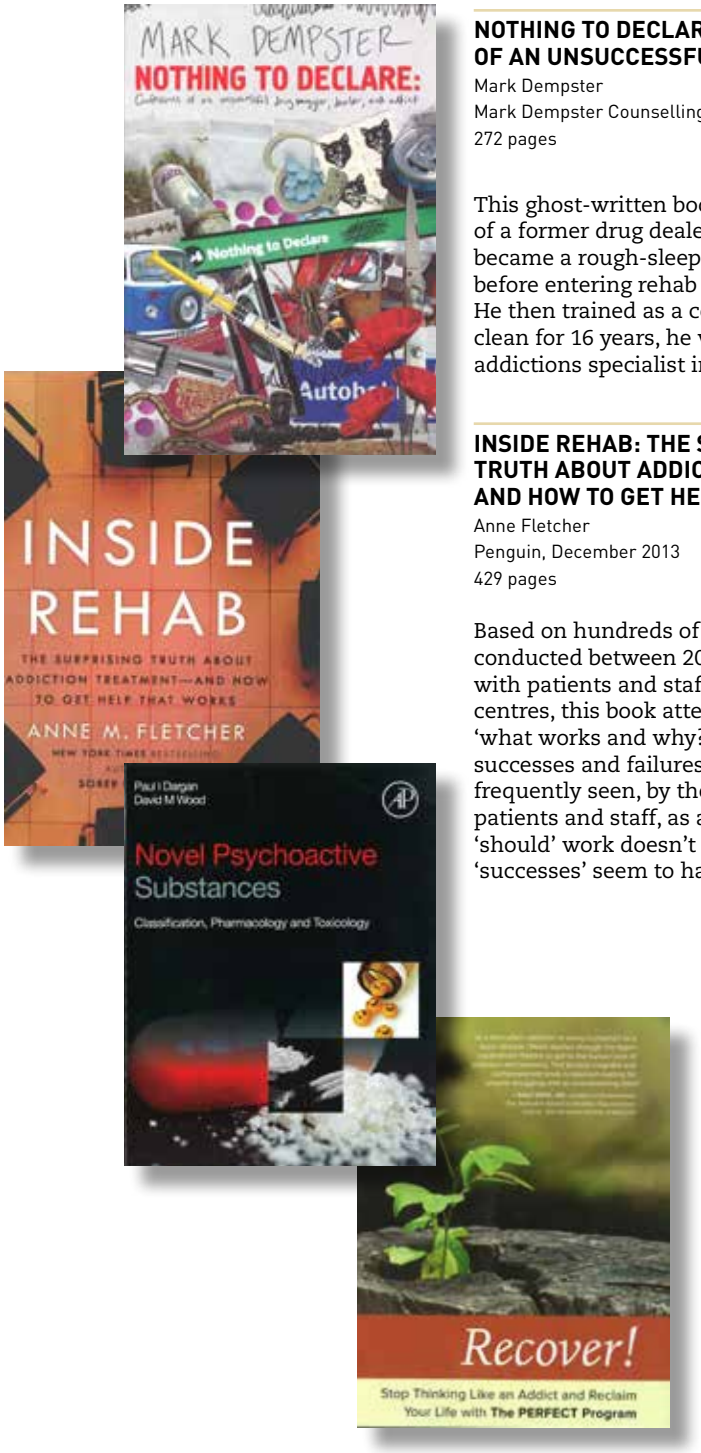
The rest of the book places drinking in a contemporary American context. Much American drinking is seen as "time-out" behaviour – "Miller Time". I am not from the US so cannot comment on the accuracy of this portrayal, though I feel the increasing popularity of home drinking means that the "time-out" thesis is at times problematic and needs refining. The next chapter on how advertisers target the young and old has much of relevance to say.

The conclusion examines why students drink. The answer is: for the same reasons as adults. Dr Chrzan successfully conveys the importance of alcohol in negotiating the transition between being a young person to an adult with responsibilities, often through using interviews she has conducted as part of her research. This discussion is presented within the context of facilitating young drinkers to make this transition safely.

There are times where I think the experiences described are probably restricted to a US setting. However there is much here for the general reader, academic, historian or researcher. For those wishing to gain an insight into why society has normalised drinking so that frequent drinking and intoxication is seen by many as unproblematic, I recommend this book.

1 Edwards G.: 2000: *The American Prohibition Experiment: in Alcohol the ambiguous molecule*, London, Penguin.

Reviews in brief



NOTHING TO DECLARE: CONFESSIONS OF AN UNSUCCESSFUL DRUG DEALER

Mark Dempster
Mark Dempster Counselling, November 2012
272 pages

This ghost-written book tells the story of a former drug dealer and user who became a rough-sleeper in London before entering rehab in Bournemouth. He then trained as a counsellor. Now, clean for 16 years, he works as an addictions specialist in Harley Street.

INSIDE REHAB: THE SURPRISING TRUTH ABOUT ADDICTION TREATMENT AND HOW TO GET HELP THAT WORKS

Anne Fletcher
Penguin, December 2013
429 pages

Based on hundreds of interviews conducted between 2009 and 2013 with patients and staff at 15 rehab centres, this book attempts to identify 'what works and why?', acknowledging successes and failures. The results are frequently seen, by the author and by patients and staff, as a mystery. What 'should' work doesn't always, and some 'successes' seem to have no explanation.

NOVEL PSYCHOACTIVE SUBSTANCES: CLASSIFICATION, PHARMACOLOGY AND TOXICOLOGY

Dargan & Wood (Eds)
Academic Press, September 2013
464 pages.

This highly recommended book is edited by a pharmacologist and a toxicologist who have included papers on legal, economic, epidemiological and sociological aspects of NPS in their well-chosen and well-written selection. There is an emphasis on the difficulties of legal definition and the problems this presents to legislators. There is also an emphasis on the impact of prohibition and consequent lack of regulation and control of NPS, a situation that the authors say has turned users effectively into human guinea pigs for manufacturers and legislators. The book's 17 chapters will increase readers' knowledge and understanding. Highly recommended in a field where knowledge is constantly expanding.

RECOVER! STOP THINKING LIKE AN ADDICT AND RECLAIM YOUR LIFE WITH THE PERFECT PROGRAMME

Stanton Peele & Ilse Thompson
Da Capo Press, February 2014
320 pages

This is the most recent publication in Peele's 40 years of authorship. The title questions much conventional thinking regarding addiction treatment, including the ethics and efficacy of the 12-steps approach. Peele and Thompson emphasise the role of harm reduction and brief interventions, seeing them as preserving the health of individuals and saving lives. They reject 'brain disease' explanations of addiction, seeing addiction rather as a symptom of dysfunctional societies and families.