VOL 27 | ISSUE 5 | **SEPTEMBER/OCTOBER 2012**

Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- Benzos
- Drug therapy
- Anthrax
- Alcohol detox

Treatment Outcome Profile

Top trump or joker in the pack?

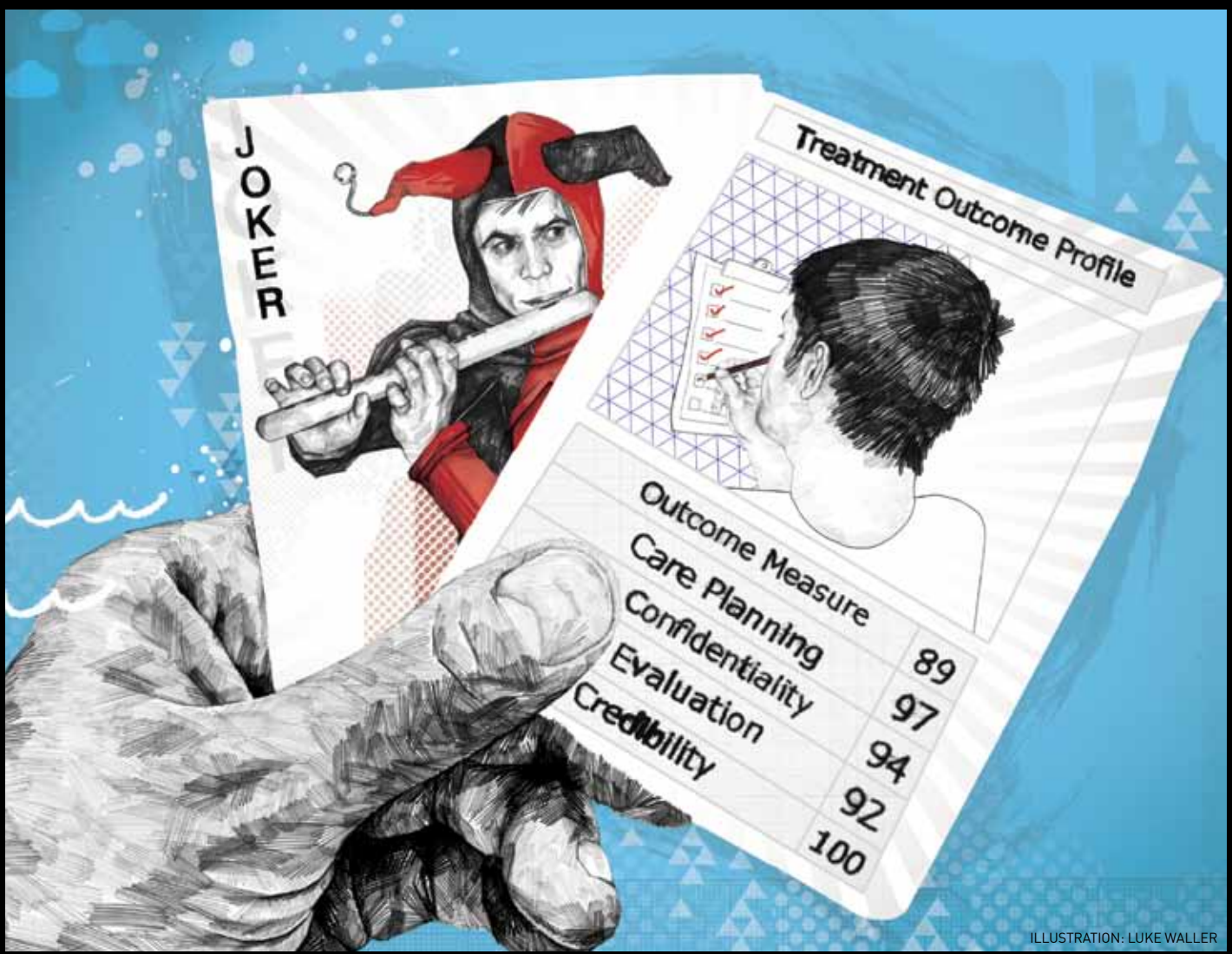


ILLUSTRATION: LUKE WALLER

Leeds Addiction Unit

in collaboration with the University of Leeds School of Healthcare

Addiction Studies
BHSc (Hons)
Graduate Diploma
Diploma of Higher Education
Certificate of Higher Education
Community Treatment of Substance Misuse

Enrolling now for
September 2012 & February 2013

Programmes and modules combining theory, research, policy and practice are available by ***distance learning*** or ***attended taught sessions*** at Leeds Addiction Unit

Modules include: *Motivational Interviewing • Research • Cognitive Behavioural Coping Skills • Harm Reduction • Psychopharmacology • Child Bearing Drug Users & Child Protection • Dual Diagnosis • Criminal Justice • Social Behaviour & Network Therapy •*

phone **0113 295 1330**
or email
lau@leeds.ac.uk

www.lau.org.uk/training

Short courses, accredited programmes and stand alone modules
We also offer courses tailor-made for your group or organisation. Contact us for details

Leeds Partnerships NHS
NHS Foundation Trust

UNIVERSITY OF LEEDS

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

- Commissioning
- Service Reviews
- DIP Management
- DAT Co-ordination
- Needs Assessments
- Project Management
- Group & 1-1 drug workers
- Prison & Community drug workers
- Nurses (detox, therapeutic, managers)
- many more roles...

Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

VOL 27 | ISSUE 5 | **SEPTEMBER/OCTOBER 2012**

Druglink

When good news is bad news

For the first time since drug use became a political issue in the 1960s, most metrics are on a downward curve – and have been since 2002. Statistics on drug use are plagued with uncertainty, but when they all reveal a similar picture, clearly a pattern is emerging. Why is this happening? To what degree can any government take credit? This decade has seen a substantial increase in investment in treatment and for the first eight years of the new century, we had a booming economy. Beyond that are arguably factors which sit outside government influence. For example, the relative strength of modern day cannabis may have put many potential users off. More generally, drug use having become more normalised in society, might then be just as prey to fashion as any other cultural artefact. Drugs don't appear to be as 'cool' these days as they once were.

Yet according to a recent UKDPC poll, over 70% of MPs think drug policy has failed, a view echoed by both sides in the drug debate, who for their own purposes claim that we are in a crisis with drug use spiralling out of control. Interestingly though, only a minority of MPs support law reform. So what do the rest want to happen? If the only measure of success is no drug use at all, this is clearly unrealistic.

Nobody can afford to be complacent on this issue; we still have around 300,000 people with serious drug problems, and with youth unemployment rising steeply against a background of severe financial austerity, who knows what might be coming round the corner? But to suggest as some do that we are currently going to a drug hell in a handcart is just a wilful refusal to acknowledge the facts.

Harry Shapiro
Editor and Director of Communications and Information

Druglink is sponsored by Ansvar Insurance and The Brit Trust for 2012

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.

SUBSCRIPTIONS
Subscription for the year (six issues): £55
To subscribe call
020 7234 9730

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
The inclusion of an advertisement, flyer or free sample in *Druglink* does not imply any endorsement of a particular product or service by DrugScope or *Druglink*.

Design
Helen Joubert Design
helenjoubertdesign.com

Print Holbrooks Printers Ltd, Portsmouth PO3 5HX

CONTRIBUTIONS
Druglink welcomes letters and other contributions. Send direct or contact Harry Shapiro
Email:
harrys@drugscope.org.uk

Material published in Druglink does not necessarily represent the views or policies of DrugScope

ISSN 0305-4349

News

Features

Regulars

Rise in prescription pills

Anti-depressant prescriptions, of which there were nearly 50 million individual prescriptions last year, accounted for the largest rise of all dispensed drugs in England. A report, *Prescriptions Dispensed in the Community*, England 2011 by the Health and Social Care Information Centre reported a 9.1 per cent, or 3.9 million, rise of anti-depressants prescriptions compared to 2010.

Second family court

Britain's second specialised family drug and alcohol court is to be set up in Gloucester. The country's first family drug and alcohol court was set up in London in 2007. Research found it helped parents to resolve drug and alcohol problems and as a result, ensured more children returned to their parents at the end of care proceedings.

Legal highs analysis

A survey of 22 'legal high' drugs sold online in 2011 found that two of them contained banned Class B cathinones such as mephedrone. The research, carried out by a criminologist and a chemist from the University of Leicester and published in the *British Medical Journal*, concluded that legislation has not been effective in stopping the sale of illegal drugs over the internet.

Cheap drink incentive

The Office of Fair Trading (OFT) has warned that government plans to impose a minimum 40p price per unit of alcohol could backfire. The OFT told MPs that shops will have an "incentive" to promote their cheapest drinks because they will profit from higher margins on these products. It added the interference in prices could set a dangerous precedent in undermining the free market.

Just Say Gnome

A man turned to cultivating cannabis plants after his garden gnome firm fell on hard times. Jason Lee was caught growing hundreds of plants at his yard in Flintshire after his landlords received a £70,000 electricity bill. Lee, who admitted his decision to go from gnomes to cannabis had been "catastrophic", was sentenced to two years jail.

Heroin drought reflected in drug death statistics

The heroin drought of 2010 is thought to have been the main reason for a drop in heroin-related deaths in 2011, which in turn may have prompted the rise in deaths from methadone and benzodiazepines.

The drought affected much of the country from around November 2010, driving the purity of the drug at street level down to record lows of 13 per cent for several months in some areas.

As a consequence, drug services reported an increase in primary heroin users switching to benzodiazepines, such as diazepam and street methadone and other opiates such as Tramadol.

The latest figures for England and Wales, from the Office for National Statistics (ONS), revealed deaths involving heroin and morphine fell from 880 in 2009, to 791 in 2010 and 596 in 2011. Between 2009 and 2011, methadone-related deaths rose from 408 to 486, Tramadol-related deaths from 87 to 154 and benzodiazepine from 261 to 293.

Across the board, there were 1,772 male and 880 female drug poisoning deaths (involving both legal and illegal drugs) in 2011, a six per cent decrease since 2010 for men – but a three per cent increase for women.

But the mortality rate from illegal drugs was still significantly higher in men (43.4 deaths per million of the population) than in women (14.4).

A third of all male drug deaths and just under half of all female drug deaths were suicides. The highest mortality rate from drug misuse was in 30 to 39-year-olds.

"The increase in deaths involving methadone correlates with findings from the British Crime Survey showing the proportion of 16- to 59-year-olds using methadone in the last year increased significantly in 2010/11," the ONS said.

"In addition, the latest *Druglink* Street Drug Trends Survey found there had been an increase in the use of methadone (and other substances) by primary heroin users, possibly as a result of the heroin drought."

The drought is thought to have been triggered by a combination of a poppy blight in Afghanistan, flooding in Pakistan, enforcement efforts especially in Turkey, traffickers stockpiling the drug and diversion into the lucrative market for heroin in Russia.

Drug-related deaths in Scotland have reached record levels, according to the latest figures, which also show strong signs of being influenced by the drought, which impacted on Edinburgh and Glasgow.

There were 584 recorded deaths in Scotland in 2011 – up 99 on the previous year and a 76 per cent increase on 2001. Methadone contributed to nearly half of all the deaths, while heroin and morphine were implicated in 35 per cent.

Methadone was involved in 275 deaths in Scotland last year, up from 174 in 2010. The number of deaths involving heroin and/or morphine fell over the same period, going from 254 in 2010 to 206 last year.

Capital's Olympic visitors targeted by Scientology-linked drug campaign

A Scientology-linked anti-drug group called The Foundation for a Drug-Free World has used the opportunity of thousands of overseas visitors to London to distribute their literature across the capital.

Timed to coincide with the London Olympics and Paralympics events, Foundation organisers say a team of volunteers have handed out one million booklets, entitled *The Truth About Drugs*, within the Olympic Park and in streets in surrounding boroughs during the Games. The booklets have also been placed in other locations, and have been spotted in a West End cinema and a community pharmacy.

The booklet is full of scientifically inaccurate information about drug addiction and sensational accounts purportedly from users. Under a section called 'How do drugs work?' the booklet informs readers, "Drugs block off all sensations, the desirable ones with the unwanted. A small amount acts as a stimulant. A greater amount acts as a sedative. An even larger amount poisons and can kill. This is true of any drug." And this from an ecstasy user called Ann: "One day I bit glass, just like I would have bitten an apple. Another time, I tore rags with my teeth for an hour."

The booklets cite the website drugfreeworld.org printed on its front and a phone number for the UK branch of the Foundation for a Drug-Free World on the back. But nowhere does it make clear that the group is linked to the Church of Scientology. The main Scientology website does clearly acknowledge the link, however.

The Church's drug rehabilitation wing, Narconon, runs a handful of drug treatment centres in the UK. It believes the best way of treating drug addiction is with heavy doses of the vitamin Niacin (vitamin B3) and five-hour long saunas, in at attempt to rid the body of drug 'residues' locked in the fatty tissues of the body, which according to their literature, cause cravings.

Last month, a London mother discovered that her local primary school had brought in Narconon workers to teach her 10-year-old son about drug abuse.

St Jude and St Paul's Primary School in Newington Green arranged for Narconon to come in and talk to year six pupils. But, after finding one of their booklets in her son's schoolbag, Amanda Steele told *The Evening Standard:* "These aren't the sort of people I want to come in to teach my kids about drugs. In fact, I don't want them to come anywhere near them."

Narconon's flagship treatment centre in Oklahoma has been the subject of controversy this year after three patients died there in the last 10 months. In July 20-year-old Stacy Murphy died while in a 'withdrawal unit' at the centre.

Critics claim Narconon's rehab centres are used to help recruit people to the movement. This is denied by Narconon.

Teen cannabis use could lead to IQ decline

People who smoke cannabis during their teens risk permanent damage to their intelligence, the latest research has shown.

A long-term study that followed a group of over 1,000 people from birth to the age of 38 in Dunedin, New Zealand found that the IQ of those who used cannabis heavily in their teens (defined as, on average, four days per week or more) had fallen by eight points by the time they approached their 40s.

Friends and relatives of the regular cannabis users reported that these users had more everyday memory and attention problems, including forgetting to pay bills and misplacing common items like keys and wallets.

The study, where participants' mental abilities were tested as teenagers and then again 25 years later, appears to be the first convincing evidence that cannabis has a different and more damaging effect on young brains than on those of adults.

Giving up cannabis made little difference – what mattered was the age at which young people began to use it. Those who started after the age of 18 did not demonstrate the same IQ decline.

Madeline Meier, one of the authors of the study, which was carried out by researchers from King's College London's Institute of Psychiatry and Duke University, North Carolina, said: "Marijuana is not harmless, particularly for adolescents. Somebody who loses eight IQ points as an adolescent may be disadvantaged compared to their same-age peers for years to come."

Australia puts a match to tobacco branding

Cancer UK described it as "a seductive marketing tool that attracts young people into a habit that kills half of all long term smokers".

Now, with a landmark ruling that will see all tobacco products sold in plain olive green packets with graphic health warnings in Australia from December, the branded cigarette packet appears to be living on borrowed time. Already the subject of a four-month UK Department of Health consultation into tobacco packaging that ended in August, health campaigners and tobacco firms will be eyeing the developments on the other side of the world with keen interest.

In August, Australia's highest court endorsed a law, challenged by all the major tobacco firms including Britain's Imperial Tobacco, to ensure all distinctive colours, brand designs and logos are removed from packets. The law will be enacted at the end of this year.

Back in March 2011, the UK government published a tobacco control plan for england, which included a commitment to explore options to reduce the promotional impact of tobacco packaging. A Department of Heath spokesman said the many submissions received as a result of consultation were in the process of being analysed.

Concentrated, highly visible drinking zones create north-south divide

A significant drinking culture and a lack of leisure opportunities are the main reasons young people in the north of England drink more heavily than their counterparts in the south, a study has claimed.

Local variations in youth drinking cultures, published by the Joseph Rowntree Foundation, explored the lives of young people in two unnamed regions of England to attempt to explain the north-south divide in harmful drinking.

It said while the primary motivation for drinking was "sociability, having a good time, laughter and fun", in the case of the northern city, this was a more significant part of local culture. The city's high concentration of bars and pubs, coupled with the high visibility of the area's "exuberant drinking culture" both in the streets and parks, encouraged heavier drinking.

The report said that young people across the board actively sought out "clusters" of youth-orientated bars, but that a concentration of these zones in the northern city meant young people drank more than they originally intended. The researchers found more spaces where young people drank alongside adults in the northern city.

"Despite a wish to limit the number of licensed premises in the north east, planning authorities had been unable to resist commercial pressures to allow clubs and bars to fill units that would otherwise be vacant," said the report.

In the south east, young people below the legal age of drinking engaged in a wider range of leisure activities, sports and hobbies. By contrast, young teenagers in the north "experienced constraints on their leisure from issues associated with access and costs, but costs were a more significant factor".

In conclusion, the report recommended that town planners needed to avoid the concentration of youth drinking venues, separate them from more adult-orientated pubs and clubs and make public spaces and non-drinking leisure activities more open, and affordable, to young people.

inside DrugScope

DrugScope has moved...

The DrugScope offices have moved back south of the river! We are now located in Borough. Our new address is: DrugScope, Fourth Floor, Asra House, 1 Long Lane, London SE1 4PG. Our phone numbers have also changed; you can now reach the office by calling 020 7234 9730 by fax on 020 7234 9773.

New team member

We are delighted to welcome Paul Anders to the DrugScope Policy and Membership Team as our new Senior Policy Officer. He joins us from Homeless Link, where he worked as Employment Manager and London Regional Manager. You can find an introductory column from Paul in the September *Members' Briefing*; he can be reached by email at paula@drugscope.org.uk.

Alcohol strategy briefing

The Policy and Membership Team have produced a briefing on the government's alcohol strategy and what it means for our sector. Find it here: http://tiny.cc/DS-alcohol-briefing

Read all about it!

The DrugScope Press Office continues to receive an average of 50 to 80 calls per month from local, regional, national and international media, across print, online and broadcast outlets. A lot of work goes into preparing background briefings or providing information and data for journalists, producers and researchers; we have also been supporting the BBC drama series *Holby City* and *Eastenders* with information provision and script checking recently. In late August, new research into the effect of cannabis use on adolescent brain development attracted significant media attention. This was immediately followed by the release of new ONS drug-related deaths statistics, which also grabbed the headlines. We had a very busy few days; Martin Barnes spoke to 16 local BBC radio stations in the course of one afternoon and DrugScope's comments were picked up in *The Sun* and *The Daily Mail*, the two most widely read newspapers in the UK. You can always see our latest press releases at www.drugscope.org.uk/Media/pressreleases

CANNABIS COMEDOWN

Britain appears to be losing interest in using illegal drugs. What is going on? **Max Daly** looks behind the statistics.

In July, two sets of government statistics, from the NHS and the Home Office British Crime Survey: Drug Misuse Declared (BCS), again revealed that, overall, drug use has been falling in Britain. Unsurprisingly, the findings were barely reported: if there is no scare factor to a drug story, the media has a habit of ignoring it. But what is interesting about these statistics is that they pose an unexpected and tricky question: why has drug use fallen?

While these official statistics may not be perfect – the BCS for example does not reach students living in halls of residence, the homeless, people in rehab or prisoners – they do provide a relatively solid yardstick with which to measure general drug use trends. These days, research is more robust. Ten thousand adults were interviewed for the first BCS report in 1996. This year the net was widened to 46,000.

So what exactly do the statistics show? The NHS figures contained in the report Smoking, drinking, and drug use in young people in England 2011 for young people aged 11-15, show a dramatic fall since 2001 in those who have ever taken drugs, declining from 29% to 17% while the figures for those even being offered drugs has fallen from 42% to 29%.

According to the BCS, in 1996, just over 11 per cent of adults had used an illegal drug in the last year. By 2002, it had risen to just under 12 per cent. In 2011-2012, the figure sits at just under nine per cent.

In the last 15 years, the use of amphetamines and hallucinogenic drugs has nose-dived, ecstasy use has peaked and fallen, cocaine use rocketed from nowhere, but has now levelled off, while a string of newly adopted drugs, such as ketamine, GHB, mephedrone and Spice, have been added to the menu.

Last year the NTA revealed that the numbers of people entering treatment for heroin or crack had fallen by 10,000 in two years, markedly among young people. NTA chief executive Paul Hayes said he thought this was because of what has been called the 'scarecrow effect', where young people can see the damage caused by heroin and crack to older members of their community, or in some cases, their family.

But the prime mover behind the downward trend is cannabis, by far the county's most used illegal drug. In 1996, 9.5 per cent of adults admitted using cannabis in the last year. This increased to an all time high of 10.9 per cent in 2002-2003, but has since dropped to a current figure of just 6.9 per cent. The fall in cannabis use has been even more dramatic among young people aged 16-24. In 1996, 26 per cent had used the drug in the last year, rising to a high of just over 28 per cent in 1998, but tumbling by almost half that proportion to 15.7 per cent in 2011-2012. The NHS survey showed a similar drop in cannabis use in younger school students, from 13.4 per cent in 2001 to 7.6 per cent in 2011.

> YOUTH CULTURE IS INCREASINGLY CORPORATISED AND SANITISED. THERE IS CERTAINLY NOTHING GOING ON NOW THAT CAN COMPARE TO THE ECSTASY REVOLUTION THAT TOOK PLACE IN THE 1990S

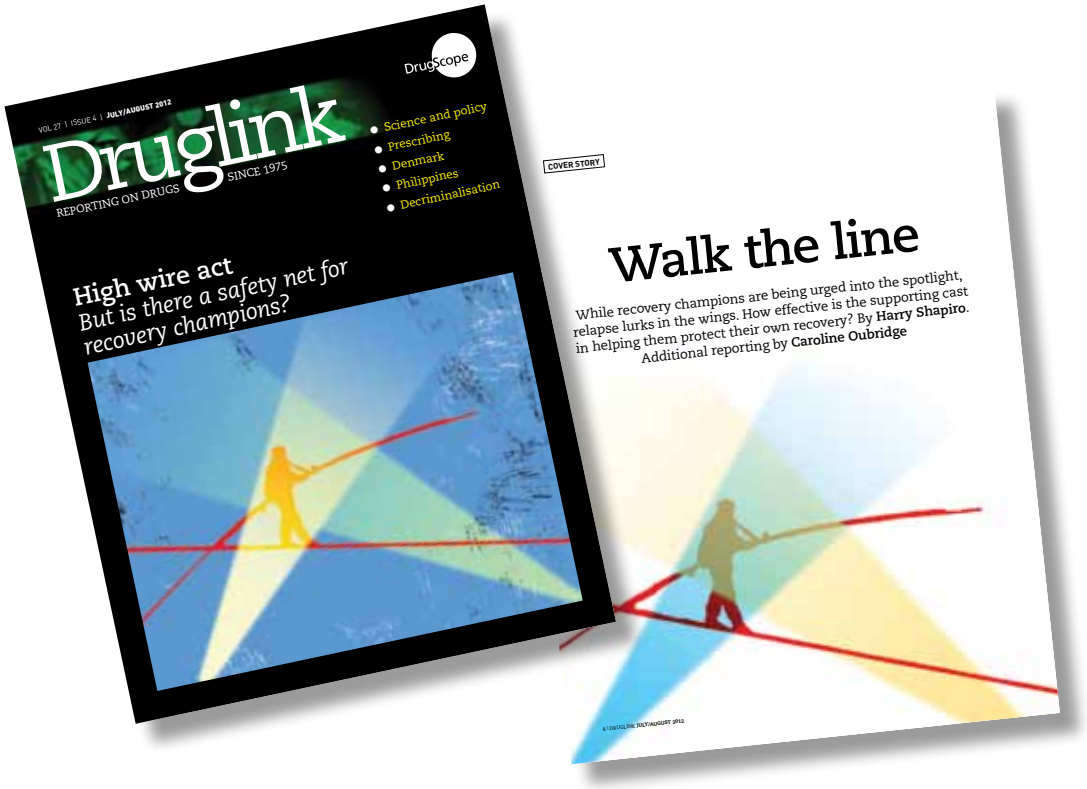
Why are people, especially the young, falling out of love with cannabis? In the absence of research, the most likely reason, ironically, is the boom in cannabis production in the UK. The rapid expansion in professional skunk growing from 2004 onwards, driven by organised Vietnamese gangs, accelerated the fall in cannabis use from a very gradual decline beginning in 2002. (What this showed incidentally, was that the reclassification of cannabis from Class B to C in 2004, had no detrimental impact on use despite the claims of many antidrug campaigners). The domestic cannabis trade, coupled with a clampdown by the Moroccan government on its prolific illicit hashish industry, which significantly reduced exports to Europe and therefore its availability in the UK, meant that skunk, generally a far more potent form of the drug than hashish or regular weed, became the dominant player in the cannabis market.

There is now a lack of choice for cannabis consumers, which may be driving down trade. In some parts of the country it has become difficult to buy anything but skunk, which some cannabis users avoid because of its powerful effect. It is likely that the reduction in smoking tobacco, used to make cannabis joints, has also impacted on the use of the drug.

While there are some notable exceptions in the form of drugs such as ketamine and mephedrone, drug use across the board has been falling. Even cocaine, the boom drug of the last decade and the main reason behind the fact that Class A drug use is higher than it was 15 years ago, has declined in popularity. Karenza Moore, lecturer in criminology at Lancaster University who specialises in the dance drug scene, suggests there are a number of explanations for this downturn.

"There is an economic element to this. Disposable income is down, cost of living is up and perhaps we are seeing the truncation of youth and a loss of independence as a result. Culturally, it seems young people are less rebellious than previous generations. I call it the Justin Bieber Effect: youth culture is increasingly corporatised and sanitised. There is certainly nothing going on now that can compare to the ecstasy revolution that took place in the 1990s."

Responses to 'Walk the Line' recovery champions article in *Druglink* (Vol 27, Issue 4, July/Aug 2012)



Society at fault, not 12-step

The article, 'Walk the Line' holds a light up to my own experience. Though I still remain abstinent after 13 years, I have found the role of a recovery champion something of a poisoned chalice.

Towards the end of the article, Harry Shapiro states that AA and NA are good for helping people to avoid taking that first drug or drink, but he adds they are inadequate for supporting life's other serious issues. As I read this, my body's fight-flight chemistry was triggered. The underlying dynamics that I understand as addiction resurfaced. My chest and shoulders tightened and my pulse grew faster. I am ok. I have a bedrock of personal recovery capital to work this stuff through. But it is hard to have your world constantly misrepresented like this.

For me, being a recovery champion has been difficult mainly because of the political agendas of those I meet. The shame felt by people who relapse, or remain on replacement prescriptions, is often a result of the cultures they grow up in, not 12-step fellowships.

Fellowships welcome these people, they do not judge them. Fear of becoming abstinent is not the same as shame. Abstinence is a place of greater emotional, physical, psychological and spiritual health, not acceptability or fundamental goodness. The perception that this is not so needs addressing.

As a recovery champion, I am personally worn down having to weather the constant prejudice that come from treatment 'professionals'. That my life is and has been upheld by something dysfunctional and inadequate. That all my relational issues are at the centre of the same dynamic. Trust, respect, honesty etc. – these apply to addiction, marriage, parenting, employment and health. My 12 step programme meets all these needs for me. Many of the treatment professionals I meet feel threatened by the idea that community replacement prescribing, and MI are not enough, or even not close to enough, to meet their clients needs. It is at this point that the definition of 'recovery' being 'change', and the urgency to value levels of change that fit poor outcomes, is adopted.

There is no 'one size fits all', but please, let's not leave people (clients) wearing the clothes of recovery that our personal prejudice would like, but do not keep them warm enough to fully function and have the lives we believe achievable for ourselves.

Adam (full name supplied)

Protecting recovery champions

'Walk the line' highlighted the potential for relapse amongst recovery champions and the need for adequate support and protection for them. In Nottingham, we recognised the value of recovery champions and the inspiration they can provide to their peers. We have always got people off drugs, so we embraced the recovery agenda.

Utilising our recovered ex-service users without putting their recovery in danger was a challenge. We have a history of not being interested in looking good at the expense of service users welfare, illustrated by the fact we have never had to advertise for our numerous ex-service users, carers and 'lived experienced' staff.

Our conclusion may be of benefit to other organisations looking to harness champions whilst maintaining their distance. We decided upon a DVD format, [the creation of which] involved snowballing contacts, old notes, Christmas cards, residential rehabilitation (thank you to the Ley) and social media. Over 200 'possibles' with multiple years of recovery behind them were identified. Some 100 were identified and we now have 56 inspirational stories, caught on film and played in our waiting room celebrating recovery.

The focus is not on the difficult years or the voyeurism that is unnecessary, unhelpful and too often the consequence of face-to-face interactions. Disclosure exists, but instead the focus is on how to stop, what is great about abstaining and advice to aspirational current users.

The effect is cognitive dissonance and renewed confidence. Six months on, we are aware of no relapses. The protective pre-filming contract prevents any Facebook, phone recording or random playing beyond a monitored NHS waiting room. Only three copies of the DVD exist, and our priority is protecting our participants and what we see as this valuable therapeutic gold dust.

If anyone wants to visit, these films can be seen on most Monday afternoons in the waiting room when new assessments and carers are most in need of hope. All this achieved with minimal risk to our recovery champions, hopefully protecting them by virtue of a 'virtual status'.

Nick Coombs
Team Leader, Substance Misuse Services
John Storer Clinic, Nottingham

Recovery equals responsibility

Congratulations on 'Walk the Line', a well-considered piece about relapse among recovery champions. It's an issue that's important to me both in my own life as somebody with a history of drug dependence, but also as somebody who manages a team of advocates and mentors, all of whom have had their own issues with substance misuse.

The field has always employed people with a history of substance misuse problems, and we've all known people who have looked as though they had a golden future ahead of them, only to see them crash and burn. Historically, the field tended to write them off. The higher their profile before relapse, the more likely it seems that we'll sweep it under the carpet.

Just two brief points. From my own experience, relapse has only ever

been associated with my attempts to cease medication and become

completely abstinent. As long as I continue to take my meds, I could work and function as well as anybody else. Take those meds away and it

isn't long before I relapsed to street use. Unfortunately, the field has historically regarded people in substitute prescribing as being just a small step away from street use. The sooner we're able to come to view medications like methadone and subutex as akin to any other medicine, the sooner we'll see a more robust model of recovery that includes a much larger proportion of our ex-heroin using population.

My second point is really about responsibility and growth. All too often, we take people at the very early stages of their recovery journey to occupy these roles. Nevertheless, it's important to provide training and have regular conversations about responsibility. Yes, relapse is a part of the condition. Some people find the state of being completely abstinent to be intolerable, and for whatever reason, return to use. As an addict myself, I understand that impulse and find it difficult to condemn it.

However, for me, the mark of somebody's recovery isn't whether they

can sustain a state to total abstinence or not – but rather it's whether they're able to take responsibility for and own up to their return to use. When people are willing and able to do this, it's easy enough to get them back into treatment, give them a break from their responsibilities, possibly find another role in which their drug using status isn't quite so critical. The problem is when people revert to old behaviours of thinking they're cleverer than everyone else, that nobody will notice the fact that they've started using again, and gentle confrontation is met with blank denial.

I understand that this is prompted partly by the sense of shame at having relapsed, and anxiety about losing the small amount of status that you've accrued. But that's already gone. What's at issue now is how much of that you can salvage -- and the easiest way to salvage that stuff is by demonstrating a degree of honesty, maturity and personal responsibility that I consider being much more central to the idea of someone's recovery than the particular molecules that happen to be floating around in someone's neurochemistry at any given time.

Peter McDermott

Duncan Selbie

If it isn't already, the name **Duncan Selbie** is set to become very familiar to those of us working in the drug and alcohol sector. The Chief Executive of Public Health England spoke to **Harry Shapiro** about his plans.

The NTA is being abolished and its 'key functions' transferred to Public Health England. Could you summarise what the functions of PHE will be in regards to drug and alcohol services?

The NTA has had its critics, but as a body it was tasked with championing drug treatment both nationally and locally. PHE will be a substantially larger organisation, with substance misuse just one of a number of responsibilities. How do you respond to concerns that PHE will not provide the same leadership for, and give sufficient priority to, drug and alcohol treatment? Will PHE be a national champion for treatment and recovery?

How will PHE's responsibilities for drug and alcohol treatment be reflected in its senior management and decision making structure? Will there, for example, be a clear 'champion' within PHE for drug and alcohol treatment?

First, I'd like to say that it is with great delight and ambition that I take on the role of chief executive of Public Health England. I've learnt from previous responsibilities in the NHS and the Department of Health that the important all too easily gets swamped by the urgent. And nothing could be more important than protecting and improving the nation's health and wellbeing.

In terms of drugs and alcohol, the Government is clear in its ambition for everyone with a problem to have access to treatment and every opportunity to recover. To translate this into action on the ground, local authorities will want to develop an understanding of their population's needs so they can shape responses which take account of local circumstances. Our role in Public Health England is to be the link between that local and national aspiration, and championing this.

Public Health England will have dedicated drug and alcohol expertise at every level to offer practical know-how and advice to local government and the NHS.

Current investment in drug and alcohol services represents up to half of local public health service ring-fenced budgets. Given, for example, local authority spending cuts, the number of responsibilities for Health and Wellbeing Boards and the ending of the pooled treatment budget, what safeguards (if any) will be in place to prevent reductions in spending for drug and alcohol treatment?

It is important to emphasise that our commitment to local action led by local government is absolute, and our objective in Public Health England is to support this in every way we can.

There will of course be competing demands for resources in public health, as in all aspects of the public service. The Department of Health has already announced its intention to build drug treatment need into the formula that will determine local allocations. This will be based on the current pooled treatment budget methodology. The practical effect of this will be to give local areas an incentive to continue to provide high quality drug services that leads to successful completion of treatment and reduced relapse.

Directors of Public Health in local authorities will be taking over responsibility for commissioning clinical drug and alcohol services from the NHS. Will the NHS Constitution be binding on public health commissioners and services – and, generally, what levers will you (i.e. PHE) have to ensure that clinical (and other) standards are maintained?

It is vital that high standards of evidence and clinical governance continue to apply.

The Health and Social Care Act 2012 made it clear that local government must have regard to the NHS Constitution when carrying out their public health functions. A full public consultation on potential changes to the NHS Constitution will be launched later this year.

Will PHE have a role in supporting and improving the commissioning of treatment and recovery services? If so, how will it seek to do this?

What information will PHE require local authorities and service providers to provide in terms of data recording and monitoring of service provision and treatment outcomes? Will, for example, NDTMS continue?

Good quality data has helped drive improvement and continues to be vital.

Public Health England will support commissioners by providing expertise, bespoke support, benchmarking performance and through sharing best practice. I have spent my first weeks in post meeting people across the country to build our understanding of how Public Health England will best do this.

Local authorities will be able to access similar, high quality information and intelligence about drugs and alcohol as now, including NDTMS, but this may be enhanced through greater integration with other public health functions, for example understanding the drug and alcohol issues in a wider context of the social determinants of health. This will be made possible through closer working with other public health knowledge and intelligence expertise, such as those currently in public health observatories and the cancer registries.

While DrugScope members welcome the potential opportunity for more investment in addressing alcohol misuse and dependency, there are concerns that investment may be directed to more locally high profile – and popularist or media driven – issues such as binge drinking at weekends. What will PHEs position be on this?

Action on alcohol and drugs is not limited to addressing problems of dependence. Local authorities have a responsibility to address the wide range of issues resulting from alcohol and drug misuse. It will be Public Health England's role to support them in this.

What role, if any, will PHE play to ensure that drug and alcohol treatment is provided by services and staff with the necessary competences, skills and knowledge?

Public Health England will have a workforce development role and will continue to support the Substance Misuse Skills Consortium. However, this will not replace the central role of providers and the professions, who will continue to have lead responsibility for ensuring their people have the necessary competences, skills and knowledge.

The drug strategy recognises that recovery requires access to a range of services and support, including accommodation, training and employment. How will PHE work with other national bodies and government departments to ensure that this ambition for supporting recovery is achieved?

Everything important that will happen in public health will happen locally. Locating public health responsibilities with local government offers the exciting opportunity of integrating treatment with the local factors that sustain recovery – access to jobs, stable homes, education opportunities and children's services.

The NHS drug services in Manchester have recently lost out to the third sector competitors. This is not the only example and is causing concern that NHS clinical expertise is being priced out of the market to the ultimate detriment of service users. How do you respond to such concerns?

Across England over the past decade, the growing involvement of the voluntary sector has been a vital catalyst to securing improvements.

There are 149 local drug treatment systems configured according to local need, circumstances and evolution. Public Health England will work with local government and providers to ensure that treatment systems continue to be resourced, supported and led to achieve the best possible outcomes for service users.

If treatment systems are to deliver the best health improvements for their populations, they need to be built on evidence of what works. This is unlikely to be achieved if either price or incumbency is seen as having primacy.

TOP of the form?

The controversial Treatment Outcomes Profile (TOP) form has been in use – and under scrutiny – for five years. Now, TOP has been suggested as a crucial measure for Payment by Results. New research by **Ira Unell** and colleagues reveals a continuing lack of staff confidence in the TOP.

Launched in 2007, TOP was designed to be used for a variety of purposes. It was intended as a clinical tool with individual patients/clients to measure progress and identify areas of improvement, areas where more work needed to be done and as an aid to care planning. It was hoped that agencies would use TOP to improve services. Finally, it was thought that TOP could be used for commissioning purposes: "At local, regional and national levels, the information will be used to monitor the effectiveness of services and partnerships" (NTA).

From the start, however, the enterprise was controversial. Despite a long and extensive pilot programme to develop TOP, many within the drug treatment field felt that it was flawed. In an article in *Druglink* (Over the TOPS?, Vol. 22 Issue 5, September/October 2007), Diane Taylor quoted sources within the treatment field and research workers questioning in particular the validity of the section on offending and criminal involvement. This has been the most controversial of the sections because it requires the treatment worker to ask the patient/client to disclose recent offending committed within the last 30 days, including "shoplifting, drug selling, theft from or of a vehicle, other property theft or burglary, fraud, forgery and handling stolen goods, committing assault or violence".

While the NTA recommends that the treatment worker should provide assurances that the information provided will be completely confidential, drug users might be sceptical, especially those who attend a criminal justice treatment service where the staff of that service is required to report to the court on the behaviour of the client.

By 2009, after two years of experience with TOP, practitioners were even more sceptical of the validity of TOPs data, again especially about the offending and criminal involvement section. One study by Luty and colleagues analysed the TOPs forms of 200 individuals who attended their drug treatment service. They found that 67% of their sample declared no paid income to fund their Class A drug use. Their average spending for Class A drug use alone was £988 per month (not to mention the spending on Class B & C drugs and alcohol). The authors concluded that "the section on crime in the TOP form is unreliable and completely invalid."

General Practitioners were at the forefront of protests about the use of the section on offending and criminal involvement. In a response to the NTA on TOP, Linda Harris, on behalf of the Royal College of General Practitioners, welcomed the effort to record outcomes on treatment but drew attention to the section on offending and criminal involvement. She argued that General Practitioners do not trust the "quality of the information being reported back from patients in relation to the crime question…". She further argued that some localities now record a complete cessation of criminal activity recorded from TOP. This is hardly credible as a result of treatment.

In 2010, a team from Leicester Community Drug and Alcohol Service and Leicester University conducted a survey to measure the confidence of those who provide drug treatment and record the data in the TOP questionnaire.

The survey was conducted in the East Midlands. The treatment agencies were NHS community drug teams, a shared care prescribing service and two criminal justice drug treatment teams. They were experienced drug workers (average length of time in the field was over 9 years). There were 158 people who could have completed the survey and 106 actually responded (67%).

The TOP questionnaire is divided into four sections: substance use, injecting risk behaviour, crime, and health and social functioning. This is followed by questions asking clients to rate psychological health, physical health and quality of life on a 20 point scale. There are also questions about work, education and housing.

The first question of our survey asked, "To what extent do your clients/patients answer the following TOP questions honestly?" followed by each of the four sections. The respondent was asked to mark on a 10 point scale ranging from "Clients answer honestly" to "Clients answer dishonestly".

The second question asked "To what extent do you think that the answers you record on each of the TOP sections represent a true picture of your client's behaviour?" Again, the respondent was asked to mark on a 10 point scale which started with "Answers record true picture" to "Answers do not record true picture", for each of the four sections.

The third question asked the respondent to rate the usefulness of TOP (again using a line which was marked between "Useful" to "Not Useful" on a 10 point scale) for assessing new clients, for monitoring client progress, as a way of assessing agency effectiveness for commissioning purposes, and as a way of assessing a particular form of treatment.

The last two questions asked what

proportion of clients appear to trust that the answers they provide in TOP will be kept confidential and what proportion of drug treatment staff in their own or other treatment agencies fill in the TOP form without specifically asking their clients? For these two questions, there was a line to be marked ranging from 0% to 100%.

The results are shown in the tables below:

QUESTION 1	*Client answers honestly = 10* *Client answers dishonestly = 0*
Substance Use	Average = 6.2
Injecting risk behaviour	Average answer = 6.2
Crime	Average answer = 2.1
Health and social functioning	Average answer = 6.5

QUESTION 2	*Answers record true picture = 10* *Answers do not record true picture = 0*
Substance Use	Average answer = 5.5
Injecting risk behaviour	Average answer = 5.5
Crime	Average answer = 2.0
Health and social functioning	Average answer = 5.4

QUESTION 3	*Useful = 10* *Not useful = 0*
For assessing new clients?	Average answer = 4.5
For monitoring client progress?	Average answer = 4.5
As a way of assessing agency effectiveness for commissioning purposes?	Average answer = 3.3
As a way of assessing a particular form of treatment?	Average answer = 3.0

QUESTION 4	
What proportion of your clients appear to trust that the answers they provide in TOP will be kept confidential?	58.1 %

QUESTION 5	
What proportion of drug treatment staff in your own or other treatment agencies fill in the TOP form without specifically asking their clients?	56.6 %

SUMMARY CATEGORIES	**No. of answers in that category**
Terminate TOP entirely	12
Drop or change questions on criminality	21
Less frequent use of TOP	5
Shorten time scale (currently up to 4 weeks) asking patients/ clients to remember drug/alcohol use	5
Keep it as it is, useful measure of progress	3

We also asked: 'How would you improve TOP?'. Out of 106 questionnaires, 68 made at least some comment on how TOP could be improved. There were a wide range of answers, but they could be categorised under the following headings:

Treatment workers who complete the TOP questionnaires seem to have low levels of confidence in the questionnaire and its validity. Indeed, a surprisingly high proportion (56.6%) of treatment workers believe that other treatment workers complete the questionnaires without even asking their clients.

Overall, the level of confidence in the honesty of the answers from clients were modest in three of the four sections (substance use, injecting risk behaviour, and health and social functioning), scoring between 6.4 – 6.5 out of a possible 10. As you might expect, the fourth section (criminality) scored much lower – 2.1 out of a possible 10.

The same pattern emerged when respondents were asked if each of the sections portrayed a true picture of their client's behaviour. Three of the four sections scored between 5.4 and 5.5 out of a possible 10. The fourth section – criminality – once again achieved a very low score: 2.0 out of a possible 10.

TOP was designed with a number of purposes in mind. It was intended to help clinicians measure their clients'/ patients' progress, to assess the treatment effectiveness of individual agencies and to test the effectiveness of different types of treatment. The East Midlands survey suggests it has failed to convince the majority of those who provide the treatment and collect the data that it is a worthwhile exercise.

With confidence so low among those who collect and record TOP data, it should be asked if the time and cost of collecting this data is worth the effort. Valid and reliable outcome data is crucial in measuring the effectiveness of treatment. TOP is a first attempt to collect this data across drug treatment agencies in England. It has failed to gain the support of workers across a sample of agencies and the meaning of the results of TOP data is open to question.

- **Ira Unell** – Senior Lecturer in Substance Misuse, Leicester City Alcohol and Drug Service
- **Marilyn M** Christie – Clinical Psychology Unit, University of Leicester
- **Alex Satchwell** – Research Associate
- **James Rathbone** – Research Associate

Getting better outcomes for drug users

Responding to Ira Unell's article, **Rosanna O'Connor** emphasises how the TOP helps workers, managers and commissioners deliver effective care plans.

Drug treatment in England has undergone a significant shift in recent years to increasingly orientate towards improved outcomes for drug users in treatment. When the treatment system first expanded a decade ago, the priority was to improve access for the thousands who remained untreated, a mission which was undoubtedly accomplished. Once that had been achieved, the task moved from getting drug users into treatment and stabilising them, to focussing more on their recovery from addiction and reintegration.

The Treatment Outcomes Profile (TOP) was designed to support putting improving user outcomes at the centre of treatment. We know that drug users come into treatment to get better and to get off drugs. Families and communities also benefit when drug users get better. As the recent clinician-led expert group on medications in recovery recognised, previous strategies gave "insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence."

What matters to users and what matters at a system level is that treatment outcomes are improving. Together, progress is being made. Treatment is now much better at getting people out: users starting treatment now are much more likely to recover than those who started in 2005-06. The number of drug users successfully completing treatment last year increased by 18%, an increase of 150% since 2005-06. Whilst these outcomes of course cannot be attributed to any unique contributor, TOP is part of this wholesale individual and systemic change to improve the quality of treatment so that more recover from drug addiction.

For the treatment worker and the user, TOP provides a tool to track progress towards goals set out in the recovery care plan. It can provide a visual representation of how the user is progressing. It can structure conversations between the user and the worker. And it helps users to see where they are in relation to others like them. Its effectiveness in doing this is a product of the therapeutic relationship developed between an individual and the drugs worker and quality or meaningfulness of their exchange.

The questions TOP asks should be part of the routine interaction between a treatment worker and the user. If the ground covered by TOP presents a challenge then it suggests that there is cause to be concerned about the extent to which the service is using keyworking sessions to "plan, review and optimise" with users, as the expert group put it. The results from the services and areas that are using TOP to underpin their leadership in improving user outcomes indicate that TOP has the potential to be effectively used as part of a recovery-orientated system. Where services continue to underperform, it not only minimises the recovery potential of service users, but jeopardises the service itself as funding becomes more closely linked to outcomes.

For service provider managers, TOP reports can help with case management, by reviewing cases collectively in team meetings. It helps early identification of people not doing well in treatment. It shows how the provider is performing compared to others with similar client complexity. It helps ensure all clients get a consistent level of service by identifying any gaps in provision. It can provide data to scan the horizon for future drug trends within the local treatment population.

For local area commissioners, TOP shows how services are performing

© PHOTOFUSION

compared to others with similar client complexity. It can direct service improvements, such as prompting reviews on particular areas of concern. It helps show if services are meeting assessed need. Identifying progress at six months into treatment can predict future outcomes that may need early action. TOP can also provide data to act as a negotiating and persuading tool with local partners, such as evidence that providing job opportunities and housing improves users' recovery outcomes.

Contrary to the views represented by Ira Unell and colleagues, many treatment workers, users, services and partnerships are using TOP to improve user outcomes. Some of the best performing partnerships in the country are also the ones making the best use of TOP to inform their clinical practice. One London borough, for example, used TOP data to identify the need for improvements in the reduction of crack cocaine use by clients in the area. Within six months, abstinence rates amongst crack users had increased from a third to 70%; those deteriorating had fallen from 10% to 3%; and the average reduction in crack use rose from six days a month to over 10 days. In one South Yorkshire partnership, a rise in problematic alcohol use at six month review was identified via the TOP quarterly outcomes report, which prompted a review of how alcohol interventions are targeted towards clients in treatment.

If TOP is viewed, as Unell and colleagues suggest, as purely a form filling exercise, then it is hardly surprising that the potential benefits to users are overlooked. How well TOP is used in each local area depends on local leadership and on the vision and commitment of individual workers, service manager or commissioner. But the potential to use TOP to inform improvements to services, systems and interactions is there to be realised.

SOME OF THE BEST PERFORMING PARTNERSHIPS IN THE COUNTRY ARE ALSO THE ONES MAKING THE BEST USE OF TOP TO INFORM THEIR CLINICAL PRACTICE.

It is not intended to be a system-wide measure of precisely how much offending has reduced by. To judge TOP on that basis is to miss the point somewhat. The crime question is an essential part of the conversation between a treatment worker and users who are or have been offending, so to leave it out would be neglecting a vital barometer of the user's progress towards recovery. System-wide assessments of how treatment reduces crime have been carried out by anonymously cross-matching drug treatment data with the Police National Computer.

There is a wealth of material available to providers and partnerships from TOP, and the NTA wants to work with the sector to make those tools as easily accessible as possible. Having listened to feedback from the sector about making TOP reports more accessible, we are piloting a new version of the quarterly outcomes report which will be available later in the year, along with a range of new tools to support treatment workers, providers and partnerships to make the most from TOP. In the meantime, talk to your local NTA team about using the bespoke outcomes reports. We would welcome your feedback about how the information available to you from TOP could be improved.

Improving user outcomes is only going to become more important in the future landscape for drug treatment services, not less. Therefore making better use of the tools at our disposal to get better outcomes can only benefit users, families and communities, as well as the drug treatment sector. In this time of transition, it is now more important than ever that, as a sector, we can demonstrate outcomes. In this respect we are ahead of many other sectors who may be vying for the same limited resources. Demonstrating outcomes will be vital in this environment – now is not the time to give up this advantage.

Rosanna O'Connor, NTA Director of Delivery

Have we seen the back of smack?

A sustained fall in the estimated number of heroin users; fewer people coming forward for treatment, an ageing heroin using population. So has the Trainspotting era run out of steam?
By **Roger Howard** and **Nicola Singleton**.

It is never easy to estimate the numbers of people who are dependent on heroin. The chaotic nature of the lifestyle of many of them means they are not included in most general population surveys, so indirect methods of estimation have to be used.

In the UK such methods, which make use of the fact that many people in this group have contact with treatment or the criminal justice system, have been used regularly over recent years to estimate numbers of 'problem drug users'.

Although the exact definition of problem drug use varies across the country, problem opiate use, mostly heroin, is generally an important component of it. Data from these estimates suggest that, while the UK still has comparatively high rates, the numbers are decreasing, largely driven by falling prevalence of problem opiate use in England. There are no equivalent series of estimates available in Wales or Northern Ireland while in Scotland the prevalence of problem drug use, which in this case is defined as problem opiate or benzodiazepine use, has not decreased

But this apparent decline in the numbers of people using heroin or other opiates in England is only part of the picture. Of at least as much significance is the change over recent years in the age profile of those people who are dependent on heroin.

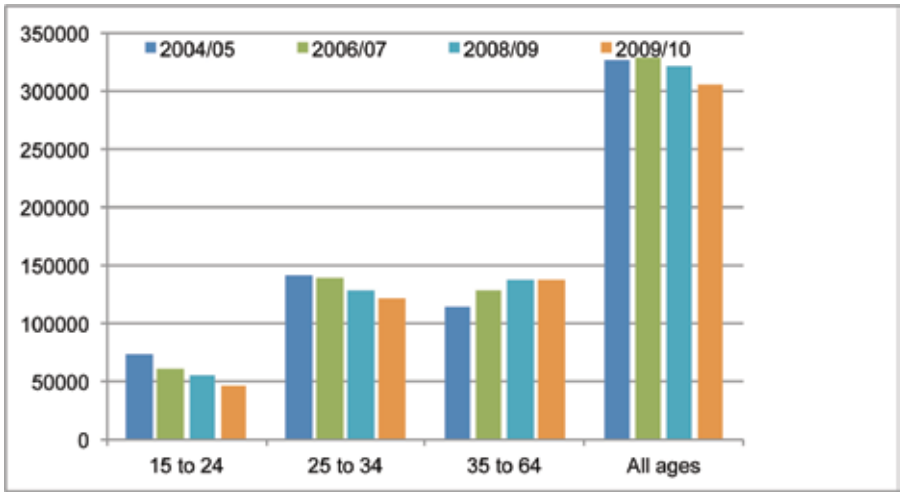
Between 2004-05 and 2009-2010 in England the estimated number of problem opiate users (which includes people in treatment) aged 16 to 24 years declined markedly, while a decrease is also seen in those aged 25 to 34 years. But the number aged 35 to 64 has increased (see Figure 1). A similar pattern is also seen in Scotland.

There are good published statistics on people in treatment and starting treatment episodes. In England, these show that from 2005-06 to 2010-11, the number of adults being treated for opiates use has increased from 139,544 to 166,221. However, the number of people aged 18-24 in treatment for opiate use fell from 22,581 in 2005-06 to 12,048 in 2010-11: a drop from 69% of all those in treatment in this age group in 2005-06 to 49% in 2010-11. At the same time the number of people in treatment for opiate use aged 40 and over almost doubled, from 25,687 to 50,933.

Over this six-year period, the total adult treatment population has become considerably older. The aging trend is even more marked among those in treatment for opiate use. Whereas, 16% of people in treatment for opiate use in 2005-06 were aged 18-24, in 2010-11 they made up only 7%. The equivalent proportions for those aged 40 or above were 18% in 2005-06 rising to 31% in 2010-11.

A similar trend can be seen among people starting a new episode of treatment. The proportion of new treatment episodes related to opiate problems fell slightly, from 72% in 2005-06 to 67% in 2010-11 but within this group the proportion aged 18-24 fell from 19% in 2005-06 to only 11% in 2010-11

Figure 1: Trends in problem drug use (opiates and/or crack) in England by age group



and the proportion aged 40 and above rose from 15% to 24%.

Scottish treatment statistics show a similar pattern with a decreasing proportion of young people and an increasing proportion of older people among new treatment entrants, while among the younger age groups those presenting for treatment for heroin are making up a smaller proportion of treatment entrants.

This is not just an British phenomenon; a similarly aging heroin-dependent population is seen in many Western countries including, for example the Netherlands, Switzerland and the United States, despite different policy stances.

So heroin dependency and the need for treatment and support is increasingly becoming an issue for older adult groups. In 2009 the NTA said 'we are seeing a shift away from the 'Trainspotting' generation'. It appears they are aging and new generation(s) are behaving differently. So how to explain this?

Clearly, an apparent decrease in the prevalence of heroin use and the numbers presenting for treatment is something to be welcomed. It suggests hope for the many individuals involved, and for their families and wider society.

Yet, not only is predicting the future difficult in this field but so is understanding the present. The myriad factors that influence drug use can be daunting, and in the changing patterns of heroin use we are undoubtedly looking at more than one explanation.

The reasons for this are a matter for speculation. The apparent decrease in the number of young people developing heroin problems may be due to heroin use becoming less 'fashionable' following the surges of the 1980s and 1990s. This would fit with the epidemic model of drug trends, with rapid escalation and gradual tail-offs.

But this still needs its own explanation. One possible answer is that, as with stories about crack use in the US in the mid-1980s, a younger generation saw their elder siblings or close friends using heroin and losing control or dying. The visible reality of heroin may have put off others from starting to use. Public information and educational programmes may have contributed too. Or perhaps an increased focus on early interventions may have helped some young people before their problems became too entrenched.

It might also be that the public are turning away from drug use more generally as part of a general shift towards less risky behaviour, also seen in some other trends such as a decline in the popularity of smoking and overall alcohol consumption. Certainly recent British and Scottish Social Attitudes Surveys suggest a hardening of attitudes towards decriminalisation of cannabis following a period of increasing support for such action.

Besides the reduction in new users, another plausible explanation for the aging population of opiate users in treatment is that expanded and improving treatment systems are leading to more people accessing and being retained in treatment for their heroin dependency. If this is the case, the recent focus on recovery may change this. But it might be that older heroin users have such entrenched problems that their lives are more difficult to rebuild.

Finally, some argue that supply-side interventions have helped reduce demand for heroin, either through affecting street prices or through edging some users out of the market with continual enforcement interventions, such as Integrated Offender Management or repeated neighbourhood busts. Yet the long term decline in heroin prices suggests the success of supply-side interventions may have been limited. However, the decline in purity of supplies may also have worked to make heroin use less attractive.

Perhaps we should reverse the question: rather than ask why heroin became less popular, we should be seeking to understand why it was as popular as it was in the first place. A plausible explanation is that the economic factors of the 1980s created a specific situation that led to the original epidemic. If that is the case, we should be concerned that there is a risk of similar problems re-emerging, although the toxic mix of deprivation and unemployment plus the arrival of smokeable heroin from Iran probably made a significant difference. Prior to that, heroin was largely injected which threw up a 'natural' barrier between heroin users and other drug users. Even so, serious, long-term economic decline has, of itself, the potential to fuel a rise in problematic substance use.

Whatever the explanations, we have an aging heroin-using population. Heroin dependency and the need for treatment and support is increasingly becoming an issue for older adult groups.

The drug field is constantly facing new challenges and needing to adapt, and this aging heroin-using population presents policymakers, local commissioners and service providers with some knotty problems.

Older users are likely to have tried different treatments, including residential, many times. Should we simply support recovery efforts at the risk of relapses, hoping to succeed with one last push, or should we also look to expand other evidence-supported solutions, like heroin-assisted treatment for this group?

In The Hague there is an experimental care home, which provides aging addicts with a safe place to live – and use drugs. The goals are different from the UK's treatment centres: to stabilise the health of residents and provide their days with structure. Many are likely to stay there for the rest of their lives. One can imagine the outraged response of local and national politicians to this in the UK.

Or look at the implications for the new benefits system. If there is a cohort of older heroin-addicted people who realistically stand little chance of finding work, it is hard to see how the new benefits system will cope with such people. The expectation that they find work may be unachievable and so we would be setting some people up to fail. The understandable desire to be ambitious potentially conflicts with what evidence and experience suggests can be achieved.

The criminal justice system will also be faced with the need to adapt if the prisons end up accommodating aging heroin users still committing crimes.. Like many systems, drug treatment and recovery is likely to face the law of diminishing returns, where each additional unit of effort becomes more expensive. The strain on our criminal justice and health systems will be significant if they are expected to pick up the slack where treatment finds progress difficult.

A renewed focus on recovery as a journey rather than a single destination (ie abstinence for all) is likely to be better suited to this group with long term problems, improving services and providing for a series of stepped and achievable outcomes. And new approaches, such as heroin-assisted treatment, may provide the first of these steps. Every policy needs to be ready for the times where it cannot succeed, by preparing a Plan B.

Roger Howard (Chief Executive) and **Nicola Singleton** (Director of Policy & Research) at the UK Drug Policy Commission

Diazepam daze

Drug enforcement officers in Scotland are starting to seize large quantities of tranquillisers they believe are being either manufactured in illegal UK-based laboratories, smuggled from abroad or bought online. By **Jason Bennetto**.

What do a hair salon, an industrial unit, and a white van on a Scottish country road have in common? The surprising answer is huge quantities of the Class C tranquilliser, diazepam.

In March, police officers raided an industrial unit and six homes in the historic town of Paisley, about ten miles west of Glasgow. They found 30,000 diazepam tablets, cash, cocaine and suspected drug-making equipment.

Two months later and the police and the Scottish Crime and Drug Enforcement Agency (DEA) were back in Paisley to carry out a late night raid at a hairdressers'. Officers reported finding six kilos of diazepam – tens of thousands of tablets – during the operation.

In June in the Scottish Borders just north of Selkirk, a white Transit van was stopped on the A7. The police seized 1,000 blue diazepam tablets from the vehicle.

The growing popularity of diazepam in Scotland is reflected in the rise in seizures by the police from 571 in 2000/01, to 2,139 in 2006/07, and 3,605 last year. In the year ending April 2011 the eight Scottish police forces recovered 678,100 diazepam tablets. Diazepam – best known under the now defunct brand Valium – makes up 85 per cent of the benzodiazepines recovered in Scotland.

The demand for diazepam is being fuelled by heroin users who, fed up with the poor quality and scarcity of their drug of choice, are switching to tranquillisers, according to Scottish based drug agencies and the DEA. Since the end of 2010, there has been a heroin "drought" that has affected the availability and strength of the drug. There is also growing evidence that recreational drug users and heavy drinkers too are using diazepam in increasing numbers, unaware of its potentially dangerous side effects and the risk of addiction.

Kenny Simpson, a drugs expert for the Scottish DEA and a former police drugs squad officer, is unequivocal about the scale of the diazepam problem in Scotland. "It's huge," he said.

The DEA believe that organised crime in the UK is becoming involved in the production of diazepam. Simpson explained: "one of the real challenges is the changing face of drug dealing. We are finding 1000 to 5000 tablets in a single bag – it is being mass-produced and I think part of this is taking place in the UK.

"Intelligence suggests there are a number of amateur laboratories now operating across Scotland, creating their own illegal versions of the drug."

Simpson also revealed that there were significant imports from laboratories in India and Pakistan who produce generic and counterfeit diazepam that had branded stamps on the tablets – such as STADA, MSJ, Roche, Tensium and D10 logos – and sealed in blister packs. This in contrast to the poorly produced crumbly pills, suspected to come from UK labs.

Gareth Balmer, the Dundee project manager for Addaction, confirmed this trend. He said: "Benzos are like our crack in Scotland. There has been high benzo use in Scotland for a long time, but the big change is where the drug is coming from. In the past it was diverted prescriptions – from grannies etc – but we are now seeing bulk diazepam from overseas."

The popularity of diazepam is further demonstrated by the fact that in 2010/11 it was the second most commonly reported drug used (34 per cent or 2,707 people) after heroin (62 per cent) of those individuals attending specialist treatment services in Scotland.

Diazepam acts as a sedative to relieve severe anxiety, which can put the drug user into a stupor. Large quantities can produce a feeling of euphoria.

The main demand is for the high strength 10mg tablets, although there is a market for 2mg white and 5mg yellow tablets. The popular 10mg tablets sell from 50p to £1 each, but can be considerably cheaper if bought in bulk.

Heavy users often take from 5 to 10 tablets at a time, with some taking from 20 to 50 a day, up to about 100 a week – far exceeding the maximum 'prescribed' dose of between 2-10mg (2-4 times daily).

When sold on the street the tablet's nicknames include blues, benzos, vallies, diazies, wobblies, Roches, Manos, and charge sheets. The "charge sheet" reference has been adopted because some heavy users go on crime sprees as the drug can result in them losing control and their memory. Users start to think they are "invisible", explained one drug worker.

A more recent illicit source of the drug is online sales. Some tablets are bought direct from overseas drug firms, while several online sites have sprung up in which diazepam and other benzos are offered for sale in the UK. On one of the best known diazepam forums in

which people sell drugs, there are more than 70,000 messages. In one post, 1,000 diazepam were on sale for £250.

Of course, there is no way of knowing what is in the drugs or whether they are genuine. The unknown strength of many of the tablets, and the mixing of diazepam with heroin, other benzos and alcohol, are part of the reason that drug agencies are especially concerned about the health implications of widespread diazepam misuse.

John Arthur, director of Crew 2000, a national drugs charity based in Scotland, said that his organisation had identified "rebound anxiety and mental health implications with diazepam use". He continued, "In some recent cases with street Valium, there seemed to be various reports of suicidal thoughts and low mood after use."

"There are concerns that people using Valium to come down off stimulants mean that sometimes, they are just putting off the inevitable. They may start using more and more to offset the anxiety and depression which sometimes follows stimulant use and this can lead to a dependency before they know it."

Gareth Balmer, from Addaction, added: "Diazepam is a very difficult drug to treat. It is behind many drug-related deaths. In fact, I believe it's been involved in every single death we've seen [at the Dundee service] in 2012."

National figures for Scotland on drug deaths in 2012 are not yet available, but the National Records of Scotland's Drug Related Deaths in Scotland 2010 reported that of the 485 drug related deaths, diazepam was implicated or potentially contributed to a quarter (122 deaths). Heroin and/or morphine were implicated in, or potentially contributed to, about half (254 deaths). Methadone was linked to just over a third (174 deaths). More than one drug is often responsible for a death.

Diazepam was the most commonly reported drug found in victims of drug-related death, with more than three quarters of cases (77.5%) followed by heroin/morphine (63.7%) and methadone (44.9%). It should be noted that these reports do not state whether the substance caused the death or not.

But it is not just those with serious drug problems that are turning to diazepam. Gareth Balmer noted: "We are beginning to see people who are going out for a few drinks and are starting to dabble with benzos." He added that he was concerned that with the struggling economy and rising unemployment more people could turn to benzos to cope with stress.

HEAVY USERS OFTEN TAKE FROM 5 TO 10 TABLETS AT A TIME, WITH SOME TAKING FROM 20 TO 50 A DAY, UP TO ABOUT 100 A WEEK – FAR EXCEEDING THE MAXIMUM 'PRESCRIBED' DOSE OF BETWEEN 2-10MG (2-4 TIMES DAILY)

Mike Linnell, spokesman for the drugs agency Lifeline, which carried out research about diazepam users in Redcar and Cleveland in July 2010, confirmed that this problem was not confined to Scotland.

He said that his organisation has noticed a "worrying trend" of more recreational drug takers – typically cannabis users – starting to take diazepam. Linnell said that the UK-wide popularity of tranquillisers, most commonly diazepam, which was identified in the *Druglink* 2008 and 2011 Street Drug Trends Survey, continues. The survey found that 16 out of 20 town and cities across the UK reported rapidly rising levels of tranquilliser use in 2010.

Linnell commented: "My impression is that since the heroin shortage there's been a huge and growing problem with benzo use throughout the country."

You have only to tap into one of the online benzo forums to gauge the drug's enduring appeal – and threat. As one user recently wrote: "I have plenty of experience with benzodiazepines after being on and off them for over 8 years or so, and sometimes very high dosages where I have had blackouts for like 2 weeks at a time.....I'm amazed I'm still alive."

Legal note:

All the benzodiazepines including diazepam are Class C drugs under the Misuse of Drugs Act. However you can be in lawful possession of the drug so long as it has been prescribed by a doctor. But according to the Home Office, if you were caught in possession of diazepam that had not been prescribed for you, then you could be charged under the Act. This would include pharmaceutically produced drugs that had been stolen, bought online or illicitly produced.

Jason Bennetto is a freelance journalist and senior lecturer on the journalism MA course at City University London.

Flashback

Problems with benzodiazepines in Scotland are nothing new. While heroin use soared in England in the mid 1980s, the drug was relatively scarce and of poor quality north of the border. Quality and availability improved into the early 1990s, but by then a culture of injecting Temazepam (and also Temgesic, or buprenorphine) had grown up. Temazepam was produced as a liquid inside a capsule making it easy to inject. When the manufacturers were made aware of what was happening, they changed the formulation from liquid to gel. This did nothing for the situation except make injecting more hazardous; users would simply liquefy the gel for injection only for it to resolidify in the vein, causing many users to lose limbs. Temazepam use was also implicated in incidents of violence and a steep rise in the number of drug deaths in Glasgow in the early 1990s. The capsules were often green in colour, called eggs or jellies on the street and sold for about £1 each. Most were dealt by gangs who stole the drug in wholesale amounts, but there were also numerous anecdotes about the elderly selling part of their prescription to supplement their pension. Some users were reportedly swallowing anywhere between 60-100 tablets a day.

In 1992, the ACMD recommended that Temazepam became a Class C drug, but it took nearly three years for the government to announce the change along with the banning of the gel-filled variety which was still being prescribed. In 1995, BBC's Panorama filmed a documentary in Paisley as an area ravaged by the health and crime consequences of non-medical benzodiazepine use. More than fifteen years on, nothing much seems to have changed apart from the colours.

Harry Shapiro

Seize the moment

Despite dramatic representation in films, heroin withdrawal is not inherently life-threatening. Not so with alcohol. Workers need to be aware of all the issues, as detoxing from alcohol is no simple matter. By **Dr Karim Dar** and **Dr Raquin Cherian**

Nowadays, there is much concern about our drinking culture; the degree to which it fuels anti-social behaviour, and the health consequences and costs for the nation. In 2010, the National Institute for Health and Clinical Excellence (NICE) produced recommendations for preventing alcohol harms covering pricing, availability, marketing and licensing, as well as screening with young people and adults using brief interventions.

But what about people for whom preventative measures are too late? In 2009/10, there were just over a million alcohol-related admissions to hospital in England, double the figure for 2002/03 and costing NHS England nearly £3 billion. Many of these people will be at risk from the potentially life-threatening effects of alcohol withdrawal and be in need of specialist intervention either in the community or in-patient facility. So what are the key issues?

TABLE 1

Symptoms of alcohol withdrawal syndrome	Time of appearance after cessation of alcohol use
Minor withdrawal symptoms: insomnia, shaking, mild anxiety, stomach upset, headache, heavy sweating and palpitations	6 to 12 hours
Visual, auditory, or tactile hallucinations	12 to 24 hours (these symptoms are usually resolved within 48 hours)
Withdrawal seizures: generalised tonic-clonic seizures	24 to 48 hours (these symptoms can be reported as early as two hours after cessation)
Alcohol withdrawal delirium (delirium tremens): hallucinations (predominantly visual), disorientation, rapid heart rate, hypertension, low-grade fever, agitation, heavy sweating	48 to 72 hours (these symptoms peak at five days after cessation)

Clinical features of alcohol withdrawal

Once a regular heavy drinker has stopped drinking and the blood alcohol level decreases significantly, Central Nervous System (CNS) overexcitation occurs. This is what people experience as withdrawal symptoms. These symptoms usually peak between 24 and 36 hours after someone has stopped drinking and may dissipate after 48 hours. Table 1 shows the range and timing of withdrawal symptoms.

Generally, the symptoms of alcohol withdrawal relate to the amount of alcohol drunk and the duration of an individual's recent drinking habit. Most people with this problem have a similar spectrum of symptoms with each episode of alcohol withdrawal.

Withdrawal seizures are more common in patients who have a history of multiple episodes of detoxification. Causes other than alcohol withdrawal should be considered if seizures are focal, if there is no definite history of recent abstinence from drinking, if seizures occur more than 48 hours after the patient's last drink, or if the patient has a history of fever or trauma. In this context, causes including epilepsy, head trauma or infection need to be considered. It is important to ascertain the correct diagnosis, as many patients with alcohol related seizures are told they are epileptic and are prescribed anti-epileptic medication long term, which they don't need.

Alcohol withdrawal delirium, or delirium tremens (DTs), is characterised by clouding of consciousness and delirium. Episodes of delirium tremens have a mortality rate of 1 – 5 per cent. Risk factors for developing alcohol withdrawal delirium include concurrent acute medical illness, daily heavy alcohol use, past history of delirium tremens or withdrawal seizures, older age, abnormal liver functions, and more severe withdrawal symptoms on presentation.

Choice of treatment setting

In most patients with mild to moderate withdrawal symptoms, outpatient detoxification is safe and effective, and costs less than inpatient treatment. However, certain patients should be considered for inpatient treatment, including some who should be assessed for inpatient settings regardless of the severity of their symptoms. Relative indications for inpatient alcohol detoxification are shown in Table 2:

Based on our current understanding of alcohol withdrawal syndrome and recent research studies, some characteristics are identified as conferring a risk of more severe withdrawal symptoms, prolonged symptoms or withdrawal-specific complications, such as DTs or seizures.

With advances in treatment, mortality rates during withdrawal have decreased drastically, with more recent studies indicating mortality rates in the range of 1 per cent. Patients with co-existing illnesses, especially those with cirrhosis, DTs and those transferred to the ICU and subjected to mechanical ventilation are thought to be at greater risk of dying during withdrawals and detoxification.

TABLE 2:

Relative indications for inpatient alcohol detoxification
• History of severe withdrawal symptoms
• History of alcohol withdrawal seizures or delirium tremens
• Multiple past detoxifications
• Concomitant medical or psychiatric illness
• Recent high levels of alcohol consumption
• Lack of reliable support network
• Pregnancy
• Older adults

TABLE 3:

Factors predicting severe/ complicated withdrawal
• Recent high amounts of alcohol consumption
• History of severe withdrawal
• History of seizures or delirium tremens
• Concomitant use of other psychoactive drugs
• Poor physical health
• Co-existing psychiatric disorder
• Being elderly

Wernicke's encephalopathy (WE)

This a form of acute brain injury resulting from a lack of thiamine (vitamin B1) that most commonly occurs in chronically alcohol dependent people. In alcohol dependent patients, thiamine deficiency occurs due to poor dietary intake and/or intestinal malabsorption. It is estimated that healthy subjects absorb 4.5 per cent of an oral dose of thiamine, compared to only 1.5 per cent in alcohol-dependent subjects. The syndrome is characterized by severe cognitive impairment and delirium, abnormal gait, and paralysis of certain eye muscles.

WE is not a withdrawal complication, but it is usually identified in acute hospital presentations, including patients presenting with alcohol withdrawal. It can co-exist with and should be distinguished from acute alcohol withdrawal, hepatic encephalopathy, and other causes of confusion.

WE is initially reversible, but if untreated or inadequately treated can lead to Korsakoff's syndrome, a chronic and disabling condition characterised by severe short-term memory loss and impaired ability to acquire new information. Patients with this syndrome fill in gaps in their memories by narrating fictitious/ inaccurate accounts (confabulation). Korsakoff's syndrome is not dementia or delirium.

Approximately one-quarter of patients with WE recover completely if treated appropriately, one-quarter show significant improvement, one-quarter only partially recover, and one-quarter show no improvement over time. Approximately one-quarter require long-term institutional care. It is imperative that treatment is initiated early, as delays in treatment may worsen the patient's prognosis. No effective treatment of Korsakoff's syndrome has been found. All heavy or chronic drinkers should be considered at risk of developing WE. Given that so many patients with WE are undiagnosed and thiamine is safe and costs little, all patients undergoing alcohol withdrawal should be treated with thiamine to prevent WE. And given the major clinical repercussions of not treating WE, all patients with any feature of WE should be treated as though WE is established.

Medically-assisted detoxification

Patients who experience alcohol withdrawal should be detoxified with medications to treat their symptoms and reduce risk of complications. The medications with best efficacy and safety for managing alcohol withdrawal (essentially a state of nervous system excitation) are the benzodiazepines Librium and Diazepam. They are given initially in high doses, as withdrawal symptoms peak in the first 48-72 hours, and then gradually reduced in dose and stopped usually after 7-10 days.

Nerve damage during alcohol withdrawal and detoxification

Although the majority of detoxifications are uneventful, alcohol withdrawal represents a period of significant clinical risk for some that requires attentive medical management. Some withdrawal episodes may appear to be mild enough to be treated without medications, but this approach may have long-term harmful consequences for patients. Why is this?

Alcohol use can cause brain damage, and at least some of this damage may occur during periods of alcohol withdrawal rather than during periods of alcohol use. Alcohol withdrawal is a vulnerable time for the brain, with well-recognised neurological complications such as seizures, delirium tremens and long standing brain damage. But it is now increasingly recognised (but not widely known) that impaired cognitive functioning is also widespread during the first months following detoxification. Between half and two-thirds of abstinent alcoholics show signs of cognitive impairment during this period, with residual deficits persisting for years after detoxification in some people. The most severe deficits have been observed in visuospatial abilities;damage here might mean you could go out for a walk and not find your way home because you have lost the power to retain the visual memory of the map to retrace your steps. Severe deficits can also occur in motor skills and coordination, abstract reasoning and new learning.

Multiple episodes of alcohol withdrawal not only cause immediate neurotoxicity (damage to nerve cells), but also lead to cumulative changes in what is referred to as 'neuronal excitability'. This phenomenon, referred to as "kindling", means that neurons (nerve cells) are increasingly sensitised over time. In clinical terms this manifests itself as a progressive worsening of each withdrawal episode, particularly the predisposition to experience alcohol withdrawal seizures. The question of whether benzodiazepines and other medications such as Acamprosate can prevent neurotoxicity associated with repeated alcohol withdrawal has recently been researched with initial positive findings.

So to reiterate – multiple detoxifications, particularly if not managed with effective dosage of medications, can make these subclinical neuronal deficits worse. This is why it is extremely important that patients do not try to reduce or stop drinking on their own, if for example, there is a wait for inpatient admission for detoxification.

For more details on detoxification see:
www.nice.org.uk (put alcohol detoxifcation in the search box)
http://bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf

Dr Karim Dar is Consultant Psychiatrist in Addictions and **Dr Raquin Cherian** is a Staff Grade Psychiatrist in Addictions, CNWL NHS Foundation Trust.

ACID TESTS

Controlled drugs like opium and cannabis have long documented histories as medicines; morphine is still the gold standard treatment for pain relief. But since the discovery of LSD, the psychedelics too might have their own clinical applications. By **Jeremy Sare**

When Albert Hoffman, a scientist working for the Swiss pharmaceutical company Sandoz discovered the psychedelic properties of LSD in 1943, he also noticed something else. Because the effects were so mind-warping, he decided they were similar to those of psychosis and so dubbed LSD 'psychomimetic'. This roused the curiosity of other scientists who thought they could use LSD to reproduce psychosis and so hopefully lead to a better understanding of the condition.

But little of clinical significance happened in the 1950s. Some work appeared to be merely 'tests', with imprecise objectives; more of a simple observation of the drug's curious effects on human consciousness. Conventional subjects, including suburban housewives, were interviewed under its influence and filmed gasping at wild spectrums of colours. Christopher Mayhew MP was famously filmed for TV in 1955 recording his experiences under the influences of another hallucinogenic drug, mescaline. The experiment was conducted by Humphrey Osmond, who coined the term 'psychedelic'.

Other, more sinister, trials of LSD were carried out by the military (in the US, UK and the Communist Bloc) designed to explore its effectiveness in incapacitating the enemy and as a truth drug for interrogations. Often subjects were administered the drug without giving their consent and seemingly without much screening on their suitability or any assessment of their existing mental health.

There was also a lesser known branch of clinical research carried out in the 1950s and 60s which has been largely forgotten. Before LSD and other psychedelics like psilocybin became associated with cultural rebellion, there were many research projects into their effectiveness in therapy for conditions including depression and alcoholism.

Psychedelic-assisted psychotherapy combined the administration of the drug through a therapeutic approach; the drug was only administered once or just a few times. The work on dependence was of particular interest as the effects of the drug appeared to be able break 'ego boundaries' and so disrupt cycles of addictive behaviour.

Dr Ronald Sandison carried out thousands of tests on psychiatric patients in Powick Hospital in Worcester. He published a paper in 1954 ('Psychological Aspects of the LSD Treatment of the Neuroses', British Journal of Psychiatry, April 1954 100:508-515) describing the use of LSD-assisted psychotherapy on 36 patients with severe neurotic disorders: the results showed positive psychological benefits with no serious adverse effects. Sandison's paper aroused great international interest at the time but failed to achieve sustained scientific credibility. He went on to work until 1972 with a total of 683 patients, who by then had received over 13,000 doses of LSD. In 1997, 250 former patients launched legal action for compensation claiming that they were used as guinea pigs in LSD trials (Worcester News, 26 January 2004). Eventually, in 2002, according to the British Medical Journal, the NHS agreed to pay £195,000 damages to settle the claims of 43 of the patients.

The cessation of research into psychedelics coincided with the main psychedelic drugs being brought under domestic and international control, with their classification as Class A drugs under the UK Misuse of Drugs Act, and a United Nations Convention which deemed all psychedelics as "substances posing a…serious threat to public health which are of very little or no therapeutic value."

So was that the end of research into the possible clinical applications of psychedelic drugs? For many years, yes, although before it was banned in the USA in 1985, MDMA was being used by some marital therapists, a practice which continued in a few other countries. Warring couples were given a low dose prior to the consultation in order to encourage a more empathic environment.

Meanwhile, the Multidisciplinary Association for Psychedelic Studies (MAPS), based in Santa Cruz, California, was established in 1986. Surprisingly, MAPS has government support. Brad Burge, MAPS Director of Communications, says, "In the US, the Federal Drug Administration's willingness to evaluate proposals for psychedelic research on the basis of their scientific rigor rather than on political attitudes towards psychedelics in general has been a major catalyst for the resurgence of the field."

"As a result of our focus on the specific uses of psychedelics in combination with therapy for specific, diagnosable conditions, our research got a great deal of attention from both international media and the research community. Our specifically medical and therapeutic approach to psychedelic research makes it easy for people to see the value of our work."

MAPS have also been working with psychotherapist Dr. Peter Gasser, on LSD-assisted psychotherapy trials on Swiss patients in advanced-stage cancer and other terminal illnesses. Dr Gasser said, "I am convinced that LSD can be a good aid for psychotherapy. You have to imagine that people are facing death and are terrified of dying... even panicking. They look back on their lives for a spiritual meaning. It is well known that LSD can often help this happen." There were only 12 subjects in the study, but in 30 treatment sessions, there were no reported serious negative reactions. Full results are expected soon.

MAPS Director, Rick Doblin says, "With careful research and honest education, we are whittling away at the culture of fear and irrationality that has restricted research on psychedelics for decades. Study by study, subject by subject, we are showing the world that in the right contexts psychedelics can be effective tools for healing and personal growth."

So what about the UK? Professor David Nutt of Imperial College, London, has established a Psychedelic Research Programme in conjunction with the Beckley Foundation. Their first research study indicated some therapeutic potential for psilocybin in the treatment of depression and also cluster headaches. They are now preparing a research programme into LSD. If granted, it will be the first application for human research using LSD in the UK in forty years.

He says, 'I believe that the complete absence of research on the utility of these drugs for brain research and treatment is a scandal of massive proportions and the most serious failure of the research community over the past fifty years. It derives completely from their legal status and this should urgently be rectified."

The UK Medical Research Council (MRC), which is backed by the Department for Business, Innovation and Skills (BIS), funds a wide range of research projects but keeps an impartial

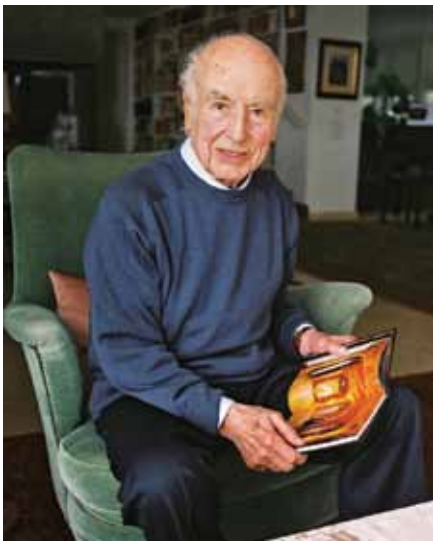


PHOTO: MAPS

Albert Hofmann, the father of LSD shortly before his death in 2008

WE ASSESS APPLICATIONS ON THE BASIS OF THEIR SCIENTIFIC VALIDITY WHICH IS NOT DETERMINED BY THE REGULATIONS UNDER WHICH A DRUG IS CONTROLLED

view on the legal status of psychedelic drugs. Catherine Elliott, Head of Clinical Research and Ethics at the MRC says, "The MRC see there is a need to develop new treatments for mental health problems, particularly as they affect 2-3 percent of the population. We need find ways to identify the mechanisms of how mental health worsens and what is effective treatment. But we assess applications on the basis of their scientific validity which is not determined by the regulations under which a drug is controlled."

The range of drugs with psychedelic properties in the UK has recently broadened with the rapid emergence of legal highs and club drugs. But that is not to say there are increased opportunities for research. When these new drugs become controlled, they are placed in Schedule I of the Misuse of Drugs Regulations as having little or no medical value. There is some concern, particularly from David Nutt, of the proportionality and appropriateness of this policy. He told The Guardian, "The situation [on research] is about to get worse; the government's new temporary drug control orders, under which methoxetamine is the first substance to be controlled, automatically puts new substances under Schedule I for the year that they are controlled. The likelihood of the drug then being downgraded is very remote, given that research will be practically impossible, especially within the year's timeframe."

The Home Office administers the licensing regime and a spokesman said, "The Home Office licensing regime already enables research to take place through a system of controlled drug possession licences, allowing bona fide institutions to carry out scientific research.

"This regime recognises the importance of such research and enables that to take place in an appropriate environment, ensuring the necessary safeguards are in place."

The medical profession may still be waiting for a concerted research programme, but Channel 4 has gained permission to air a series (with a transmission date of 26/27 September, at time of writing) called Drugs Live, which promises to be "a live drug trial". Professor David Nutt (Imperial College, London) and Professor Val Curran (University College, London) are leading research into MDMA, to which Channel 4 has negotiated access. The broadcaster says, "With outstanding access to the leading researchers in the field, viewers will be able to see for themselves the actual effects drugs have in unparalleled detail and get a front row seat to witness compelling science as it unfolds." Whatever the merits of this research, using subjects such as the actor Keith Allen taking ecstasy in an MRI scanner, it risks being presented by the media as indulgent and lacking the necessary scientific robustness.

This kind of activity is probably more of a hindrance than a help to those scientists trying to overcome decades of public fear, media scepticism and political caution, to persuade the powers that be that drugs more associated with hippies than hospitals can have a legitimate role to play in clinical medicine.

Jeremy Sare is a freelance journalist.

THE RESPECT AGENDA

In the second of his two-part article on Danish drug policy, Blaine Stothard looks at the provision and amenities for active drug users in Copenhagen.

It was snowing when I arrived at the entrance to BrugerForeningen (BF – Danish Drug Users Union) in Copenhagen's Nørrebro district, but the climate inside was anything but wintry. Before I had taken my coat off, I had been noticed and welcomed by some of the 'active users' – in BF's terminology defined as current substance users involved in attending and managing BF's premises and activities.

On the third floor of a building used for social and community purposes, BF provides a drop-in room service from 10am until 3pm, after which it's members only (for a fee of about £12 a year). There is just one paid employee, but there is always a duty officer and a trainee in attendance during drop-in opening times. All the work is done by the users. Other facilities in the building have hosted conferences, anniversary celebrations and their 'User Friend of the Year' award – recipients of which have ranged from NGO workers to politicians.

BF's Chair, Jørgen Kjær, introduced me to the users. The first person I spoke to told me: "I feel at home here – because I am at home." This sentiment was echoed by others during my visit, reflecting BF's success in creating an atmosphere of respect for self and others and of 'peace and quiet.' This contributes to stabilising users and ensuring that their using behaviour is as safe as possible, with information and seminars on safe injection – keeping users alive and, ideally, in improving health.

Tobacco smoking is allowed and cannabis is tolerated: it's a pre-dinner ritual for some to promote appetite and accompanies a public hand washing ritual before the evening meal 'to show that we care for one another.' Cocaine and alcohol are not permitted on the premises, however: Jørgen Kjær says that it can make individuals' behaviour unpredictable, selfish, aggressive or confrontational, behaviours which would undermine the peace and quiet ethos.

BF organises seminars for politicians, the media, and drug and alcohol practitioners, including the police, and arranges placements for social work training institutions. Regular safer injection seminars are run for first-time attenders, with refreshers for longer-term users. Clean works are easily available in Copenhagen and BF's activities include a syringe patrol, operated since 1997, which collects discarded works from streets and other publicly accessible areas in Vesterbro, an area of Copenhagen frequented by injecting drug users because of its open market.

Another activity undertaken by BF is to show users how to make 'safer' crack. They justify this, both as a way of engaging with crack users who are often marginalised even within the drug-using community and to assist in the production of a substance which is 'cleaner' than that bought on the street. They want to encourage the substitution of ammonia with baking soda, as there have been cases of acid attacks between dealers in dispute.

BF's wider aims include re-establishing the humanity and dignity of users, setting a political agenda for reform and countering stigma and prejudice. BF was also active in the campaign for the provision of medically prescribed heroin introduced on a limited basis in 2008.

Not surprisingly, the campaign attracted a lot of media attention. One article in *Berlingske Tidende* (think *Daily Telegraph*) pinned on the BF notice board described the situation of a 27-year old female cocaine and heroin user, who obtained some of her income from commercial sex work. She had a 71-year old client with necrophiliac tastes who would 'feed' her with sedatives and sleeping pills until she was comatose and then have sex with her. She was 'paid' in more drugs. This helped shift some public and political opinion towards supporting the legalisation of heroin prescribing, so that users were not reliant on degrading behaviours and lifestyles to fund their substance use.

However as mentioned in the previous article, the strict rules and regulations surrounding provision make it unattractive for many users; because the prescribed heroin has to be injected – it cannot be smoked or sniffed – users who have never, or who have stopped injecting, now have to in order to comply with the regime.

Out on the streets, the voluntary agency Fixerum operates a 'Fixerlance' (a combination of fixerum and ambulance) in and around Vesterbro. This provides a sheltered space for users to prepare and inject their (illegal) heroin using sterile equipment. Fixerlance is staffed by volunteers, including qualified doctors and nurses, who are legally required for administration of naloxone, with which

Fixerum Chair, Michael Lodberg Olsen

PHOTO: BLAINE STOTHARD

ASKED ABOUT HIS MOTIVATION FOR HIS CAMPAIGNING, FIXERUM'S CHAIR AND DRIVING FORCE MICHAEL LODBERG OLSEN SAYS SIMPLY, "IT'S BECAUSE I LIVE HERE"

the mobile fixerum is equipped. Two users can be seen at a time.

Fixerlance had a low-key launch in September 2011. Fixerum was prepared to contest any legal and court actions, by residents or the local authority, but there have been none. Some of Fixerum's funding, including its Fixerlance purchase, has actually come from local residents and businesses. Fixerum has offices in the former meat-market buildings in Vesterbro. The buildings are now used for a variety of social and commercial purposes: one catering enterprise, established by former illegal drug users, rejoices in the name Junk Food.

Asked about his motivation for his campaigning, Fixerum's Chair and driving force Michael Lodberg Olsen says simply, "it's because I live here." With other volunteers, Olsen had previously opened a café and health centre for users, including a room for smoking cannabis and crack. Police acceptance of this activity required that the premises were not used for dealing. When the City Council realised this, and that the toilets were being used to inject, Olsen had to leave the management body and his role as director. The City Council took over the running of the café, with guards at the toilets, and closed the smoking room. Fixerum argued for extended opening hours; instead they were reduced.

On a more positive note, in June this year, a national law was passed permitting the establishment of consumption rooms. Fixerum is now commissioned by Copenhagen City Council to provide the Fixerlance service seven days a week until a building-based consumption room is opened in 2013. Concern among campaigners that the new law would, in line with the regulations for medically prescribed heroin, require users to inject has been allayed: consumption room users can inject, smoke or sniff their heroin. Such conditions, along with the credibility established by existing staffing, are likely to encourage take-up of this service. Olsen estimates that five fixerums are needed in Copenhagen to cater for users buying on the illegal market: users of prescribed heroin cannot take it away from the clinic where it is supplied.

Another hot topic at the moment is the provision of naloxone. Currently a prescription-only medicine, administration has been extended in a trial involving BF where 14 active members have been trained. BF and the harm reduction campaigning organisation Gadejuristen are pushing for the availability of naloxone to be extended to users, families and friends. Campaigners see increased availability of naloxone as essential to a wider campaign to reduce drug-related deaths – 276 in 2011, compared to 115 in 1995, in a country with a population of 5.5 million. Revised regulations on the availability and administration of naloxone could, campaigners hope, form part of a new national drugs strategy.

Many campaign aims require new or amended legislation –regulation of medically prescribed heroin and the wider availability of naloxone. Some first steps were taken this summer: the Ministry of Health will now allow prescribed heroin to be ingested in tablet form but has rejected suggestions that smoking heroin also be allowed. Use of nasal spray is still being considered. *Druglink*'s readers may be familiar with Copenhagen City Council's proposals to regulate production and supply of cannabis, still on the political agenda although the initial proposal that legislation be prepared was rejected by the Ministry of Justice in May.

About 600 users visit Vesterbro's open market for illegal drugs. About 40 per cent live in the area. Some users with whom Fixerum has contact are not Danish citizens. Eastern Europeans known to Fixerum and other agencies are frequently homeless. Awareness is growing of an association between crack use and asylum-seekers. There is some overlap between users, homelessness and commercial sex work, but prostitution does not seem to be a major source of funding of illegal drugs purchases.

The overriding impression from my visit is the disparity between national legislation and the highly responsive practice of some voluntary agencies, such as BF and Fixerum. The work of these agencies has direct personal support from many politicians, local and national, and some funding from Copenhagen City Council and national Ministries. This is strikingly illustrated by the acceptance of BF's current illegal drug users as appropriate individuals to be trained in the administration of naloxone. Although this is beginning to change, the personal and financial recognition and support for the work of these voluntary agencies has yet to translate into legislation which would allow users throughout the country to benefit.

Blaine Stothard is a prevention specialist and *Druglink*'s book reviews editor.

Headspace

...drugs from the left field

David Biddle
Deputy Chief Executive, CRI

A service by any other name...?

There have been a number of articles recently, as well as considerable comment, surrounding the commissioning of drug services resulting in NHS trusts losing contracts. Indeed, the last edition of *Druglink* added to that list in its attempt to deal with the retendering of services in Manchester. As a major provider of third sector clinical services, I regret that CRI was not given the opportunity to inject a modicum of balance in articles that directly address our performance and reflect upon our reputation.

Like other charities, CRI has taken over a number of drug service contracts in recent years from NHS Trusts. I would also point out, at the risk of muddying the waters, that we subcontract to and are subcontracted by, several NHS trusts. All of these contracts have to be judged quite simply by the quality of our governance, clinical work and the outcomes we achieve, otherwise we would not be awarded more. Contract award is not simply a question of 'cheapness'; NHS trusts compete within the same financial envelope and it is increasingly a question of approach.

Amongst the whole range of issues thrown up in the debate about charities taking over drug and alcohol services from the NHS, there are two points I would like to make.

First, the 'bogey' that only the NHS 'can do it well'. I welcome the move to the commissioning of integrated systems and the move away from predominantly maintenance based services that now require service providers to demonstrate ambition, vision, real engagement with service users, and flexibility in responding to their needs.

It does not necessarily follow that new systems are inherently inferior to those that are being replaced

The inclusion of Payment by Results (PbR) in that process is a real challenge for organisations – from all sectors – to adapt, focus upon a wider range of outcomes and successfully deliver and consequently 'stay in business'.

It is clear to me that the third sector has developed expertise and the clinical governance to deliver safely within this environment – and that this is not the exclusive domain of the NHS, who have, in many areas, shown less ability to move quickly and respond to the demands of the whole range of stakeholders, or indeed deliver the necessary quality outcomes.

Making sure that service users are safe and retained during this process of change is a responsibility on all organisations, out going and newly commissioned, when implementing new services. It does not necessarily follow that new systems are inherently inferior to those that are being replaced, indeed there is a wealth of examples over the large number of transfers we have undertaken that the opposite is true. CRI is compliant with the NHS Information Governance toolkit.

The real task for us is to continue to strive to get it right, to do it better, and that includes the transfer of information in the contract implementation phase that ensures continuity of service. I am convinced that CRI clinical services can demonstrate major improvements in outcomes following implementation.

The second issue is one which is shared across all sectors. This is the challenge of preserving and nurturing the specialist skills, clinical and medical skills necessary to ensure the long term ability to deliver high quality services. CRI recognises its responsibility to participate in the wider task of enabling specialists to acquire and develop these skill bases. Developing critical mass in medical services allows for us to facilitate research and training opportunities that can only benefit the whole sector.

It is clear that the changes over the past few years are delivering better outcomes for service users. It is also clear that NHS trusts able to rise to the challenge are being successful in winning contracts in this environment. CRI's passion is to deliver quality and effective services, the success of our mission – along with other providers – and the outcomes we achieve will eventually settle this debate.

CRI just concentrates on doing what we do best: helping service users achieve their full potential and realise their ambitions; providing stability, support and structure for their journey to recovery; helping to improve their physical and mental wellbeing; and helping them become contributing members of their communities.

These are clear, simple goals that should be at the centre of all drug and alcohol recovery provision. Ultimately, it is the service user that comes first and that commitment cannot be compromised.

Mind Games

Addiction. What's it all about? Two books – one pretty brain challenging in its own right – attempt to shine a light.

Reviews

Dr Robert Hill Consultant Clinical Psychologist (Addictions) South London and Maudsley NHS Foundation Trust

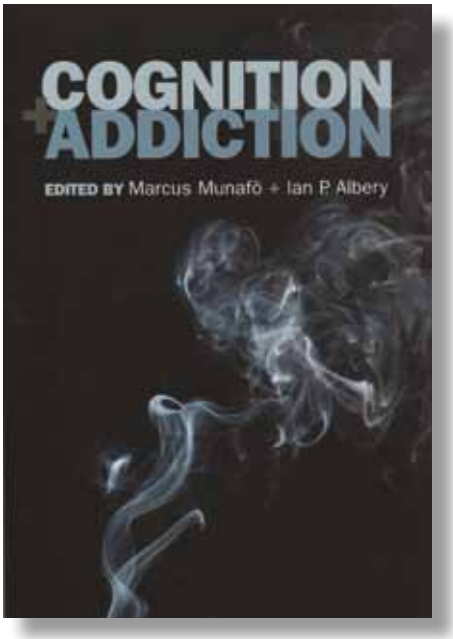
Isolating the neurobiological and/or neuropsychological pathways associated with addiction is something of a holy grail for addiction medicine, and Munafo and Albery's book is a helpful synthesis of the current state of play. Originally published in 2006, the book fills a useful gap between non-addiction books that deal with cognitive biases and specialist addiction journals which may be too complex to be read by more than a small number of academic readers.

The opening chapter, 'Theoretical perspectives and approaches', is a solid review of the differing arguments concerning biased cognitions within addiction. Although not an easy read, the chapter does provide both an overview and sufficient explanation for readers looking for something with depth. Fast forward 250 pages to the final chapter, 'Appetite lost and found' by Frank Ryan, and one finds an extremely helpful chapter which situates the debate concerning cognition within the clinic. Between the two are eight chapters written by researchers and academics focusing on a number of key drivers for addiction, including memory frameworks for addiction, attentional biases, motivation, loss of control, anticipatory processes and implicit cognition. I do not intend to attempt a summary of these chapters, nor am I going to suggest that these chapters are easy to read – they are not. Indeed, one has to approach the volume for what it is: a scholarly account of a current debate. While this may appear to restrict the audience for this book to those already working in this research field or those wishing to enter it, I think this would be, if not a mistake, then at least a pity.

The reality of most addiction services is that there is a whole network of people involved either directly or indirectly in treatment, research and policy surrounding addictive substances or behaviours. Thus, there are service users, trained clinicians, untrained clinicians, those in recovery, researchers, commissioners, managers and so on and so forth. Some people may wear one hat, others two, others a whole wardrobe. Generally speaking, each grouping occupies a carefully constructed and articulated world from which one rarely strays. Service users are, one suspects, vastly outnumbered by these additional networks and can often, and particularly within the research field, remain primarily subjects or participants.

As I read through *Cognition and Addiction* I was very conscious of reading it as a clinician in addiction and the wide gulf between what addiction researchers are finding out and what goes on in the clinical world. Reading the book was a bit of a rollercoaster ride between easy and difficult material, often in the same chapter. On the whole though I recognised that not only could just about every paragraph be deciphered, but that every paragraph contained within it an idea or piece of evidence that could be usefully shared both with clients and front-line clinicians and staff .

That much of the research that emerges in the book bypasses intentionality to focus on automatic or learnt non-conscious processes should not, I feel, make any difference. These are ideas about addiction that, while complex, are not so complex that they lie beyond explanation. Moreover, because we remain some way off having a categorical and agreed explanation for addictive behaviours, we need to find a way of bringing new ideas and hypotheses to the attention of clients and staff. In essence, while the readership for *Cognition and Addiction* will not, in the main, come from those receiving or delivering treatment within addictions, it would be quite liberating if the ideas contained within the book could be more widely debated. Speculation or wonderment about our behaviours and how our brains work – or as Frank Ryan puts it, 'how to outsmart compulsive habits' – can after all, be the beginning of a wonderful journey.



COGNITION AND ADDICTION
Edited by Marcus Munafo and Ian P. Albery.
Oxford University Press
2009
308 pages
£ 42.99

Understanding addiction behaviours:
theoretical and clinical practice in health and social care

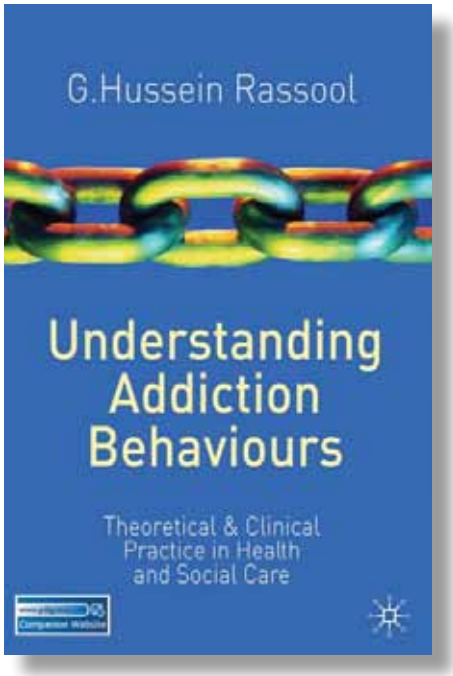
Reviews

Anne Parry
Trainee Clinical Psychologist
South London and Maudsley NHS Trust

This book considers biological, systemic, environmental and psychological approaches to addictive behaviours. It places such behaviours within a cultural developmental context. It does not come from an abstinence only viewpoint – it discusses the harm reduction approach to addictions, as well as providing a critical analysis of this model.

The book is comprised of three sections. The first conceptualises addictive behaviours within society and discusses the annual economic and social costs of addiction in the UK. The need for a wider understanding of addictive behaviours is highlighted due to the huge financial implications of addictive behaviours. Given the current economic climate of savings and reducing funding, effective working with addictions is imperative in reducing longer term costs.

The second section provides an overview of a wide range of addictive behaviours, from pharmacological addictions such as alcohol to non-pharmacological addictions such as gambling and the internet. This raises the profiles of non-pharmacological addictions. Traditionally, these have not been as recognised in the same way as pharmacological addictions, but they have recently received more media exposure.



The third section places addiction within different contexts, for example working with dual diagnosis and addictive behaviours. It offers information on how to apply harm reduction models to tackling substance misuse, tobacco, gambling, internet addiction and HIV and other blood-borne viruses.

The recovery model and the treatment of addictive behaviour are not mentioned in the book. This seems something of an omission, as the recovery model has been emphasised within the drug treatment system since the coalition's 2010 Drug Strategy was announced. The strategy sets out clear objectives to support recovery and reduce the use of illicit and other harmful drugs. There is a greater emphasis than ever before on broader factors such as social capital, wellbeing and integration into society. The book has therefore neglected to discuss the application of this model to addictive behaviours.

G HUSSEIN RASSOOL
Palgrave Macmillan
2011
312 pages
£ 22.99

Supporting Families and Carers (NTA: 2008) emphasised ways in which services can involve families in drug users' treatment and how services can be developed to support and include families and carers. The book acknowledges that carers play an important role within the treatment journey and lists some interventions required to support carers, though it does not expand on them.

The final chapter discusses care pathways and models of care for people who are using drugs and alcohol, and discusses the settings in which care would be received within the UK health framework. However, the treatment pathways put forward in the book are based around the National Treatment Agency's *Models of Care* (2006.) The NTA have since (2011) consulted on a new national framework for recovery to replace *Models of Care for Treatment of Adult Drug Misusers* (2002, 2006) and *Models of Care for Alcohol Misusers* (2006). This could, therefore, be considered outdated information – even more so with the final content of the Health and Social Care Bill far from clear.

This book offers a basic understanding of addictive behaviours for health and social care professionals. It offers a perspective of a wide range of addictive behaviours which could be particularly helpful for clinicians who are not familiar with the addictions field. It could also be helpful for those who are only familiar with pharmacological addictions as it includes a broad range of addictive behaviours other than substance misuse. However, the book does not provide detailed intervention strategies and so is unlikely to be useful to professionals seeking practical guidance on interventions.

Students from both health and social care disciplines will find *Understanding addiction behaviours* particularly useful. It provides information to assist in the assessment of addictive behaviours and offers insights into possible intervention strategies, drawing on evidence-based practice, NICE guidelines and recommendations from the World Health Organisation.

43 factsheet

Heroin and anthrax

Produced by Scottish Drugs Forum in association with Health Protection Scotland

SDF Scottish Drugs Forum

What is anthrax?

Anthrax is a bacterium which creates spores that can infect the body, produce lethal poisons and lead to death. The infection among heroin users is most likely to be acquired through:

- spores entering the skin or tissues under the skin (such as fat or muscle), via injecting contaminated heroin into the body;
- breathing in spores while smoking or snorting contaminated heroin (inhalation).

Who contacted anthrax in the 2009-10 outbreak?

All confirmed cases had a history of recent heroin use. Some had deliberately injected into veins or to muscle – or accidentally injected into muscle or the fatty tissue just beneath the skin.

Some reported only smoking heroin, some were homeless, others were in settled accommodation. Some, not all, were on methadone treatment. Ages ranged from late 20s to mid 50s. More men were affected than women.

Can you spot the contaminated heroin?

No. The spores are too small to be seen by the human eye. Heroin powder normally varies in colour, texture and how well it dissolves – depending on the batch and how much it's been cut.

Contaminated heroin cannot be identified by appearance or in terms of how well it dissolves and therefore all heroin has to be considered potentially dangerous.

Signs and symptoms of anthrax infection

Early identification of anthrax can be difficult, especially among heroin users whose general health may be poor anyway.

How someone reacts also depends on whether the spores entered through the skin (via injection) or through the lungs (via smoking). So look out for anyone who uses heroin and is feeling poorly – especially if they have a wound, redness or swelling at or close to an injecting site.

But other early symptoms can be similar to other illnesses like the 'flu, and may include feeling nauseous or even having difficulty breathing.

factsheet 43

What to look out for

Infection at the injection site was the most common presentation in the 2009-10 outbreak. Someone may be infected with anthrax if he or she shows any of the following symptoms:

Anthrax infection at an injecting site (below the skin – in subcutaneous fat or muscle tissue)

- infection (redness and swelling) of the injection site or an area close to it;
- tenderness/pain/discharging of fluid or pus from wounds;
- may be accompanied by a raised temperature and feeling generally unwell and weak, with aches and pains including headache.

Anthrax infection in the skin (classical cutaneous/skin anthrax):

- usually occurs 2-7 days after exposure;
- usually begins as a raised/swollen itchy red bump, similar to an insect bite;
- within 1-2 days, developing into a clear blister/abscess and then an ulcer which may be painless. It may also be black in the centre;
- feeling 'flu-like, with fever, headache and/or nausea;
- person-to-person spread of cutaneous anthrax is extremely rare.

Anthrax infection though inhaling (inhalation anthrax):

- flu like illness (fever, headache, muscle aches, cough), which may cause breathlessness and chest pains;
- rapid deterioration of consciousness – lapsing into a coma.

What to do if someone has symptoms

If a heroin user shows any of the above symptoms, you should actively assist them to be seen urgently by their nearest hospital accident and emergency department or GP. Things you can do include:

- helping them find their way to hospital or GP surgery;
- accompanying them to hospital or surgery;
- arranging for someone else – family or friend – to be there with them.

Are there risks to workers and family?

The risk to non-heroin using individuals appears to be minimal. There are no documented cases of infection spreading from one person to another as a result of any form of intimate physical or sexual contact.

However, there is a potential risk from touching skin lesions, especially where skin is broken.

- healthcare advice should be taken on the best way to heal a wound;
- small wounds can be covered with a waterproof dressing;
- wounds should be dressed and should not leak through the dressing;
- care should be taken to avoid contact with the wound or any wound discharge by wearing single use gloves to dress wounds or to clean up any spillages;
- afterwards, remove gloves and wash hands with soap and water.

How services can minimise anthrax risks

- Offer quick access to individually-tailored and effective treatment for drug problems;
- Continue to advise users not to share needles, syringe, filters and other "works";
- Advise users of the importance of filters;
- Advise users of the importance of using new filters each time they inject. Filters must be discarded after each use;
- Encourage injecting users to limit citric acid – tissue damage caused by the acid can allow infection to set in more easily;
- Look at whether dosage levels for people on substitute medication are adequate to reduce the risk of "topping up" with street heroin.

DRUG & ALCOHOL FINDINGS

Has methadone been rehabilitated?

The use of substitute medications such as methadone in treatment for opiate dependency has always been controversial. But what does the clinical evidence say? **Mike Ashton** takes a look at where things currently stand...

Residential rehabilitation and 'maintenance' prescribing of opiate-type medications serve as poles to which antagonistic treatment philosophies pin their colours. Divisions were reflected by parties contesting the 2010 election, from the Greens who wanted more heroin prescribing to the Conservatives, for whom methadone was "drug dependency courtesy of the state". Labour responded to this criticism, but without abandoning the mass methadone programme it believed had cut crime and infectious disease.

In its national drug strategy, the Conservative-led coalition which took power rowed back from pre-election rhetoric, offering contradictory sentiments in which both poles could find comfort. A key sentence ("Medically-assisted recovery can, and does, happen") brought maintenance under the safer political umbrella of 'recovery'. But the strategy also heralded a determined attempt (for most, but not all patients) to eliminate what makes maintenance 'maintenance' – its indefinite and often long-term nature – downgrading it to a phase preparatory to "full" recovery rather than a complete recovery option in itself. Picking up the baton, the 2010/11 NTA annual plan reframed methadone as "a time-limited intervention that stabilises [patients] as part of a process of recovery, not as an end in itself". The agency recognised this "radical reform" had risks, evident in a US experiment (Source study 1) which found that despite extra support offered to detoxification patients, maintenance saved more lives at relatively low cost.

Debates came to a head when, in 2012, an expert group convened for the Department of Health delivered its guidance (Source study 2) on how methadone and other medications can aid recovery. The report sought to reconcile competing perspectives, facing forward to show these treatments can be part of the recovery agenda, despite that agenda's associations with abstinence (no methadone) and leaving treatment (no or curtailed maintenance). At the same time it faced backward to preserve acceptance of the need for long-term and even indefinite prescribing, the legitimacy in recovery terms of staying in as well as leaving treatment, and the value of harm reduction gains short of abstinence. Its insistence that the nature and duration of treatment are to be decided between clinician and patient, not dictated by policy, continues the tradition established by the 1926 Rolleston report (Source study 3), which protected the privileged addict-patient relationship from encroachment by drug control regulations.

Today oral methadone is the workhorse and injectable methadone and heroin play a minor role. The UK arrived at this point after decades when it alone permitted heroin for the treatment of heroin addiction. Having restricted this to a few hundred specialists, in the 1970s Britain moved decisively to the more 'normalising' oral methadone regimens pioneered in the USA (Source study 4). From the mid-'90s, mainland European countries adopted (Source study 5) the heroin prescribing option the UK had largely abandoned, adding supervised consumption, an approach which cycled back to Britain via the RIOTT trial (Source study 6) with similar results: for these seemingly intractable patients, heroin worked better than methadone, but a surprising number did well when methadone was tried again in more optimal form.

Arousing visceral opposition and passionate defence, prescribing opiate-type drugs to opiate addicts for as long as needed at the discretion of the treating doctor has for decades been the mainstay of heroin addiction treatment in Britain. Because opposing camps value different things, evidence alone will not decide whether it stays that way, but research does reveal what patients and the rest of us stand to lose or gain from a change in policy.

Selected entries from the Drug and Alcohol Findings Effectiveness Bank project. For the full story with more information, citations and links visit: http://findings.org.uk/count/downloads/download.php?file=DL5.php

SOURCE STUDIES

1 Methadone maintenance beats detoxification as cost-effective life saver Masson C.L. et al. "Cost and cost-effectiveness of standard methadone maintenance treatment compared to enriched 180-day methadone detoxification." *Addiction:* 2004, 99, p. 718–726.

2 Expert report seeks to rehabilitate methadone Strang J. *et al. Medications in recovery: re-orientating drug dependence treatment.* [UK] National Treatment Agency for Substance Misuse, 2012.

3 1926 Rolleston report defends patient-doctor freedoms *Report of the Departmental Committee on Morphine and Heroin Addiction*. HMSO, 1926.

4 Seminal US study substitutes oral methadone for roller-coaster heroin injections Dole V.P., Nyswander M. "A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride." *Journal of the American Medical Association:* 1965, 193(8), p.646–650.

5 Continental Europe transforms UK heroin prescribing tradition Ashton M., Witton J. "Role reversal." *Drug and Alcohol Findings:* 2003, 9, p.16–23.

6 Continental-style heroin prescribing works too in Britain Strang J. *et al*. "Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial." *Lancet:* 2010, 375, p. 1885–1895.

Headspace

...drugs from the left field

Dr Marcus Roberts
Director of Policy and Membership, DrugScope

Every picture tells a story

I should begin by making absolutely clear that the photo on the left has nothing to do with drug use; it is an entirely unrelated picture of a young man in blue work overalls. The picture on the right is, of course, about drug use – it is the familiar stock image, a young woman injecting herself, nasty-looking bruises up her arm. Photo libraries are able to provide DrugScope with plenty of images of the second kind. But it is virtually impossible to find a photograph of somebody who looks like they are contentedly or gainfully employed (or in education or training or simply happy) that can be used in a context that would suggest that they have a history of substance misuse problems.

I know this because DrugScope recently produced two leaflets on employment – for employers and service providers respectively – as part of a project that we are being funded to deliver by Trust for London. We were not allowed to use any of the pictures that we originally selected to illustrate these leaflets, which included the image of the man in blue overalls above. It took a further month to nail down six photographs that we could get permission to use, and three of these all featured the same woman.

Now, it is understandable that photographic models generally do not want their images to be used in a way that may imply things about them that are not true (or are true, but which they would rather not be publically identified with). Photo libraries generally include proscriptions on using images in a way that depicts the person photographed in a way that associates them with a 'potentially sensitive subject matter, including, but not limited to mental and physical health issues, social issues, sexual or implied sexual activity or preferences, substance abuse, crime, physical or mental abuse or ailments'.

We approached several photo libraries to see if they could help. We soon realised it wouldn't be easy to find the kind of pictures we needed – positive images of people in employment. An e-mail copied to us from someone at one photo-library, declared 'personally, I think it's a no-no. Even if a picture is model released, no-one (even if it says posed by models) wants to be portrayed as someone with either a drug or alcohol problem'. Nor do most photo libraries currently see a need to stock or provide images of people who are former drug or alcohol users that portray them in a positive light – presumably because there is not the demand.

A statement of 'standard license prohibitions' for use of such photographs explains that where an image 'undisputedly reflects the model or person in such potentially sensitive subject matter…the content may be used or displayed in a manner that portrays the model or person in the same context and to the same degree depicted in the Content itself'. Translated from the legalese, this means that we could have filled the leaflet for employers with images of people with syringes in their arms or simply looking unwell, desperate or menacing – but that might have undermined its message, which was that 'stereotypes about people with a past history of drug use are common…we want to help you to avoid this by looking at people with previous experience of drug and alcohol use differently'.

It is often commented that service providers and service users may find it difficult to 'picture' people in recovery. If we are serious about tackling stigma, then we should be concerned that there appear to be literally no pictures of recovery in the photo libraries that supply the images that illustrate our narratives and guidance around drug use and recovery.

wired in to recovery

addaction

27-28 November 2012

SAVE THE DATE

Addaction/Wired-In 2nd National Recovery Conference 2012

Liverpool Crowne Plaza Hotel

Addaction and Wired In to Recovery have come together to host the 2nd National Recovery Conference, this year to be held at the Crowne Plaza Hotel in Liverpool.

Following the hugely successful 2011 conference in Birmingham, we will once again be inviting all Recovery Champions, Treatment Providers, Commissioners and Policy Makers to discuss and understand what recovery means, and how treatment should be effectively offered, directly from those who have experienced it themselves.

Confirmed Speakers include:

Mitch Winehouse
Founder of the Amy Winehouse Foundation

Professor Keith Humphreys
Professor of Psychiatry, Stanford University

David Burrowes MP
Member of Parliament for Enfield, Southgate

Mark Johnson
Founder of User Voice and author of best selling autobiography 'Wasted'

Professor David Nutt
Chair of the Independent Scientific Committee on Drugs (ISCD)

Mark Gilman
North West Regional Manager of the National Treatment Agency

Plus: Damien Kelly – The Brink // James McDermott – R.I.O.T. // Robbie Davison – Can Cook // Dominic Ruffy - Rehab Grads // Chip Somers - Focus 12 // Magdalena Harris – The Hep C Trust // and much more

Who should attend:
Community, Therapeutic and Strategic Recovery Champions // People wanting to become Recovery Champions // Substance Misuse Workers // Treatment providers // Commissioners // General Practitioners // Clinicians // Policy Makers // and anyone who is interested in learning more about recovery.

For more information, contact
David Badcock
d.badcock@addaction.org.uk
020 7251 5860

or visit

www.addaction.org.uk

www.wiredintorecovery.org

DrugScope

DRUGSCOPE CONFERENCE

A question of balance: delivering an inclusive treatment and recovery system

Tuesday 6th November 2012

Connaught Rooms, Great Queen Street, London WC2B 5DA

For a programme and booking form go to:
www.drugscope.org.uk/documents/conference2012.pdf