High anxiety: Getting perspective on ‘legal highs’
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NPS: we are not all doomed

Like ‘The War on Drugs’, the term ‘legal highs’ has become equally unhelpful and inaccurate with the usual panoply of ‘unintended consequences’. But whatever the terminology, the presence of substances, many of which have very similar effects to controlled drugs, but sit outside the law and are easily purchased online, represents a significant new dimension to the global drug scene. And without doubt, the legal challenge should not be underestimated.

That said, the problem is not necessarily insurmountable; the most visible manifestation of the new situation are high street shops which, for example, the Irish government has closed down without too much head scratching. Whether this is a wise policy or not remains to be seen. The NPS business may well be driven online, but then nobody seriously believes that you can close down all traditional drug trafficking, so why should the internet be any different? If you want to pursue a law enforcement-focused policy, then as ever, you do what you can to tackle the issue, accepting all the limitations.

In the UK, at least, not that many people are coming forward to services as yet with a currently still legal NPS as a primary drug problem. And for those workers who are faced with this, the message is ‘deal with what’s in front of you’ – the chances are that the person has taken a drug very similar to what you have been familiar with for years. And as far as education and prevention is concerned, we have a wealth of evidence of what works and what doesn’t; so no new wheels have to be invented here either.

For the media, however, NPS is the hot drug story in town right now, which inevitably has political repercussions. So it behoves all of us, whether service providers, clinicians or researchers, not to add fuel to the current firestorm.

Harry Shapiro
Editor and Director of Communications and Information
Drug-oriented internet chat forums such as Bluelight and Silk Road are buzzing with queries about what is claimed to be a ketamine ‘drought’ in the UK right now. Several online forum members are saying that they just cannot get hold of the drug at all and wondering what is going on.

Some have referenced a seizure of 225 kilos of ketamine on the M6 in February by Titan, the north west’s regional crime unit. The police estimated the ketamine haul to be worth just under £7m on the street. But if drug seizures are at the root of the situation, then the seizure of 1.2 tonnes of ketamine by the Indian authorities back in December may be more germane. The Directorate of Revenue Intelligence raided an industrial unit near the city of Jalgaon in western India. The drugs were alleged to belong to Vikas Puri, who reportedly owns pharmaceutical and chemical companies based in a suburb of Mumbai. India is the major source country for ketamine into the UK.

The situation is reminiscent of the huge seizure of safrole, the main precursor for MDMA, in Cambodia in 2008, which resulted in an ecstasy shortage in Europe. The drug in circulation was of poor quality, allowing much stronger mephedrone to gain a foothold in the UK, a position now since consolidated. What comes out of India, however, is the finished product, so any major disruption of supply could impact elsewhere quite quickly.

Worryingly, there are also reports of ‘fake’ ketamine in circulation from users who have subjected the substance to a Mandelin reagent and Marquis colour testing as well as sampling the drug themselves. Results have been inconclusive as to what the substance is, but some of what is being sold as ketamine appears to contain none of the drug at all, or is extremely badly prepared ketamine and/or even 4-Methylethcathinone (4-MeC). Whatever it is, the warnings have been stark; from users lapsing into unconsciousness through to serious nasal damage.

Is there a ketamine shortage?

While Uruguay captured the world’s attention by becoming the first country to legalise cannabis, another drug issue remains more hidden. The problem is the growing number of poor people addicted to ‘pasta base’, a by-product of refining coca into cocaine. Crude cocaine preparations such as pasta base (also known as paco or basuco) are marketed as cheap alternatives to cocaine aimed at local markets. As cocaine production has spread beyond Colombia, Peru and Bolivia, so the use of coca paste has also spread to Argentina, Chile and Uruguay. Another coca derivative known as Oxi has become very popular in Brazil over the past decade and overall, while use of cocaine by-products has been reported for years, the more recent world economic downturn is being blamed for exacerbating the problem.

It is the hope of the Uruguayan government that a legalised cannabis market whereby users can either grow their own or buy up to 40g a month from a pharmacy, will drive a wedge between the cannabis market and the market for other drugs. Opinions of course, differ; some people believe in the gateway theory of cannabis and that a legalised market will encourage more people to smoke who will then want to try other drugs. Others, who have been addicted to pasta base, have used cannabis to wean themselves off the more dangerous drug and feel that if cannabis is more freely available, more people who have a problem with crude cocaine products will have help finding a way out.

Uruguay grapples with pasta base
Mystery of super-strong E

Recent months have seen an increase in the availability of pills containing MDMA above 180mg, even in excess of 200mg in some cases, which have resulted in medical emergencies and at least one death. The main culprit identified in the UK is a red pill embossed with a dragon logo sold under the name ‘Mortal Kombat’. Why such a product should be in circulation is unknown, however, the presence of high strength MDMA is confirmed by the 4th annual report of the Trans-European Drug Information project or TEDi, funded by the Health Programme of the EU. The latest report covering July-November 2013 found that 11% of tablets tested contained 150mg of MDMA or more up to an alarming 271mg in one sample, although overall, tablet purity remained on average the same as 2012.

So why would anybody bother to put out high strength ecstasy pills? It has been shown that around 2008/09, the quality of MDMA was relatively poor as a huge amount of the main precursor had been seized in the Far East causing a drought. Mephedrone came in to fill the vacuum, but perhaps now the MDMA chemists (or at least those not also making mephedrone as well) are somehow fighting back in an attempt to recapture some lost ground, before perhaps reducing the strength back down towards a more standard dose. Time will tell.

NPS seizures

In the continuing cat and mouse game between the police and headshops, Leeds police raided a branch of Dr Hermans in Leeds city centre. Police said that they seized the products in the hunt for substances that might already be controlled, but continue to be on sale as legal substances. In Bradford, a head shop owner was convicted under Section 9A of the Misuse of Drugs Act, where it is an offence to supply articles (such as bongs, pipes etc) that could be used to administer or prepare controlled drugs. It is exceptions to this legislation that allow for the provision of injecting equipment and foil. And in another case, police secured a conviction under the Intoxicating Substances (Supply) Act 1985. This was originally brought in to prosecute shop owners who sold solvents to those under 18 years old where they could reasonably know or assume that the product would be misused. However, the current wording of the legislation restricts its use to inhaled substances. In the context of NPS, this would apply only to smoking mixtures, but not to pills or powders. The Home Office is currently reviewing the UK response to NPS.

New queries over NPS death claims

In this issue (see page 18) author Mike Power challenges the calculations from St George’s Hospital Medical School drug deaths statistics (np-SAD) on the number of NPS deaths on the basis that the figures include substances long banned and others that don’t really qualify as NPS. Professor David Nutt and former Home Office forensic scientist Dr Les King raised the point in the pages of The Lancet.

Now a similar issue has arisen with figures published by the government statistics office for Scotland. However, in this case, it is more to do with how the figures have been interpreted by the media rather than doubts over how the figures themselves have been presented. The Daily Telegraph (25 March) claimed that the figures showed that ‘a total of 36 people died in Scotland in 2012 after taking legal drugs…this represents a 300% rise on the 12 people who are reported to have died in Scotland…in 2010’. However, a closer reading of the figures reveals a very different picture. In fact, of those deaths (which the official report cites as 32 not 36), in only five cases could it be said that NPS were the only drugs implicated and even for three of those, the deaths were ‘drug-related’ rather than necessarily as a direct consequence of drug ingestion. And as the official report admits, ‘the definition of a drug-related death is not straightforward’. Drilling down further still, it appears that in 2012, there were only two deaths where an NPS was the only drug involved. One case revealed the presence of phenazepam (controlled from June 2012), but alcohol was also present. The other death involved APB (Benzo Fury).
Cutting out the middlemen

Following a consultation last year, the government is to introduce new legislation to strengthen powers of seizure against those supplying cutting agents for use in the illegal drug trade. For the 2008 Street Drug Survey, Druglink reported that a whole new industry had grown up supplying ‘bash’ as it is known in the street. Some criminals had ditched selling illegal drugs to cash in on the legality of buying and selling cutting agents.

Currently there are no laws or regulations that target the domestic trade in cutting agents; up to now any seizures of cutting agents would in theory have to be returned, even if there was suspicion that they were being used in drug production.

The new powers would be available to the National Crime Agency, all UK police forces and the Border Force enabling enforcement agencies to enter and search premises, seize and destroy suspected chemicals. Originally, the target chemicals were benzocaine, lidocaine and phenacetin (used mainly in cocaine adulteration) but could now apply to any suspect chemical.

While most responses to the consultation were in favour of the new controls, there were concerns expressed that these relatively benign substances, could be replaced by more toxic substitutes.

Catching the worm

A recent article in Vice magazine revealed the degree to which cocaine is cut with an anti-worming substance called levamisole. In 2005, around 2% of cocaine seized by the DEA in America contained levamisole, by 2011 this had jumped to 75% of all seizures – and that included samples from multi-ton shipments suggesting that cutting of cocaine was happening at source.

For those who are regular high dose users of cocaine, levamisole is by no means a benign cutting agent. Users run the risk of a condition known as agranulocytosis, where the immune system is so compromised that a small scratch or infection can develop into a life-threatening disease.

But the questions remains, why cut high grade cocaine which is costing the producers very little compared with the profits, with an adulterant that is more expensive than alternatives?

The article’s author, a chemist specialising in drug testing, concluded that there were two plausible reasons. Firstly, one of the metabolites of levamisole is a compound called aminorex which has amphetamine-like stimulant properties. Secondly, levamisole increases the amount of dopamine released in the brain and so combined with the dopamine release prompted by cocaine, would in theory enhance the euphoric effect. Conceivably, this might give traffickers and dealers the opportunity to promote their product as being of superior quality and hence more expensive.

Street cannabis dealing angers Dutch locals

The citizens of Maastricht are up in arms about open cannabis dealing on their streets. Nothing very newsworthy there, except it is the country’s new policy of clamping down on cannabis ‘tourism’ and closing down any cafes near schools, which has seen an unwelcome return of old ways. Not every city has fully embraced the new regulations; foreigners can still smoke in any of Amsterdam’s 200 hundred cafes. But with its 14 ‘coffeeshops’, Maastricht has gone the whole way, and in consequence, locals say that the streets have become more intimidating as dealers hassle tourists and fight over turf. There are also concerns that the dealers are not just selling cannabis; the original idea of the coffeeshops was to put some distance between a legalised environment for using cannabis, and the street drug scene.
DISUNITED NATIONS

Behind the scenes at the UN’s latest drug summit, frantic negotiations took place in order to acknowledge the changing nature of the drug debate. But as Max Daly discovered in Vienna, all the world could do was agree to disagree.

The UN’s High Level meeting in Vienna (March 13-14) marked the midway point in its 10-year action plan to reduce or eradicate the use and production of illegal drugs by 2019.

The aim of the meeting was to track progress, acknowledge new challenges and look to the future before a special session of the UN General Assembly in 2016. Discussion was to be concluded with the publishing of a joint ministerial statement (JMs), a consensus on what needs to be done.

At first glance the meeting, attended by 1,300 delegates from 137 member states, simply involved countries updating each other in an often robotic fashion, on how they were doing in terms of tackling their own drug problem and the latest issues they were facing. They were all dutifully seizing drugs, helping users and noted the rise of NPS. Alongside this, there were three roundtable sessions, during which countries explained where they were in terms of reducing demand, reducing supply and tackling money laundering.

Although there were interesting nuggets of information that came from all this – the importance of alternative development in drug producing zones, Uruguay explaining that it owed it to its citizens to legalise the use and production of cannabis and Sweden cementing its reputation as the hardline drug warrior of Europe – the two day meeting was largely an exercise in window dressing.

Most of the real discussion had already taken place. For several months, in a complex game of brinkmanship, representatives from countries had, in the run up to Vienna, been banging their heads together in order to agree on a statement.

But the chasm of opposing views on international drug policy is widening and countries stand on either side of the rift; those interested in increased harm reduction and legalisation, such as Ecuador, Uruguay, Mexico, Portugal, Germany, Czech Republic and Switzerland; and those who want to preserve zero tolerance style approaches to drug policy, such as Pakistan, Saudi Arabia, Japan, Thailand, Sweden, China and Singapore.

Unsurprisingly, these pow-wows came to nothing. The key battlegrounds – the use of the death penalty for drug offences, the inclusion of the expression ‘harm reduction’ and the acknowledgment that some jurisdictions were experimenting with new drug policies – remained entirely unresolved and therefore were cleansed from the final statement. In the end, all the UN member states could do was to sign a piece of paper saying they would agree to disagree. The consensus ended up a virtual clone of the agreement made in 2009.

At a press conference to mark the end of the meeting, UNODC executive director Yuri Fedotov somewhat cheekily described the JMS as a “broad consensus”.

He played down talk about Uruguay or the two US states sparking a new trend in cannabis legalisation. “So far I don’t see any other countries, or group of countries, that may follow the route which has been taken by Uruguay,” he said.

Fedotov had earlier said legalisation was not a solution to the world’s narcotics problem. He said legislation in Uruguay was not compatible with the “letter and spirit” of international drug control conventions, however the UN has taken no action against Uruguay for its new drug law.

Between the lines, there was an interesting dynamic in Vienna. It became apparent that, because of developments in its own backyard, the US, previously a notable sabre rattler in the anti-harm reduction, pro-hardline approach to drug policy, has been forced to take a step back, it’s position undermined by the democratic decisions of its own citizens.

Russia, with one of its most senior diplomats at the helm of the UNODC, may have become the new global policeman in the war on drugs. One Russian speaker slated the efforts of the US and the UK in tackling opium production in Afghanistan as a “fiasco”.

Even so, far from being a joint enterprise, and severely hampered by the arrival and spread of NPS and online drug buying, any notion of a unified global effort to tackle the drug problem is under increasing strain and calls into question the validity of the UN drug treaties themselves.

Max Daly is author of Narcomania: How Britain Got Hooked on Drugs
Internationally, there has been a lot of interest in relation to Ireland’s Novel Psychoactive Substance Act 2010 and the impact this has had on the country’s head shop trade. But to start off, a quick bit of context.

The first head shop opened in Ireland in 2000, although it sold only drug paraphernalia. By 2005, there were six head shops in Dublin city centre selling cacti that contained mescaline. These were being sold for between €30 to €400. During this time magic mushrooms were starting to be sold in a few of these shops.

In 2006, 1-benzylpiperazine (BZP) tablets emerged onto the market and were being sold in these shops as herbal ecstasy. Around this time, head shops expanded and young people who were not using drugs were being introduced to these substances as ‘legal highs’. Tablets sold for around €5 and the average pill contained 540mg of BZP.

In 2007, white powder products started to emerge in the head shops. The majority of these were cathinone-based products such as mephedrone and were selling for €25 per half gram.

At around this time there were calls to ban BZP, which by this time had started to dominate the traditional ecstasy market. Most of these tablets were being sold as ecstasy. Garda official seizure figures at the time confirm this: less than 19,000 ecstasy tablets were seized in 2009, compared with 119,000 in 2008 and 285,000 in 2007. BZP was banned in March 2009.

Meanwhile, in late 2008, phenylmethylethylketone, the ecstasy precursor, became unavailable in Europe. This had a significant effect on the quality and quantity of ecstasy tablets available in Ireland.

Bold new laws introduced in Ireland to tackle legal highs and NPS dramatically cut the number of head shops. But the country’s drug users merely switched substances or modes of supply. Tim Bingham reports.
So with the double whammy of a paucity of ecstasy and a ban on its inferior imitator BZP, white powder substances filled the void and grew in popularity. However, services were reporting that the most common of these powders, mephedrone, was causing significant problems, specifically at the time among the homeless population.

Van Hout & Bingham (2011) undertook a study among clients that were injecting mephedrone called A costly turn on: Patterns of use and perceived consequences of mephedrone based head shop products amongst Irish injecting. Speaking to colleagues in other European countries, no one else was reporting that mephedrone was being injected.

During the next few years head shops were opening in virtually every town in Ireland. Some began offering home delivery services and were open 24 hours a day. The Garda said that mephedrone was directly linked to a spike in crime, particularly theft and mugging, among young people who had not been in contact with Garda before.

"The whole head shop thing was a massive deal for us," one Garda officer told me. "The drugs they sold broke down barriers and taboos. People who had never ever come to the attention of the Gardaí, who came from good homes and had a good education, were all of a sudden robbing people in the street and beating them. Their motive for doing it was to get more money to buy this stuff. Our robberies were going through the roof because people were becoming addicted."

On the 23rd August 2010, the Psychoactive Substances Act became law. The ultimate aim of this legislation was to shut down the head shop industry. Overnight four tonnes of psychoactive substances were handed to the police as shops closed their shutters. But as many people working in the field had predicted, after the head shops closed down, the substances still found their way onto the streets of Ireland.

In addition, Zopiclone and Xanax, smuggled into Ireland from Pakistan, India and China and sold on the illicit market from legal prescriptions, began to grow in popularity among heroin users because of the heroin drought.

Indeed, the Act generated a resurgence of BZP tablets. One Garda source said: "With the closure of the head shops a lot of drug use went underground, back onto banned substances. In one instance we seized 500,000 BZP tablets. The person who was holding onto them was of the firm belief they were ecstasy tablets."

The new law has been effective in terms of young people accessing these substances through retail outlets. However, services are reporting that they are seeing an increase in young people accessing services with mental health issues related to synthetic cannabis products.

### AS MANY PEOPLE WORKING IN THE FIELD HAD PREDICTED, AFTER THE HEAD SHOPS CLOSED DOWN, THE SUBSTANCES STILL FOUND THEIR WAY ONTO THE STREETS OF IRELAND

Research carried out by Denis Murray of Ireland’s Health Services Executive published last year showed a rise in drug debts related to the buying of NPS. The study, Professionals’ Understanding of Risk Factors for Substance Misuse by Young People and Approaches to Intervention, published by the National University of Galway, highlighted young people with poor school attendance and indebtedness, resulting in families being intimidated by drug dealers and an increase in the number of young people absconding from home due to spiralling drug debts.

Indebtedness relates primarily to synthetic cannabinoids and to amounts of between €50 and €3600. The research found that young people are obtaining synthetic cannabinoids from the internet and the street. Some are being sold synthetic cannabis as real cannabis.

So where is Ireland at in terms of drug use trends? The most recent statistics, which cover 2010, published last year by the National Drug Treatment Reporting System show that for under-18s, cannabis – whether synthetic or not – accounted for almost 50 per cent of treatment presentations.

Evidence from law enforcement reflects this trend. The Garda’s 2012 annual report reveals almost €71m worth of cannabis was seized, compared to €42m in 2011. Although the police have heightened the value of cannabis plants, artificially increasing the value of plants seized, twice as many plants were seized and tested by the Forensic Science Laboratory in 2012 compared to the previous year.

The report showed some 5.6kg of MDMA powder was seized in 2012, compared to just under 1kg in 2011. Overall, 165,000 tablets were seized in 2012 compared to 101,000 in 2011.

However, despite the law change, the seizures of MDMA paled in comparison to the seizures of NPS. There continues to be a significant market in banned head shop drugs, with similar quantities of new synthetic stimulants (46kg) and synthetic cannabis mixtures (32kg) being intercepted in 2012 compared to the year before, of synthetic cannabis were seized in 2012.

It’s now easy to access these substances via the internet and through the postal system. Customs figures show that, post 2011, there have 808 seizures of NPS at the border. Intriguingly, the vast majority of these seizures, 614, were of NPS imported from Hungary.

This country’s new Psychoactive Substances Act has been effective in closing down head shops and it appears that the result of this has been to dent the ‘legal high’ status of NPS – as most are now bought on the illicit market. But there have been unintended consequences of the Act, whereby some young people are moving over to using other, more risky, substances from street dealers.

Certainly, banned NPS are still available and being sold under a different name. We know that mephedrone is now a frequent cutting agent in cocaine and even ecstasy pills. Some former NPS buyers have merely shifted their drug of choice and there is growing evidence they are using anti-anxiety medications, while ketamine is on the increase among Irish clubbers.

In conclusion, the Act hasn’t made drug use any safer, as drug workers and drug users have even less idea as to what the contents of the pills and powders really are now.

*Tim Bingham* is an independent trainer and researcher on drug trends and harm reduction in Ireland.
The rise of problematic stimulant use within the gay drug scene is stretching already limited services for LGBT users. Rebecca Lees investigates what is driving this scene and what is being done to help those who needed help.

For the lesbian, gay, bisexual, and transgender community, drug and sexual health issues are, as one drugs worker puts it, two sides of the same coin. Yet support from mainstream services isn’t always joined up and there remains a great sense of stigma, isolation and shame reported by LGBT people seeking support.

The landscape has changed dramatically in a short space of time, with the use of club drugs – and chem sex – exploding. A few years ago, there were fears the UK was on the brink of a crystal meth crisis following an epidemic in America. The predicted explosion didn’t happen; Home Office figures show that 17,000 people in England and Wales took crystal in 2012. Yet of this relatively small number, a disproportionate amount was from the gay community – and the consequences are alarming.

Department of Health figures released last year show a 21% increase in new HIV infections between 2011 and 2012 amongst gay and bisexual men in London, leading the Terrence Higgins Trust to call for a ‘greater focus’ on helping gay men experiencing drugs and safe sex issues in the capital. Charities report that, whereas the drugs of choice used to be ecstasy, cocaine and ketamine, there has been a marked swing towards crystal meth, mephedrone and G (GHB or GBL), and this shift has coincided with a rise not just in HIV cases but also in hepatitis C and other STIs.

Monty Moncrieff, chief executive of London Friend, the UK’s oldest LGBT health and wellbeing charity, says that drug use by gay and bi men has changed dramatically in the past five years. “In 2005, nobody was using crystal meth at all and nobody was using mephedrone,” he says. “A very small amount were using G alongside other drugs, but now, about two thirds of the people we see are using these drugs.” Originally a legal high, mephedrone was easily available and is, as Moncrieff puts it, “just so more-ish”. And it’s not just the drugs themselves that have changed. The way users are taking drugs has shifted, with more and more injecting mephedrone and crystal rather than swallowing or snorting them.

The results are increased needle sharing and risky sex in organised chem-sex parties.

“Gay men and drugs have always gone hand in hand but it used to be that they might go to a club, pull and end up in bed at the end of the night,” says Moncrieff. “The pattern has changed and now it’s deliberate. Smart phone apps such as Grindr facilitate very easy access to meeting other men and co-ordinating sex, including bareback sex (without condoms). It’s bringing a huge challenge into drugs work.”

London Friend’s services include counselling, coming out support, social groups, HIV prevention and sexual health awareness. Since 2011 it has also been the home of drug and alcohol support service Antidote, which was initially managed by Turning Point. Operating on the same principles as mainstream support but applying them in an LGBT-competent way, the project’s specialist nature is critical to clients, many of whom have experienced a lack of understanding, isolation and shame at mainstream clinics.
Moncrieff believes that this sense of shame and anxiety is at the root of the drug use and sexual behaviour of about 90% of Antidote's clients, even though different triggers bring them through the door in the first place. “All your life you've been told that your relationship is second class,” he says. “People have grown up with that and it's led them to think their sex life is dirty or shameful. Men are constantly reconciling their gay identity with the rest of their identity and a lot of their drug use is connected with that. We hear people saying that their drug use facilitates this amazing sex that they have never felt entitled to. When you strip it down, the correlation between drug use and identity is stark.”

One drugs worker in the north west, who asked not to be named, agrees that LGBT users face a lot of prejudice from mainstream service providers. In Manchester, Liverpool and the surrounding areas, crystal meth hasn’t taken hold as it has in London, but GBl is prevalent and the use of ketamine is, she says, ‘huge’. Cocaine is also popular with gay men. Drugs are being taken in places like saunas, with users becoming so high they don’t know what they are doing or, later, what kind of sex they have had, increasing their risk of HIV and other infections. “There is a need to promote safer sex and provide condoms,” she says.

“I don’t think (mainstream) drug services have quite grasped that sexual health and drugs are two sides of the same coin. They don’t fully understand the nature of LGBT drug use, for a couple of reasons. Firstly, there's the stigmatisation of what it is to be gay in the media. Secondly, there's the vulnerability. Young people are still being thrown out of home for coming out. Homophobia is alive and well and gays are the last bastion to pick on. And, of course, the type of sex they have disinhibits them and takes away that stigma and shame for the moment.”

Hence the need for specialist LGBT drug services. Working with the gay community can be a highly specialised role, not just in terms of understanding and being comfortable talking about gay and lesbian sex but also for medical reasons, such as knowing the reactions of recreational drugs with prescription drugs. For example, HIV is measured in a ‘viral load’ – the amount of HIV in the bloodstream – and cocaine and crystal meth can increase the viral load of a HIV positive person and cause them to become ill quite quickly.

London Friend carries out an annual survey asking clients if they feel it’s important to access an LGBT service and the response is clear, with just 12% of users considering accessing mainstream services. “They feel safe in this environment and that they don’t have to explain themselves,” says Moncrieff. “There’s a commonality that makes it easier.”

**SHAME AND ANXIETY IS AT THE ROOT OF THE DRUG USE AND SEXUAL BEHAVIOUR OF ABOUT 90% OF OUR CLIENTS**

LGBT drug users also tend to inhabit a slightly different demographic to the mainstream. A mainstream service might be set up to work with opiate and crack users, which doesn’t necessarily correlate with gay drug use. Mainstream users are more likely to have a chaotic lifestyle, whereas gay men are more likely to be working, in a relationship and own a home or be a reliable tenant. “Our clients come from absolutely all walks of life, including high-powered professional jobs,” says Moncrieff.

“They are more likely to have a recovery capacity because, often, their lives are more stable. The problems are with keeping their job or relationship when the drug use is creeping up and starting to have an impact, and this is a change for services to understand and to provide for.”

As the prevalence of HIV and hepatitis C rises and more clients seek post-exposure treatment, one of the challenges for services is to educate about dangers users might be unaware of. Many clients don’t initially realise, for example, that G is addictive. As a result, after partying relatively safely for a long time in a controlled way with drugs such as ecstasy, they suddenly find themselves needing strong stimulants every couple of hours, every day. As a consequence they can be awake for two, three or even four days at a time, which has a significant impact on their health.

It seems that there’s a long way to go before the LGBT community receives the attention other drug using groups get. As the worker in the north west points out: “When six kids collapsed after taking GBl in Liverpool it was in the news, but it’s been happening in the gay community for years. The LGBT group is constantly ignored and it needs looking into more.” In Wales, research is underway. Substance misuse organisation New Link Wales, which promotes engagement with diverse communities, has already conducted a scoping study and is now working with Cardiff University and Cardiff Mardi Gras to get a fuller picture of the issues.

“Within the LGBT community in Wales there is a deep level of dependency,” says chief executive Lindsay Bruce. “There are a lot of theories about why but we don’t know which apply to Wales yet. One of the issues we’re looking at is gender atypicality. People with a ‘fem’ identity spend a lot of time pretending to be straight and take longer to come out, so there is more closet stress. With the butch community, they are visibly gay and wear it; for example, matching blokes drinking pint for pint, so they are more vulnerable to hate crime and discrimination.

“Some turn to drink and drugs to relieve this stress but other people use drugs differently. I’d be interested in looking at sexual rituals. There is an excess, as in ‘let’s try everything once’. The excess becomes the point of pleasure and it’s not about climaxing but about how long you can go for, so they use stimulants and Viagra to overcome biology.”

Cocaine, amphetamine and crystal meth use is prevalent in Wales, whilst another problem is the use of hormones by transgender people. There’s a feeling within the community that buying illicit hormones isn’t misuse, yet unless properly prescribed, there are dangers such as overdosing. Another issue is the use of unprescribed painkillers following gender surgery, and these complex matters are not on the radar of some mainstream services.

New Link Wales acts as a bridge between communities, volunteers, agencies and training providers to make sure minorities such as the LGBT group can get appropriate and effective support. London Friend also provides training to other services to help them understand the issues their LGBT clients may be experiencing.

“The question for us is: how are we going to improve the health of LGBT people?” says Moncrieff. “How do you make it easier for people to be who they are? It’s about drugs but it’s also about wellbeing and happiness. A lot of people are feeling low-level pressure internally on a daily basis, and it’s a big public health challenge.”

Rebecca Lees is a freelance journalist
Cultural shifts

Stereotypes of Asian substance use probably assume heroin to be the main problem drug. But is this an outdated view? Max Daly speaks to those on the frontline.

Britain's Asian population has always had a reputation as the least likely ethnic group to take drugs. In the mid-1980s, when deprived urban areas in the UK were witnessing escalating heroin addiction, it appeared from those coming into services that Asian people, many also living in poverty in these cities, had remained unaffected by the epidemic.

According to a 1986 report by Lord Kamlesh Patel (who at the time worked with Asian drug users in Bradford), Asian drug users certainly existed – and some were dependent heroin users. It was just that they seemed to be 'missing' from the treatment system. One contributory factor was the heightened stigma that they seemed to be 'missing' from within the Asian community and the reluctance of some Asian problem drug users to seek help in white-dominated drug services.

This is also reflected in terms of recreational drug use, according to official drug use statistics from the government's annual British Crime Survey (now called the Crime Survey for England and Wales). Since the government began collecting statistics on the ethnicity of Britain's drug users in the late 2000s, white and Black people have consistently been far more likely to have taken drugs in the last year than Asian people.

However these bald statistics hide a changing dynamic in the ethnicity of drug use and addiction in Britain, and it is a development that has become apparent, at first hand, to drug services specialising in helping Asian clients. To put it simply, the perceived gap in drug use habits between Asian people and the wider population is rapidly narrowing.

In 2008-9, 10.8 per cent of the white population aged 16-59 said they had used drugs in the last year. By 2012-13, this had fallen to 8.6 per cent. However, among non-whites, the proportion of last year drug users during the same four-year period had increased, from 5.1 per cent to 5.7 per cent.

This was not driven by a rise in drug use in the Black community, which had also seen a fall, from 7.6 per cent to 6.2 per cent, but instead by Asian drug users, up almost 50 per cent in four years from 2.6 per cent to 3.8 per cent.

The rise is largely the result, the statistics show, of an increase in the use of cannabis and stimulants such as cocaine by Asian people – despite a downturn in the use of these drugs by white and Black people.

It's a trend that has also been spotted by those working on the frontline. “We have seen a big rise in recreational cocaine use among young men, particularly at weddings and parties,” says Sohan Sahota, founder of Nottingham-based drug treatment charity Bac-In. Sahota, who set up the project in 2003 to help dependent drug users from BME backgrounds, says he thinks the rise in cocaine use has accompanied a similar rise in alcohol use among young Asian people in the UK.

Sohota says that as a result of this trend, drug treatment services like his are seeing an upturn in the number of Asians coming forward for help with problematic use of cannabis, alcohol and cocaine.

Mohammed Ashfaq, managing director of KIKIT Pathways to Recovery, a drug project based in Sparkhill in Birmingham with a large Pakistani population, has also seen a change in the profile of Asian drug users. He is seeing fewer people with heroin problems and more who have issues with other drugs. “Cocaine use is shooting up among middle and upper class Asians. There are more young men and women in colleges and university taking legal highs and cannabis,” says Ashfaq.

So what does Ashfaq think is behind these changes? “Cocaine is seen as more socially acceptable than heroin. They use drugs because of peer pressure. It is seen by some people as being cool, a sign of being upwardly mobile. They start using it as a party drug, but some get addicted.

“The interesting thing for me is that the culture of Bollywood promotes cocaine use, as a confidence booster and dietary aid. It's not said directly, it's subtle.”

Whether any Bollywood films do cast cocaine in a positive light remains open for debate, but certainly in recent years there have been a rising number of instances where stars have either ended up in rehab with a drug problem or have been rumoured by newspapers and Bollywood bloggers to be involved in drug taking and selling.

Despite the changing nature of drug use within the Asian community, and services battling for survival under swingeing cuts to provision, there are signs that drug treatment for Asian people is moving with the times.

KIKIT is setting up the UK’s first Islamic 12 Step programme which will start operating from a mosque-run community centre in Sparkhill in April. Clients of the new service will all sign up to a code based on one created by Millati Islami, a US Muslim project based in Baltimore, USA. Millati Islami, which now covers several US states, has been running Islamic 12 Step sessions since 1989.

Ashfaq drew up the UK version, which he aims to roll out across Birmingham by the end of the year, with the help of the Imam at Birmingham Central Mosque to ensure it catered for all branches of Islam.

Clients starting the programme...
have problems with a variety of drugs including heroin, crack, cocaine and cannabis. Despite the huge levels of stigma attached to it, alcohol misuse is also being tackled within the programme.

“Nowadays,” says Ashfaq, “heroin is seen as a far dirtier drug than alcohol among young Muslims. Heroin is for ‘scag heads’, while alcohol, although totally against our religion, is more acceptable.”

The other element that stereotypically characterises Asian drug use is the link between trafficking of heroin from Pakistan to the UK. It is true that some British Pakistanis have become embroiled in the drug trade at all levels including drug dealing, laundering and smuggling. Lord Patel says that the rise of young Asian heroin sellers since the 1980s resulted in some of them becoming addicted to the drug themselves.

However, as Ashfaq points out, the distribution of heroin has become a truly multi-cultural affair and Muslims are unfairly accused of creating addiction in white communities. “Although people selling heroin are from all over the community, a lot of people associate heroin with us,” says Ashfaq. “Some people in Birmingham associate heroin as a problem brought to British society by the Asian community. The far right exploits and exaggerates this for their own ends by saying: ‘you lot bring it over, you got our kids on it’.”

So what makes culturally specific BME drug treatment services different from a regular service? According to Sahota, they need to be able to “deal with complex problems and issues of stigma”. His says that BME angled services are vital because mainstream services are still unwelcoming places for BME drug users.

“I’ve been working in drug services for 18 years and mainstream services are still failing to accommodate BME drug users. “They need to deal with a variety of complex problems on top of the usual issues around addiction, such as self-image, status, caste, passive rebellion, cultural and religious disobedience and cultural polarisation.”

“With Asians in particular,” Sahota says, “there seems to be a stronger denial about problems related to drug abuse, due to a deep sense of pride, social stigma and cultural shame leading the users into isolation and community ostracism, making it difficult for them to seek help.”

Drugs and Diversity: Ethnic Minority Groups, a report in 2010 by the UK Drug Policy Commission, reflected Sahota’s description. It said that drug problems within Asian communities were almost certainly underestimated because high levels of stigma attached to drug use and directed at users and their families meant that the problem often remained a hidden one.

Lord Patel says one consequence of this is for families to package their children off to live with relatives in Pakistan or India to get treated. However, he says that the treatment regimes, particularly in Pakistan, are harsh. In addition, heroin users familiar with paying £100 a gram for heroin end up in a place where it costs 50p a gram.

He is concerned that gains made in improving drug treatment for BME service users since the Labour government set up the ring-fenced Pooled Treatment Budget could now be lost, as a result of cost cutting and disinvestment. Experts agree that it is outliving services, such as those for BME users, which are most likely to get the chop. Indeed Bac-In, for example, has had to deal with near-crippling reductions in funding in recent years, while KIKIT is also struggling to keep afloat.

“Taboo and stigma are still there, but only a little bit more than the wider population, and this is now not the main problem facing Asian drug users. All the good work on drug treatment under Labour is in danger of being reversed, and the services that suffer are peripheral services like BME services,” says Lord Patel.

Max Daly is co-author of Narcomania: How Britain Got Hooked on Drugs

WE HAVE SEEN A BIG RISE IN RECREATIONAL COCAINE USE AMONG YOUNG MEN, PARTICULARLY AT WEDDINGS AND PARTIES

ISLAMIC 12 STEPS

1. We admitted that we were neglectful of our higher selves and that our lives had become unmanageable.
2. We came to believe that Allah could and would restore us to sanity.
3. We made a decision to submit our will to the will of Allah.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to Allah and to ourselves the exact nature of our wrongs.
6. Asking Allah for right guidance, we become willing and open for change, ready to have Allah remove our defects of character.
7. We humbly ask Allah to remove our shortcomings.
8. We made a list of persons we have harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong, promptly admitted it.
11. We sought through Salaat and Iqra to improve our understanding of Taqwa and Ihsan.
12. Having increased our level of Iman (faith) and Taqwa as a result of applying these steps, we carried this message to humanity and began practising these principles in all our affairs.
At your service?

There are few subjects more fraught in our sector right now than the issue of how drug and alcohol services are commissioned. In the first of a two-part article on commissioning in England, Sara McGrail reveals how smaller agencies are being forced out of the market.

It was the Monday before Christmas that the head of a small treatment service in the south-east heard that her agency had not got through the first stage of the tender. It wasn’t really a surprise. Although the agency had been providing local services for over thirty years, commissioners had made it close to impossible for the charity to compete for its own services.

The commissioners had decided to “bundle” all 4 of the existing contracts into one mega-contract. This is an increasingly popular approach. Bundling – used primarily as a cost cutting mechanism by commissioners – is an approach that the healthcare regulator Monitor has concerns about. A case of putting “all your eggs in one basket”, bundling means that just one provider manages and provides services across the whole of the care pathway in one area. It’s attractive for commissioners as it takes all that pesky coordination out of their day job. However it also often rules out smaller organisations from bidding – as they may lack experience of delivering all of the services across the pathways. From a performance management perspective, bundling may look attractive. After all you only have one organisation to take care of – but in reality, bundling narrows the market, restricts choice and gives large providers significant advantages over commissioners. That’s why it causes Monitor such concerns.

As a result of the bundling, the commissioners in this case set a turnover threshold (the level of existing funding those bidding must already have) of £20 million. This was later reduced to £12 million after a challenge. However for the charity – as for many charities dedicated to working in one area – their turnover was never even going to reach half of that specified.
Once again, they – and organisations like them – were excluded.

In research commissioned by Action on Addiction in 2012, The Size and Scope of the Voluntary Addiction Sector in England and Wales, the NCVO found that within the substance misuse field only 8 charities have a turnover in excess of £10 million. The commissioners’ requirement that all bidders had a turnover of £20 million meant that less than 2.2% of non-statutory providers nationally would be able to bid. So much for opening provision up to the non-statutory sector and Small to Medium Enterprises.

For a small local charity with a proud history of delivering high quality services, the cards were on the table. Their only possible way of defending the services they had provided – successfully – for over 30 years was to enter into a consortium arrangement with a larger provider.

When we talk about consortia in this context we need to be careful. Commissioners generally require one responsible agency to hold the contract to guarantee accountability. More often than not, when people refer to a consortium they actually mean a subcontracting relationship. In the long term this also crushes competition. It restricts the local and national market for services – driving smaller local charities and social enterprises out of business if unsuccessful, or effectively forcing merger if they are successful. This in turn reduces innovation, increases costs and limits choice for commissioners and service users.

Within the Procurement, Patient Choice and Competition (PPCC) regulations there is a clear understanding that this is problematic. Health regulator Monitor, whose role it is to police the PPCC regulations, advises that bundling should only be used where there is a demonstrable advantage to people using services that can only be achieved in this way. Using the regulations as its guide, Monitor should have been able to intervene in this commissioning – and press commissioners to alter their approach. However they couldn’t. The reason for this is that drug and alcohol treatment (and sexual health services) are the responsibility of Public Health England and these two areas of healthcare are not only excepted from the PPCC regulations, they are also not commissioned under the NHS constitution. What’s more, while nationally we are going through an exercise to establish a National Service Framework for Sexual Health Services – to set some ground rules down about what can and should be commissioned – no such exercise is taking place for drug and alcohol services.

CONTINUING TO SPEND THE AMOUNTS WE ARE ON PROCUREMENT PROCESSES THAT DON’T NATURALLY YIELD BETTER RETURNS FOR COMMUNITIES IS WASTEFUL IN THE EXTREME

The charity contacted PHE, the Department of Health, the Parliamentary and Health Service Ombudsman, Local Government Ombudsman and Monitor to ask who was responsible for oversight of commissioning of these services given their exclusion from the PPCC regulations. No one could answer the question. In the end they – like many other small charities – made the decision to seek legal advice.

According to the charity’s lawyers, commissioning of drug treatment services is effectively unregulated. It is clearly set outside the framework of the PPCC regulations. As it is defined as a “Part B” contract under European legislation there is no requirement for the local authority to do much more than attend to some minor regulations with regard to advertising and notices. The Social Value Act which is meant to make local authorities consider the social and economic impact of their commissioning decisions – though likely in future to be augmented by additional European regulations – currently only requires authorities to consider the impact of procurement decisions rather than mandating this approach. There is no clinical oversight, and unlike other health services, as it is no longer considered an NHS service, the rights of people who use drug and alcohol treatment services to exercise choice and make decisions about their own healthcare are not protected.

For the charity, this meant the only legal recourse open to them would be to go to judicial review. However the costs of this (the process would have started at about £45k) are prohibitive – impossible and possibly unethical – for a small charity to fund. The only option was to bid within a subcontractual arrangement – and for the charity to acknowledge that its days of independence were probably gone.

Across the country this situation is being played out over and over. Small local charities are finding it hard to compete with the large national companies and relatively affluent Foundation Trusts. It seems that these are the organisations who will come to dominate the drug and alcohol service sector in England. These apparently straightforward commissioning decisions are bringing about a quiet yet irreversible revolution within the drug and alcohol sector.

Since January 2011 the majority of drug and alcohol service commissioners in England have commenced procurement processes for their drug and alcohol treatment services – though this information is not collated anywhere. Even with a conservative estimate of the costs of this you can approximate a total spend on each one of around £120k (both bidder and commissioner costs). This suggests that over the past three years we have spent – in England alone – somewhere in the region of £17 million pounds just on the administrative processes that underpin procurement. If you add into that the costs of implementation of any new or recommissioned service – including TUPE – you are looking at costs averaging around £350,000 per area. This would give us a nationwide spend over the last 24 months of around £50 million.

To put this in context, according to DTORS treatment cost calculations from 2009, £50 million is enough money to provide an additional 8245 people with effective drug treatment from entry to successful completion, provide an additional 1500 staff within drug treatment services or to inflation proof...
the current allocations for drug and alcohol treatment spending until 2019. Public procurement is bound – at least in theory – by European and UK legislation. This legislation – aimed at guaranteeing fairness, transparency and equity in the spending of public money – in reality does little for health and social care services except to create work for lawyers, managers and consultants – and headaches for commissioners and providers. Very few people understand it fully. The language is arcane and legalistic, the processes are complex. An average set of tender documents will contain as a rule around 10000 words. The responses required from providers will usually lie somewhere between 18000 and 30000 words. So as well as being expensive, tenders are time consuming – with commissioners required to evaluate maybe up to 10 bids at a time.

For a small organisation, responding to a tender effectively overwhelms the whole management team. Larger organisations have the resources to employ full time bid writers – whose job is solely to sell the company's products at the highest price they can to whoever will buy them. Maybe this is why one of our largest providers advertises its management jobs saying “You don’t need to know about substance use, you just need a good track record in sales”. The question you have to ask is whether all of this serves any purpose at all?

Where services consistently underperform, where interventions don’t meet basic quality standards, commissioners have to – maybe as a last resort – be able to withdraw investment and commission a different provider. However, a good commissioner working to a good specification should be able to drive improvement through effective contract management. When a contract reaches its natural end – and many can be extended to 5 years – commissioners have to go through a tender process. When the central direction of travel shifts, commissioners may also choose to re-procure the services they buy.

But even for a casual observer it is clear that there is currently much confusion in the central direction for local commissioning in drugs and alcohol. While the Government on one hand are publishing guidance on recovery services that categorically state that there should be no time limit for treatment, no arbitrary reductions of medication and no rationing of services (Medications in Recovery, July 2012); on the other they are dictating to the field that recovery must mean abstinence (Putting Full Recovery First, March 2012).

With conflicting central guidance, no national service framework, no regulation and no clinical oversight of commissioning, a provider sector dominated by multimillion pound businesses and an expectation that services will be provided progressively more cheaply through systems of PBR which have already been demonstrated to be hugely flawed – is it any wonder that commissioners are happier to re-procure than to make their current systems work? To compound the problem in many areas it is no longer specialist drug commissioners who are managing the process – but general local authority commissioners shifted into the new public health departments. Effective local partnerships – our old DAITS and DAARTS – who may have moderated some of this nonsense – have all but disappeared after years of neglect and some would argue deliberate undermining by central government.

While no one wishes to see a return to the dogmatic style of the National Treatment Agency – whose reduction of local partnerships to mere contract managers on behalf of the Home Office has played a part in giving us the system we have today – it is clear that we cannot exempt the commissioning of drug and alcohol treatment from all regulations applying to other forms of healthcare.

Continuing to spend the amounts we are on procurement processes that don’t naturally yield better returns for communities is wasteful in the extreme. Small innovative charities and SMEs have been for a long time the basis of many effective local treatment systems. To simply leave them by the wayside and hand services over to the big nationals is something we will come to regret – not least because it stifles cooperation and collaboration. Charities and trusts become rivals, not organisations united in the common interests of their service users. The collaborative approaches that defined the English substance use field have all but disappeared and even in those areas where there is no procurement process on the horizon, competition is the watchword and cooperation outside the direct requirements of the contract is increasingly rare.

When the charity head talks about the tender now, she is philosophical. Looking back over the last few years, she commented that the last time services were re-tendered, the service users really suffered as the treatment map became confusing and risky. As a result, one commissioner left abruptly, and the new provider prematurely ended an unworkable contract. Her charity and another were asked to pick up the key working functions and provide some continuity and safety for the clients. They did so. She wondered what might happen in the future if there is no alternative provider to help out.

And the future for the charity? “We started with nothing but a passion to provide good services for people in our area” she says, “One way or another we’ll carry on doing just that”. But with no local contract any more, the charity could struggle. “Our aim is to work with a small local team – paid for through charitable donations and grants – to continue to provide some of our basic services. We’re looking at continuing our work with communities who find it hard to reach services. That’s something we’ve always delivered and funded ourselves because the communities tell us they need it. There’s other services too that the local authority don’t fund, but that we provide. And we want to use our experience to build new services for people in need. One council may not want us, but others do and we have a number of innovative projects to build on and years of experience and reputation behind us. We do see a positive future for us as a charity.”

In the next article, the author will be looking at the impact of commissioning decisions on treatment services – and how changes in commissioning have impacted on service users in England. She will also be looking at what alternative approaches could be used to ensure we use public money effectively to get the services we need to the communities who need them.

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

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Earlier this year, Build on Belief held a well-attended launch event at the House of Lords. Co-founder member and Chief Operating Officer Tim Sampey, recalls that it all started as a racket – badminton that is.

**Intervew by Harry Shapiro**

Around late 2004, Terry Swinton and I went to a service user meeting at Blenheim/CDP where I was a client. We were bullied into it really by the manager. We went along because we were bored. It was full of people plotting how to overthrow the commissioner and how to get their hands on the money. Terrible. We weren’t interested in the classic service user stuff; sitting in DAT meetings and treatment and care groups, talking to the NTA.

But I was very interested in playing badminton. I got into this while I was in rehab. I had always been a severe asthmatic, so this was the first real sport I had ever done in my life and I loved it. So it was suggested that we go to the commissioner and ask for £200 to buy some rackets and other equipment. We set up a little badminton club at Blenheim/CDP on a Wednesday afternoon. We’d go down there and see if anybody wanted to play. But it wasn’t free, it cost a quid and people were saying they couldn’t afford it. So we went back to the commissioner and said, ‘we want £20 a week on top to pay for courts and buy coffee afterwards’. The commissioner was (and still is) Gaynor Driscoll and she said yes. Blenheim/CDP acted as the banker, we’d go down there, get the money and come back with the receipts. It was a way of playing badminton for free and getting people on the courts. We did this for about three or four months and then Terry said, ‘there’s something really interesting happening here. People are coming along, they are enjoying themselves and a sense of camaraderie is building up’.

I’d been getting close to finishing with treatment; I was getting tired of key working and groups, but didn’t really know what to do next. I hadn’t worked for 15 years and had a criminal record. Terry said, ‘why don’t we set up a social club on a Saturday?’ I had the same problem as a lot of people; back then my parents weren’t talking to me, my wife had just left and all my friends were still on drugs. Weekends were terrible.

So we went back to Gaynor and told her what we wanted to do. She said, ‘write a business plan’. She has always been phenomenal like that – she came to service user meetings and I could always ring her up and ask to come over for a coffee and a chat. So we drew up a little business plan and went back to Blenheim/CDP and said, ‘Can we use the building on a Saturday?’ It’s important to emphasise how revolutionary that was in 2005. We were both still clients – Terry was still scripted – and we wanted to set up a little weekend service that wasn’t abstinence-based. It also had to be fully independent of Blenheim/CDP to give us a sense of empowerment, of owning it and we had some confidence because of running the badminton club. For the first year, out of our service user budget, we paid to have a member of staff on the premises but they weren’t allowed to come downstairs from the office without our permission. Terry had this wonderful expression, ‘it’s easy. It’s like running a pub without the alcohol. You’ve just got to break up the fights. No problem’.

Back then, we had no idea of conflict resolution other than, ‘do you want to step outside and repeat that?’ None of that stuff. It was very chaotic. But we wanted to own it ourselves.

**So what went on at the club?**

When we started, we just did sandwiches, tea and coffee and showed a film. That was it. We had to build up a volunteer team and back then Terry and I would ambush anybody. We’d go into a drop in centre and say, ‘what are you doing at the weekend?’ My girlfriend and her daughter volunteered, so did Terry’s girlfriend. My only line of conversation at parties was, ‘what do you do at the weekend?’

We built up to about 75-80% of the volunteers in recovery and developing the club became a very organic process. It had been going for about six months...
before we said – ‘why don’t we do ‘check in’ and ‘check out’ like they do in the rehabs?’ Everybody sits down at the start of the day to say how they feel right now; this is what my week’s been like and so on. Then when we finish, we clear up and sit down and talk about what we did today, what made us feel good, whether we could have done something better.

What was the ethos of the service?

It has always been a non-abstinence based service which means that anybody can come in, so long as you can control your behaviour – so nobody so drunk they can’t stand, or so stoned they just gouch out, or so wired on crack that they’re not in control. We don’t differentiate between drugs or alcohol and have never followed any particular model of recovery.

Didn’t this create tensions between volunteers who were in recovery from different perspectives?

Oddly, no. ‘There were arguments over ‘what is recovery?’ and because I drink alcohol socially, some people said, ‘oh, you’re not in recovery’. But we were building something that was really working, so we never got into that whole debate and by bringing in all these different points of view, it meant that whoever came through the door, they had somebody they could talk to.

So what happened beyond tea and sandwiches?

We did struggle for a few years; it was hard to get volunteers (we couldn’t operate with less than four). Some people thought what we were doing was brilliant, others thought it was outrageous. Nothing serious happened at the club, some arguments, the police were called a few times, so there was a risk element to it, but we were very lucky. We started writing our own training for volunteers; drug and alcohol awareness, harm reduction, needle exchange, communication skills. We began to ask ourselves the question; ‘we are giving these people £6 for travel and a sandwich. What do they want?’ Well, a lot of them want to work in the field, so that’s why we started the training and social events and the award ceremony where we book the town hall and invite the commissioner, local politicians and service providers. So we created this support network for the volunteers which became quite important – and we started getting calls from people from all over London who wanted to volunteer; we had one woman who would drive up over London who wanted to volunteer; we had one woman who would drive up and sit down and talk about what we did on. Then when we finish, we clear up this is what my week’s been like and so on. Then when we finish, we clear up and sit down and talk about what we did today, what made us feel good, whether we could have done something better.

It seems that BoB is as much an organisation for the volunteers as it is for those who those in off the streets?

Yes. It is a form of interactive aftercare. People volunteer, they get training and start building their self-esteem and belief in re-integration. And so it works on two levels. It provides a weekend service in K&C (meaning K&C had a seven day a week service); we can refer people to treatment having done an initial assessment. And we have people that cross over; at the House of Lords launch, we presented awards to two guys who had been coming in off their heads for some time until one day they said, ‘How can we become you?’ We said, ‘sort that out and you’re in’.

So where is BoB at now?

We are commissioned by K&C to provide a weekend service here and in the north of the borough and a recovery café here during the day – and we are subcontracted to provide similar services for CRI and Central and North West London NHS Trust, a mentoring service in Kingston and another service in Hammersmith.

We’re a London-based service and we are not preparing to step outside London. If you want to provide a weekend service, we are the only people to go to and we are often included in the tenders of the large service providers. What we want to do is to roll out the model across London.

For more information, go to www.buildonbelief.org.uk.
A controversial service in Wales that analyses people’s drugs has been dismissed by some as a naive mistake. But **Mike Powers** argues that it could be a vital new weapon in harm reduction’s arsenal.

‘Calling all coke dealers: Welsh government will test your Class A drugs for FREE!’

So frothed the *Daily Express* in February, in a mainly fact-free news story that tried to present the Welsh-government funded Wedinos programme, one of the UK’s most innovative harm reduction schemes, as a free drug-testing service for drug dealers.

It’s true that Wedinos (Welsh Emerging Drugs and Identification of Novel Substances) will test any drug for anyone, and then post the results online – as the *Express*’s lawyers will have checked before publishing. But the truth about what Wedinos does, why it does it and what impacts it will have on drug use in the UK are a world away from the tabloid’s distortions.

Users can send samples by post to the Wedinos laboratory in Cardiff, where they undergo tests including gas chromatography-mass spectrometry (GCMS), and nuclear magnetic resonance spectroscopy (NMR). Substance misuse services, nightclubs, pharmacists, youth clubs, bars, local authorities, the ambulance service and the police are also authorised to send in samples. The Wedinos site’s harm reduction section counsels users to dose low, not to redose, and to follow standard safe practice around drug use.

The qualitative, not quantitative test results are then posted online, identified only by a reference number. Over 395 samples have been analysed and published. Over 100 different compounds have been identified and there are currently only three unidentified items outstanding, says Alun Hutchings, of Cardiff Toxicology Laboratories at University Hospital Llandough.

Dozens of different drug categories have been submitted, from banned cathinones and other stimulants and synthetic cannabinoids, to steroids used by bodybuilders, cocaine and heroin. The project’s aim is to give information to users who would otherwise be consuming drugs without any idea of their contents, and to help them avoid harm.

Andrew Westwell, who analyses the few samples that can’t be identified, says: “There’s an awful lot of stuff people are taking and they don’t know what it is. There’s no data. We have a rigorous, scientific and analytical approach to identify what substances people are using. We are providing quality information that is not currently there.”

“This is simply pragmatic harm reduction information,” agrees project lead Josie Smith. “It’s no good academics knowing what’s going on. Users need to know, too.”

‘Blodwyn’ is the online handle for a man who runs a web forum dedicated to the discussion of novel psychoactive substances (NPS). His site has 3,500 registered users and around 300 active daily posters. There are around 1,000 daily ‘lurkers’ who visit to read content but do not participate in the debate. He says that Wedinos is “a huge move forward for people” and that it makes the use of NPS “much safer”.

“Wedinos has been incredibly favourably received as it offers so much
transparency for people using NPS,” he says. “It’s also going to mean that people will be able to challenge unregulated vendors’ claims regarding chemicals. It’s also a great service if someone suffers a bad reaction – they can get the substance tested and find out exactly what it is.”

Last month, the forum sent some pills one of its members had bought online which claimed to contain only legal compounds. Wedinos found that the pills contained 5-MEO-DALT, a hallucinogenic tryptamine, along with methiopropamine – a methamphetamine analogue – and alpha-PBP, a class B, banned cathinone stimulant.

“Educating people not to accept these ‘branded’ pills and powders is a key message that we want to send out to as many people as possible,” says Blodwyn.

The Wedinos system (the name is also a portmanteau of the Welsh words wedi and nos, meaning ‘after dark’) has roots that go back to the emergence of methylone (an MDMA analogue) in 2005 and methedrone (a substituted methcathinone) in 2007 in Australia. Neither drug had ever been seen on the international recreational drug markets, but they were identified by a group of medics and harm reduction practitioners that included Dr David Caldicott. Their arrival heralded the international arrival of NPS, aka ‘legal highs’.

Wedinos was named, conceived and established in late 2010 by Caldicott, who at the time was working at Nevill Hall Emergency Department in Abergavenny, South Wales. He collaborated with Alun Hutchings of Cardiff Toxicology Laboratories at University Hospital Llandough, and Andrew Westwell of the School of Pharmacy and Pharmaceutical Sciences at Cardiff University to create a pioneering service that would allow drug users, for the first time ever, to know exactly what their drugs contained.

Caldicott had worked in Australia, and was part of a team that first identified methedrone in 2007. “We demonstrated proof-of-concept when we described methedrone. We showed that a hospital setting could be used to identify illegal drugs. The system and mechanism was designed at that time, “but the government at the time had this right-wing approach, one of complete intolerance. We had the system set up and ready to go. We just needed somewhere to locate it,” he tells me.

Caldicott is still a Wedinos board member, though he has now returned to Australia, where he works as an emergency consultant at Calvary Hospital, Canberra. He says he was concerned at the increase in emergency presentations of drug users who had experienced harm after consuming NPS. With no way of analysing the drugs on-site, he sought the expert help of Hutchings and Westwell.

“In 2009, I moved back to the UK, to Abergavenny. It’s not the drugs capital of the UK, but we were seeing some very weird things coming through, and I was pretty stunned,” he says. So stunned, he revived his Australian drug analysis project and looked for funding and backers.

WE CANNOT BE RESPONSIBLE FOR EVERY PERSON WHO DECIDES TO USE DRUGS. PEOPLE WILL TAKE DRUGS REGARDLESS OF THE LAW. WHAT THIS DOES IS TELL YOU WHAT THE HELL YOU ARE TAKING

Today, the group is funded by the Public Health Wales at a cost of around £100,000 a year, with initial setup costs in 2011 of £300,000, which was required to buy machinery.

The service has faced ethical, legal and practical challenges. Police advice was instrumental, says Smith, in arranging ways to transport possibly illegal drugs from one place to another. “We had to prove there was a rigorous chain of custody. Any system we set up had to contain a mechanism whereby there was proof of transport from A to B to C, with C being the lab and then to a safe and secure place for destruction.”

The ethical dimension of supplying individuals with information regarding their drugs’ authenticity was obviously a concern, says Smith but she points out the limits and boundaries the site operates within: “As has always been the case, each individual is ultimately responsible for their own safety. We cannot be responsible for every person who decides to use drugs. People will take drugs regardless of the law. What this does is tell you what the hell you are taking.”

Now, anyone can send in any drug whatsoever and find out what it is – a move that Caldicott says has laid the project open to attack by conservative thinkers.

Shadow Welsh health minister, Tory Darren Miller, told journalists in February: “This free service is not just testing recreational highs, but illegal and dangerous drugs including heroin, cocaine and crack, and gives advice on snorting and injecting substances.

“While the service may have been set up with the best of intentions, it is obviously open to abuse by dangerous criminals peddling harmful substances in order to fund other crime. It even includes advice on how to snort, inject and smoke those substances. I think it’s quite clear that the Welsh Labour government have given up the fight against drugs.”

“We don’t provide purity information,” says Westwell, neutering in just five words Miller’s claim that the data is of any use to dealers. “It is ridiculous to say it’s for drug dealers to identify the quality of the drugs they are dealing as we give no information on purity. We simply tell you what is in that sample. It’s about allowing users to make informed choices.

Caldicott rejects Miller’s right to even join the debate, much less influence policy. “Why does anyone ever listen to what politicians have to say about drugs policy?” he says. “They are either uninformed or out of touch with the culture, or the toxicology, or the socio-cultural aspects, or they are informed, and allow their political prejudices to determine their public utterances.

So how will the project measure its success? Smith says she wants to see a reduction in visits to A&E, along with reductions in arrests and fewer mental health problems. A user feedback component is also underway, with changes in users’ behaviour documented and analysed. Westwell and Hutchings say the volume of materials tested and analysed. Westwell and Hutchings say the volume of materials tested and analysed.

Mike Power is a freelance journalist and author of Drugs 2.0: The web revolution that’s changing how the world gets high.

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Boshe village in China’s Guangdong province (population 14,000) had many of the elements necessary to be China’s largest methamphetamine factory.

Corrupt local officials, an impenetrable Chaozhou local dialect, a village clan system so tight that families not connected with the drug syndicates were left to guess why a town where a farmer can earn just 700 yuan (£70) a month was filling up with luxury cars.

Even so, there could be little doubt what was going on behind the crudely welded grille doors of scores of hamlets in the narrow streets of the scrappy provincial town.

The operation, according to police estimates, involved a fifth of the population, produced so much in the way of noxious waste that it had poisoned the local fields and pulled so much electricity off the grid that many of the meth factories had their own generators.

When 3000 police successfully raided the town in late December (earlier attempts had been met with resident roadblocks, homemade weapons and the acid used in production of the drugs hurled from the rooftops) they uncovered a prodigious operation.

Police said the village – predictably dubbed China’s version of Breaking Bad – was supplying a third of China’s market in crystal meth; now the second most used drug in China after heroin.

In a town where almost all the surnames are Cai, keeping the neighbourhood secret hermetically sealed from outsiders and the authorities had allowed it to operate as a massive meth lab for years.

“Basically this is a family clan business, otherwise the meth industry would not have been able to grow so quickly in the past few years,” the dean of the Faculty of Law at Chongqing University, Professor Chen Zhonglin, said. “The tight family connections made the anti-drug operations harder.”

According to one local, who said police estimates of the extent of the network were exaggerated, the syndicates were even closed to those within the village.

“Only those family members or relatives of the ringleaders have the chance to join them,” he said.

The coastal area between Hong Kong and Guangdong’s Shantou has been associated with drug smuggling since the Opium Wars of the mid-19th century, its sheltered bays and islands giving it perfect access to the South China Sea.

In the early 1980s, the area was awash with surplus weapons from the Sino-Vietnamese war that made their way from Guangxi to eastern Guangdong. By the late 1990s the province’s Chaonan district, a centre for paper and printing plants, had become the banknote counterfeiting capital of the world.

With all the elements necessary for the establishment of a successful large-scale drugs operation – weapons and access to fast and often counterfeit money to purchase precursor chemicals, pay bribes and purchase other hardware – Boshe village seemed to be simply diversifying the industrial base of a region well known for poverty and crime.

Professor Karen Laidler, an analyst in illegal drug trends at the University of Hong Kong, said the ‘Breaking Bad’ label, with its image of small-scale cellar operations, understates the reality of China’s increasingly internationalized illegal drugs operations.

“China has been understood by the UN and many other organisations as a country where the precursor chemical ephedrine was quite prevalent and was being exported to other countries for the manufacturing of various amphetamine type drugs,” Laidler said.

“China did respond to those concerns and implemented a number of laws in relation to the control and regulation of ephedrine. However, it’s difficult to say how much is going and how much is coming in terms of precursor chemicals.”

The manufacturing in Guangdong? I suspect that much of that was for export.”

Hong Kong, she said, on a U.S. blacklist for the transit of heroin throughout the 1970s and 1980s until
it was lifted in the 1990s, was no longer necessarily a gateway for drugs manufactured in China. “The transit routes are not forced to go through Hong Kong any longer – there are many large ports in China where drugs can be imported and exported quite easily.”

Since 2012, China’s Food and Drug Administration (CFDA) has restricted the retail sale of ephedrine-containing over-the-counter drugs, prohibiting online sales and requiring retail pharmacies to check and record the ID of consumers of drugs containing ephedrine.

Nevertheless, state media alleged that some of the precursor chemicals found in the Boshe raid had been extracted from Contac, a popular cold medicine produced by the beleaguered British drug maker GlaxoSmithKline (GSK) already under scrutiny in China – where four of its executives are being detained over bribery charges.

Analysts, however, doubt that the teams of students allegedly employed by the syndicates to extract the pseudoephedrine from capsules could have produced enough of the chemical to account for the 23 tonnes of raw materials seized in the raid. According to the United Nations Office on Drugs and Crime (UNODC), precursor chemical seizures increased substantially in 2012.

The number of substances diverted for illicit drug manufacture increased from 20 controlled substances in 2011 (primarily ephedrine and hydroxylamine hydrochloride) to 40 uncontrolled substances in 2012, including pharmaceutical preparations such as ethyl phenylacetate

In 2012, 1,128 criminal cases were reported in China that involved the diversion of precursor chemicals and police seized a total of 5,824 metric tons of various substances used in the manufacture of illicit drugs

While the numbers represent a significant increase on the 1,834 metric tons of precursor chemicals seized in 2011, the US State Department says low-level corruption and bureaucracy remain a problem in China.

“China’s collaborative law enforcement efforts are hindered by cumbersome internal approval processes that often limit direct access by U.S. law enforcement officials to local counterparts at provincial Public Security Bureaus,” the US State Department said.

China has one of the world’s largest chemical industries, producing large quantities of precursor chemicals, such as acetic anhydride, potassium permanganate and piperonylmethylketone (PMK). It is the fifth largest exporter of ephedrine and the third largest exporter of pseudoephedrine.

The sheer scale of China’s chemical industry, with an estimated 80,000 individual chemical companies in 2009, presents widespread opportunities for chemical diversion. With many of these companies located in Guangdong province – and close to some of China’s busiest ports – the location of illicit methamphetamine factories in the region makes sense.

Most precursor chemicals seized in Mexico and Central America destined for illegal production of methamphetamine, according to the U.S. State Department, were legally exported from China and diverted en route.

In a further evidence of the increasing transnational nature of Guangdong province’s “Breaking Bad” factories, just a week after the Boshe raid, Philippine anti-drug agents acting on U.S. intelligence smashed a meth lab and seized 84 kilos of methamphetamine in a raid on a cock-fighting farm south of Manila.

Arrested in the raid were three known affiliates of Mexico’s Sinaloa drug cartel, one of the most powerful and notorious drug syndicates in the world. Named after the state on Mexico’s Pacific Coast where it was formed in 1989, the cartel’s heartland extends from Sinaloa, to Mexico’s Durango and Chihuahua states, but it is known to operate in locations as diverse as Russia, Australia and Sierra Leone.

“The Mexicans are already here,” Philippines drug task force chief Bartolome Tobias said, adding that they were getting help from “Chinese drug syndicates”. The Mexican attorney general’s office last year released a report that named Hong Kong triad groups 14K and Sun Yee On as the main suspects in the supply of ephedrine and ethyl phenylacetate to Mexican cartels feeding into the lucrative American market for methamphetamine.

Prior to 2012, Chinese police mostly dismantled small-scale operators, but in September 2012, police raided their first industrial-scale facility in Hunan, seizing 660kg of crystal meth and 19.8 metric tons of unidentified materials used in the manufacture of the drug.

Among the 14 people arrested in the raid, one was a Mexican national, a development which analysts say was the first indication that Mexican transnational syndicates were working closely with the Chinese to produce crystal meth.

For those working in the pharmaceutical industry in Asia, the blurred line between illicit drugs and the pharmaceutical industry remains a point of contention. Developers are continually searching for alternatives to easily extracted precursor chemicals found in many common products.

One Asia regional pharmaceutical executive who spoke to Druglink said the illegal drugs industry in South East Asia was now so big that it had the capacity to skew the marketing spreadsheets of some of the region’s largest pharmaceutical companies.

As recently as six years ago, he said, retail sales of certain products containing ephedrine, pseudoephedrine and codeine would show massive unexplained spikes in their sales.

“Of course, the immediate reaction of pharma marketers was that they wanted a slice of the action,” he joked. “But since then, the FDA has cracked down on it by issuing quotas. There is, of course, a medical need for these products so they monitored the sales, especially out of hospitals, of these products.

“When they could see a big volume it rang alarm bells. I think it’s true to say that whenever a product sells a lot other people in the industry are always looking at it and wondering why, particularly when there are strong sales for something curious like Contac.

“When one product is growing at twice or three times the rate of other similar products then that’s a red flag. For instance there was a product in Thailand that was being used in the manufacture of ‘yaba’ – it was getting strong sales without any marketing at all and the authorities cracked down on it.”

“It might make it attractive to marketers at first blush, but you don’t have to be too bright to work out what’s happening.”

He said that recent regulations applied in Thailand meant that the line between big pharma and illegal drug manufacturers was becoming more distinct.

“We occupy different worlds. These operators in China – if they’re not able to get these products off the shelf, extract the active ingredients they need and convert it into methamphetamine – they must be making the raw materials themselves and I guess that means a much more vertically integrated model of criminality.”

Peter Shadbolt is a freelance journalist

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Should dependent drinkers always try for abstinence?

Mike Ashton of Drug and Alcohol Findings on the milestones in the bitterest controversies ever seen in addiction treatment research.

The issue of whether dependent drinkers should always be advised to try for abstinence has been central to alcohol dependence and its treatment for decades. Far from receding into a box marked ‘pointless debates’, abstinence as a treatment objective has recently returned to prominence as an essential component of influential visions of ‘recovery’.

Not so long ago the issue in Britain and elsewhere was not just about advice, but whether alcoholics should actually be denied treatment until deterioration forced them to accept the need to stop drinking altogether and forever. Here we look at the milestones in this debate, subject of the bitterest controversies ever seen in addiction treatment, drawing on work done for the Alcohol Treatment Matrix.

Why such heat over a seemingly innocuous decision between patient and clinician on which form of reduced drinking to go for? In part it was generated by concerns on the one hand that allowing controlled drinking would let alcoholics (assumed to be unable to stop once they start) off the necessary hook of non-drinking and set them up to fail, and on the other that insisting on abstinence did nothing to improve outcomes, but did limit treatment to the minority of problem drinkers prepared to countenance a life without drink.

Behind this were alternative visions of dependence as a distinct category characterised by inevitable loss of control, or one end of a continuum of learnt behaviour, which even at its most extreme, can be replaced by learning to drink in moderation.

The controversy dates back at least to a 1962 report, Normal drinking in recovered alcohol addicts, by British psychiatrist D. L. Davies on seven ‘alcoholic’ patients from South London’s Maudsley Hospital said to have sustained controlled drinking. In 1994 they were judged to have deceived a research-naive clinician. The basis for this reassessment was a 1985 paper documenting interviews with the patients and others and a (re)examination of records, to which the original author (he had died three years before) was unable to respond. The allegations came from the prestigious figure of Griffith Edwards, who later embraced normal drinking as a goal for many patients. But he maintained that “abstinence is the only feasible objective” for those with a fully developed history of dependence. Among his criteria for identifying who should attempt which were those (see below) trialled by the Sobells in the USA.

That episode was relatively gentlemanly and limited to professional circles, but the following decade, bitter disputes originating within US research hit the headlines, in one case spawning legal proceedings. One major spat centred on a 1976 report from the Rand Corporation on new government alcoholism treatment centres. It found that fairly complete remission was the norm, that most patients achieved this without altogether stopping drinking, and that as many resumed normal drinking as sustained abstinence.

Aware of the storm their findings might provoke, the authors disavowed any intention to recommend alcoholics resume drinking. Nevertheless the storm broke, as suggesting the prospect of controlled drinking was likened to “playing Russian roulette with the lives of human beings”. With striking prescience, the authors themselves felt the most important implication of their findings was that “the key ingredient in remission may be a client’s decision to seek and remain in treatment rather than the specific nature of the treatment received” – an insight revisited decades later after another major US study – the Project MATCH trial, highlighted in cell A2 of the Alcohol Treatment Matrix.

One reason the Rand authors knew their findings might be controversial was the reaction three years before to an audacious and for the time methodologically advanced experiment conducted by husband and wife team Mark and Linda Sobell.

They had allocated hospitalised physically dependent alcoholics with what generally seemed a poor prognosis: either try for abstinence or for controlled drinking. The latter chosen principally on the basis that patients had asked for this, shown in the past they could manage it, and had a supportive environment to return to on discharge. Within each group, half were allocated to normal abstinence-oriented treatment and half to a radical procedure geared either to the abstinence or controlled-drinking goal to which the patient had been assigned. It entailed allowing patients to drink, showing them via videos how they looked when drunk, and training them how to manage or avoid what for them were situations conducive to drinking or over-consumption.

Over the last half of the follow-up year patients assigned to try for controlled drinking, and who had been trained how to manage this, spent nearly three quarters of the time out of hospital and prison and not drinking heavily, though all but four of the 40 continued to drink, the best results of all the patients. Those given the same treatment but selected for abstinence did almost as well, but many more...
did so by not drinking at all.

It seemed a clear vindication of an intervention based on seeing addiction as learnt behaviour and of the judicious allocation of even physically dependent patients to try to learn moderation. Controlled-drinking patients had been selected partly because of their “sincere dissatisfaction with [Alcoholics Anonymous] and with traditional treatment modalities”; the study showed this rejection of US orthodoxy need not condemn them to the progressive deterioration predicted for untreated alcoholics.

Just as with Davies’ research at the Maudsley, a later follow-up of the same patients cast doubt on the validity of the findings, and led one of the authors to publicly (in the New York Times) allege scientific fraud. The Sobells were cleared by an investigation set up by their employers and by one commissioned by a committee of the US Congress, and their research (though sharing some of the flaws characteristic of the time) was judged fairly presented.

In 1995 (and again in 2011) the Sobells revisited controlled drinking as a treatment objective in an editorial for the Addiction journal, which attracted eight commentaries. It accepted that “Recoveries of individuals who have been severely dependent on alcohol predominantly involve abstinence”, possibly because poor social support and lack of a stake in society in the form of a career and a job tend to go along with severity of dependence. Beyond this minority, they argued that reducing alcohol-related harm across the population demanded acceptance of the moderation goal, because many (especially less or non-dependent) drinkers simply will not accept interventions which presuppose abstinence.

Their argument had been demonstrated by a Canadian trial which tried to randomly allocate drinkers (most of whom seemed to be drinking heavily enough to meet criteria for dependence but had yet to be severely affected by their drinking) to treatment aiming for abstinence or moderation. Of the 35 allocated to abstinence, 23 either rejected it or expressed reservations, but just five of the 35 allocated to controlled drinking. That was at the start of treatment. After it had ended the picture was the same; whatever goal had been impressed on them by their clinicians, most in the end chose to drink moderately.

Skipping other important studies in Britain and elsewhere (for which see these Findings notes) we come up to date with Britain’s largest alcohol treatment trial, the UKATT study of psychosocial therapy for 742 patients seeking treatment for alcohol problems at specialist treatment services in England and Wales. I’m not looking at the main findings, but a secondary analysis of how patients fared depending on whether they had opted for abstinence as an initial treatment goal.

From our analysis you will see that regardless of their initial choice, patients did about equally well, and that even among those who at first wanted to stop drinking altogether, more later substantially reduced their drink-related problems while continuing to drink, than did so by abstaining.

UKATT was among the studies assessed in a recent European review whose conclusions were largely in line with others from North America. Though they were perhaps more enthusiastic about embracing moderation as a treatment goal, in order to make treatment attractive to the 20 to 80 per cent of dependent drinkers who preferred this goal.

The review seems to advocate shared decision-making when selecting a treatment goal, with moderation as well as abstinence on the table, so the patient makes a positive choice rather than being ‘told’ what to do. Incidentally, a Dutch study showed that shared decision-making can be systematised, and that as a result, in relation to life in general, patients feel more able to make their own decisions. They are more in control and less submissive – possibly portending a more stable shift away from a dependent mind-set than could be achieved by less explicit shared decision-making.

What seems mainstream contemporary opinion was enshrined in alcohol treatment guidance published in 2006 by the Department of Health and National Treatment Agency for Substance Misuse. It stressed that goal choice should not exclude drinkers from support or treatment, but did see abstinence as “the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly…whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate…without success”.

Even for these drinkers, if abstinence is not acceptable, moderation is better than nothing, and may lead to abstinence. We know from research that no matter how physically dependent, moderation is feasible for some, especially when there are sufficient supports in the patient’s life.

But the more severe the dependence, the more likely abstinence is to be the suitable strategy. On how the decision should be made, in relation to care planning in general, the guidance sees patient choice as not just an entitlement, but a strategy which improves the chances that the treatment approach will succeed because “it has been selected and committed to by the individual”.

This is how Drug and Alcohol Findings summed up the evidence: “Treatment programmes for dependent drinkers should not be predicated on either abstinence or controlled drinking goals but offer both. Nor does the literature offer much support for requiring or imposing goals in the face of the patient’s wishes. In general it seems that (perhaps especially after a little time in treatment) patients themselves gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal”.

Click here for an extended web version of this article. For fuller accounts see this US analysis and if you can this British perspective (turn to chapter four of the book). See also this Findings analysis of a recent UK study (the background notes are particularly informative) and this recent review. This article is based on cell C4, one of 25 cells in the Alcohol Treatment Matrix constructed by Drug and Alcohol Findings for the Substance Misuse Skills Consortium. This and the corresponding Drug Treatment Matrix map treatment sectors and influences which might affect impact, and for each sub-territory (a cell) list the most important UK-relevant research, reviews and guidance.
New to the field in 1992, a major lesson for me was discovering the absence of drug and alcohol services for under-18s. Agencies recognised this age group’s existence and needs, but felt constrained by legalities in treating them. They were also aware that introducing young people into adult services was in no way appropriate to their needs and situations.

The 1996 publication of *The substance of young needs* by the NHS Health Advisory Service was a welcome acknowledgement of the gap in services and played an important role in identifying needs and populations previously invisible to, or overlooked by decision makers, if not service providers. Along with the ACMD’s 2003 *Hidden harm*, this report was instrumental in shaping and informing policy and provision for young people affected by substance misuse.

Yet neither report figures in *Youthoria’s* 35 pages of references. This ambitious and information-packed volume aims to ‘identify differences between young people’s and adults’ substance use’ and, therefore, relevant responses and service provision. The book attempts ‘to integrate these disciplines [prevalence patterns, adolescent development, substance misuse problems, prevention and treatment] into a cohesive vision of young people’s substance misuse.’ This suggests that although much has been clarified about young people’s substance use and needs since the publication of the 1996 HAS report, practice and service provision still fall short of need.

Youthoria’s introduction indicates its intended or potential audience, from youth workers through families to commissioners and academics. The variety of this audience is certainly catered for by the extensive and comprehensive content of the book. But this coverage might also act as a deterrent to some of its anticipated audience. There is so much content and discussion it can become overwhelming. And the treatment of much of the content – a thorough exposition of theory, evidence and research studies without clear or firm conclusions – is likely to leave many readers trying to work out what the implications are for their discipline and practice. In addition, the book lacks an index – a major failing in a volume with so much valuable content.

There is also a sense that events may well have overtaken some of the well-identified groups of practitioners. One such is ‘substance misuse youth workers,’ a job description which raises hopes that such staff have been trained and are in post, but who are likely to have been re-assigned or dismissed in the wake of public sector spending cuts in the past four years. The ACMD, amongst others, has pointed to the recent dis-investment in drug and alcohol services, an area where young people’s services have always been seen as a bit of a luxury. The current political focus on new psychoactive substances and legal highs is not yet translating into specialist provision for this new(ish) phenomenon and demography.

In a different context, Harris points out that: ‘...all too often, treatment systems are developed that are based on political agendas rather than the clinical needs of those they try to help.’ He consistently emphasises the importance of needs-responsive services for young people, and an understanding of those needs and the ways in which they might be best responded to so that when political and budgetary climates are favourable, evidence and knowledge is readily available to commissioners and practitioners. There is a welcome reminder of the centrality of alcohol to young people’s needs.

Reviewers habitually look at books’ references to see what is, and isn’t, there. Given the emphasis on the significance of peer cultures for young people’s behaviours, I noted the omission of Dick Hebdige’s *Sub-culture: the meaning of style*.

Harris emphasises the need to consider all the factors that can influence substance-using behaviour in young people’s lives. Willy de Haes’ work supports this analysis, pointing to young people’s wider social and emotional needs. De Haes says that whether or not they are met heavily influences what we now call the ‘protective factors’ which are liable to reduce young people’s propensity to experience problematic substance use. He, too, is absent from the references.

Blaine Stothard is a prevention specialist and Druglink’s book reviews editor

There is so much content and discussion it can become overwhelming.
This book covers a number of important topics within the field of substance misuse. Opinion is forthcoming and evidence-based, and the chapters provide worthwhile reading to anyone working in the field, including those in clinical practice, drug service workers, nurses, policy-makers, and students and teachers on addiction courses. Helpfully, the book contains enough background information on the history of drug laws, maintenance prescribing, treatment and recovery, for the interested lay-person.

The title addresses theoretical, practice and policy issues about problematic use of drugs and alcohol, and presents a range of emerging, evidence-based perspectives. It covers aspects of international and UK drugs and alcohol policy: for example there is an outline by Richard Velleman, of the controversial yet effective Heroin Assisted Treatment (HAT). Involving as it does the substitution of illicit heroin with a supervised, controlled dose of medicinal heroin in clinical settings, HAT has been shown to be an effective second line treatment for those for whom methadone fails. There is a small but highly significant number of trials across Europe and the US that demonstrate the effectiveness of this treatment for a small, so-called 'untreatable' sample of patients.

Another focus is on drinking, with an intriguing spotlight on women and the implication of drinking behaviours in the context of social media. As well as Rebecca Brown’s focus on women and social media, Karenza Moore and Fiona Measham focus on gender and drug misuse, with a review of feminists’ pioneering work from the 1980s, alongside more recent calls to revise our understanding of female drug misuse, and newer critiques of post-feminism.

Substance misuse in the context of children and the family is outlined by Lorna Templeton, in a chapter describing the costs and burdens faced by so many families (and wider society) when a family member misuses drugs or alcohol. This is preceded by a critical exploration by Louise Hill of how drugs laws have inhibited research advances and neglected clinical opportunities. Professor Nutt makes suggestions on how to move research forward through sensible and facilitative drug laws.

The book skilfully and succinctly summarises current knowledge about substance misuse, along with thought-provoking perspectives on the wider issues related to an individual’s use and the impact it has on themselves and society. In doing so, it provides a valuable snapshot view of topics, which students and professionals might further explore.

Victoria Brooks MSc is Doctoral Researcher, National Addiction Centre, King’s College London

THE BOOK SKILFULLY AND SUCCINCTLY SUMMARISES CURRENT KNOWLEDGE ABOUT SUBSTANCE MISUSE, ALONG WITH THOUGHT-PROVOKING PERSPECTIVES ON THE WIDER ISSUES
Background:

GBL (gamma-butyrolactone) is a ‘pro-drug’ of GHB, which means that it converts to GHB within the body. GBL occurs naturally in certain food products, is found in small quantities in the human body and is available commercially as an industrial solvent and as an ingredient in cleaners, paint removers and engine degreasers. GHB is a drug which is available as sodium oxybate (or under the brand name Xyrem) as a treatment for narcolepsy in adult patients and has been used therapeutically in the treatment of alcohol and opiate dependency. GHB was developed in the early 60s as a human anaesthetic, but was discontinued due to unwanted side effects. It was used as a sleep aid and body building supplement in the 80s and later as a recreational psychoactive. GHB and GBL are sometimes referred to as G, Liquid Ecstasy, Liquid X, Juice or Geebs.

Appearance and taste:

At room temperature GBL is a colourless, slightly oily liquid that is clear to semi-opaque. It has a distinctive taste that some users have described as being distinctly chemical, like a solvent, nail varnish or paint stripper.

Route of administration:

GBL is mainly taken orally. Due both to its unpleasant taste and to it being a skin irritant, most users dilute it with juice or other liquid. IV use is strongly advised against; one user reported that this lead to “the most horrific pain you can think of…the tiny amount of GBL that was on the outside of the needle was enough to make me cry”.

Dependence and withdrawal:

Regular use of GBL builds tolerance, meaning users need to take more to feel the same effects. GBL is physically addictive and stopping it without medical supervision can be fatal; sudden withdrawal poses dangerous health risks and can require an in-patient detox. Clinical presentation of withdrawal may include anxiety, confusion, agitation, tremor, cramps, insomnia, aggression, delirium, delusions, paranoia with hallucinations, tachycardia (racing heart), low blood pressure and occasionally a schizophrenic-like state.

Typical effects and side effects:

These are some of the typical effects and side effects experienced by people who use GBL; not everyone will experience all effects listed and many can be dose dependent.
Physical relaxation | Heightened sex drive | Euphoria | Loss of inhibitions
---|---|---|---
Can enhance effects of stimulant drugs | Increased erections | Increases dopamine levels | Can ease stimulant comedowns
Unconsciousness | Increased orgasms | Enhanced sociability | Sleep aid
Nausea and vomiting | Hypothermia | Anxiety | Aggression
Physical addiction | Severe respiratory depression | Paranoia | Confusion
Collapse | Death | Psychological addiction | Coma

**Onset and duration of effects:**

Onset varies between individuals and can depend on a number of factors (including when the user last ate), but effects can be felt approximately 10-30 minutes after ingestion. 45 minutes to 1½ hours later the effects begin to level off and decrease, depending on tolerance to the drug its effects can be felt for 2-4 hours. After-effects like grogginess and sleepiness can be felt for as little as two hours or as long as twelve hours after use, although some users find a sense of increased well-being the following day.

**Dosage information:**

GBL has a very steep dose-response curve, meaning that it can only take a tiny amount to push the user from having a good time to experiencing accidental overdose, unconsciousness, coma or even death. Some rough guidelines follow, please note that these will not apply to everyone who takes the drug:

<table>
<thead>
<tr>
<th>Low Dose</th>
<th>Medium Dose</th>
<th>Heavy Dose/Overdose</th>
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</thead>
<tbody>
<tr>
<td>0.3-0.6mls</td>
<td>0.6-1.25mls</td>
<td>1.25-2mls+</td>
</tr>
</tbody>
</table>

GBL can be fatal. It is very easy to overdose on it, both because the strength can vary from bottle to bottle and because the doses involved are measured in such small quantities. These risks are greatly increased by mixing GBL with alcohol or other sedative, depressant drugs or drugs such as ketamine. Mixing with alcohol is particularly dangerous as this can trigger instant collapse or an overdose reaction. GHB and GBL have been found to reduce the efficiency of some HIV medication and have also been implicated in sexual assaults or ‘date rapes’.
A hidden threat

Much of the media hype around the rise in legal high deaths mask trends that are far more newsworthy and alarming, says Mike Power.

News reports on the latest drug death figures (2011-2012) from the National Programme on Substance Abuse Deaths (nP-SAD) managed to simultaneously miss the point, and miss a few great stories.

Legal highs, the press release said, are the top priority in drug policy today. “The prevalence of these drugs in the post-mortem toxicology tests submitted to the report has increased 800 per cent in three years, from 12 in 2009 to 97 in 2012.”

Shocking stuff. But disregarding the poor maths (12 to 97 is a 700 per cent increase) there’s also poor logic and poor science at work here, and evidence of a determination to maintain the flourishing moral panic surrounding legal highs or Novel Psychoactive Substances (NPS) that was sown by the Labour government in 2010, and tended carefully ever since.

The figure of 97 NPS deaths was quoted far and wide – but closer reading showed that only 68 deaths were found by npSAD to have been specifically caused by the use of these drugs.

Now look more closely: of those 68 deaths, 20 were actually caused by PMA and PMMA, substituted amphetamines. Neither drug can be said to be novel, since they have existed for decades – they were first synthesised in 1967 by psychedelic chemist, Alexander Shulgin. Both are Class A drugs, not ‘legal highs’.

A further two deaths were attributed to 4-MA – which is just another name for PMA. So, 22 of the 68 legal highs deaths were from PMA or PMMA. That leaves us with 44 NPS deaths.

PMA and PMMA, sold under false pretences as ecstasy tablets, almost tripled in just a year – from 7 in 2011 to 20 in 2012.

Using the npSAD’s own 2009 figure as a year zero, there has been a combined 22-fold increase in deaths from these specific substances in four years; there were none just four years ago. Where was that story?

The harm reduction messages around safer ecstasy use that were so prevalent 20 years ago are being lost in this moral panic about legal highs

Users of these fake ecstasy pills are unwitting, they are young, and they do not have long-term drug addictions or indulge in risky behaviours such as injection, or even polydrug use. Their deaths are shocking and unexpected.

The harm reduction messages around safer ecstasy use that were so prevalent 20 years ago – with users advised to dose cautiously with new and untrusted batches, to avoid other drugs and alcohol, and to remain moderately hydrated and cool, are being lost in this moral panic about legal highs. Apply them with renewed vigour to PMA and PMMA, and lives would be saved.

Moreover, as a proportion of the 1,613 deaths, NPS as defined by this study accounted for just 4.2 per cent of all drug-related deaths in the UK. Take out the 22 PMA/PMMA deaths and you have 44 fatalities, or less than three per cent of all drug deaths in the UK.

Yet every major media outlet went with the legal highs story. That’s not to deny that legal highs remain popular, or that often their use can carry severe health risks. It’s also true that from a journalist’s perspective, legal highs are a great story – I have written extensively on the subject myself (including in this month’s edition of Druglink on the Wedinos project) and will continue to do so: they offer a fascinating data point to anyone interested in the multi-stranded debate around drug use and law.

But the real killers remain heroin and morphine (36.4 per cent of 2012 deaths); and hypnotics/sedatives such as diazepam (30.3 per cent).

Might it not be useful to present this information a little differently each year? A single paper for each drug category would allow journalists to quickly compare figures across the years. A reclassification of PMA into a separate category would allow better monitoring of the prevalence of these pills and their health effects.

There were two other angles reporters did not spot. I didn’t see any stories at all on the drug problem within what people rarely refer to as “the white community”. No panicked editorials, no representatives of the white community summoned to explain or justify the fact that 97.3% of the 1,613 deaths recorded by npSAD were of white people.

Is this not statistically interesting?

Nor did I see an anguished commentary pontificating over the fact that those whose drug use killed them were overwhelmingly male, with men making up 72.2% of all fatalities.

But when it comes to drugs, statistics, policy and journalism, there’s an awful lot that just doesn’t add up.

Mike Power is a freelance journalist and author of Drugs 2.0: The web revolution that’s changing how the world gets high
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