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The kids are not alright

Ten years ago, the Advisory Council on the Misuse of Drugs published a ground-breaking report Hidden Harms. It revealed what most professionals knew already, but were afraid to address. That children and young people suffer as a consequence of parental substance misuse and that support must be provided for both adults and children. So where have we got? Sadly, in England, not very far. All kinds of structures and initiatives have been put in place, but there is little evidence of impact. There is no national leadership on this issue; astonishingly, for example, it is still not compulsory for substance misuse to be part of the curricula for doctors, nurses and social workers, although some progress has been made with continuous professional development. It is still clear that agencies caring for children and parents (whose needs are not the same incidentally) are generally not working together. After all these years, we are still having to make the same pleas for that holy grail of health and social care – multi-agency working.

And so it is left to individual professionals at a very local level to champion activity and make the vital links between agencies caring for parents and children – only for much of that good work to come undone when the person moves on. Is there any good news? Well, the fact that more people are in treatment means that indirectly, this will bring down the number of affected children. But it isn't enough.

Wales is showing the way with their Integrated Family Support Teams involving social workers, community psychiatric nurses, practitioners and other professionals that a family may need access to. The initiative was driven from the top and every area in Wales now has one of these teams all of which have the same structured interventions and governance. The rest of the UK should be looking for inspiration to The Land of My Fathers – and Mothers.

Harry Shapiro

Editor and Director of Communications and Information

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Drug policing ‘major cause of racial inequality’, reveals study

Black people are six times more likely to be stopped and searched and twice as likely to be charged with drug possession than white people, a study has found.

In Dorset, the area with the highest disparity, the report found black people are 17 times more likely to be stopped in the street and searched for drugs than white people. This is despite the fact that drug use is lower amongst black and Asian people when compared to their white counterparts.

The study showed significant disparities for cocaine possession in London, with 78 per cent of black people charged, compared with 44 per cent of white people. Black people were also almost twice as likely to be charged for possession of cannabis in the capital.

In London, which has the most thorough data for such policing and accounts for half of all the stop-and-search incidents in England and Wales, 12.4 per cent of white people found



possessing cannabis in 2009/10 were charged, with almost 75 per cent given a warning. For black people found with cannabis, 21.5 per cent were charged and 65 per cent warned.

The joint Release/London School of Economics report, *The Numbers in Black and White*, which used Home Office data and freedom of information responses from police forces across England and Wales, concluded that drug policy was a major cause of racial inequality at all levels in the justice system.

Niamh Eastwood, Executive Director of Release said: “Black people are more likely to get a criminal record than white people, are more likely to be taken to court and are more likely to be fined or imprisoned for drug offences because of the way in which they are policed, rather than because they are more likely to use drugs. Despite calls for police reform of stop and search little has changed in the last three decades, this is why the Government needs to take action and change the law.

“Decriminalisation of drug possession offences would end the needless stop and search of hundreds of thousands of innocent people every year and eliminate a significant source of discrimination with all its damaging consequences.”

New Welsh drugs alert

A project aiming to identify and test emerging new drugs has been set up in Wales.

The Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS), will go beyond identification of new psychoactive substances (NPS) to address their harms and new trends in their use alongside established drugs and performance enhancing drugs.

WEDINOS, which has the backing of Public Health Wales and the Welsh Government, was initiated by Dr David Caldicott, Dr Alun Hutchings and Dr Andrew Westwell who devised an informal mechanism whereby samples of unidentified drugs were provided by patients and tested in Cardiff Toxicology Laboratories, University Hospital Llandough. The drugs were profiled and the team began to map of trends and the harms connectd to each substance.

The WEDINOS team works collaboratively with existing UK and European Early Warning Systems and other relevant organisations.
www.wedinos.org.uk

The figures in black and white

- Over 50% of stop and searches are for drugs, 10% are for offensive weapons and less than 1% are for guns.
- The police in England and Wales stop and search someone for drugs every 58 seconds.
- Of the more than half million stop and searches for drugs carried out in 2009/10 only 7% resulted in arrest.
- In 2009/10 black people were stopped and searched for drugs at 6.3 times the rate of white people, while Asian people were stopped and searched for drugs at 2.5 times the rate of white people.

Read the report here:
<http://www.release.org.uk/publications/numbers-black-and-white-ethnic-disparities-policing-and-prosecution-drug-offences>



Taxing cannabis sales could net Treasury up to £1.25bn

Legalising and taxing cannabis could net the government £1.25 billion year in taxes, a report has claimed.

The report, by the Institute for Social and Economic Research, is the first to attempt to quantify the financial benefits of a regulated cannabis market in England and Wales.

It estimates that reduced enforcement and criminal justice costs, such as police, court and prison time, could save £300m or more alone, with the rest coming from the tax revenue that would fill the government's coffers through licensed sales of the Class B drug.

The report's authors said regulation would also provide other benefits, such as an element of quality control of the product, therefore reducing the harm of using the drug. It said quality control would be harder to regulate if the market was subject to less strict controls and consisted of large numbers of small producers.

Consumption of cannabis would rise significantly as a consequence of the switch to legal status and the lower price that results, the report said. But this would be counter-balanced by the fact that product regulation would result in a fall in potency, "so that average consumption of the psychoactive ingredient THC would rise much less than consumption of the good itself, and might even fall".

The report said that legitimising the cannabis market would draw people away from drug-dealing and crime. "Licensing would remove many people from illicit cannabis supply and thus reduce harm," it concludes.

"We estimate modest external net benefits from reform through the avoidance of scarring effects of criminal records in the labour market of roughly the same magnitude as the external cost to society of the impact on mental health."

Commissioned by the Beckley Foundation, the report, comes in the wake of significant changes in the

regulation of cannabis markets in the US.

Last year it was estimated that sales of medical marijuana in California raised \$100 million in taxes for the state. In 2014, two states, Washington and Colorado will legalise recreational cannabis and this is expected to multiply the income that the states already receive through medical sales.

Read the report here:

Licensing and regulation of the cannabis market in England and Wales: Towards a cost-benefit analysis
<https://www.iser.essex.ac.uk/d/153>

Think positive

Campaigns to get young people to stop smoking are more successful if they focus on the benefits rather than the negatives, says a study by the Wellcome Trust.

It reveals that young people have greater difficulty in learning from bad news and warnings, such as increased disease risk as they do from positive outcomes, such as having more money and better skin.

Research has found that displaying health warnings and graphic images of diseased lungs on cigarette packaging

has had little effect in reducing the number of teens taking up smoking.

"The findings could help to explain the limited impact of campaigns targeted at young people to highlight the dangers of careless driving, unprotected sex, alcohol and drug abuse, and other risky behaviours," said leading author, Dr Christina Moutsiana.

The study, published in the journal *Proceedings of the National Academy of Sciences*, was funded by the Wellcome Trust and the Royal Society.

Big Pharma trials Special K for use as anti-depression spray

Ketamine, the hallucinogenic anaesthetic adopted as a post-club comedown by a generation of drug users, is being trialed by a major pharmaceutical firm for use in the quick relief of depression.

Scientists working at the National Institute of Health (NIH) discovered that a brain receptor called the N-methyl-D-aspartate (NMDA) played a key role in depression and that ketamine could rapidly ease depression symptoms and even suicidal thoughts. Current antidepressants take weeks or months to have an effect, and then only in 30 per cent of patients.

Husseini Manji, who made the discovery at NIH, now leads neuroscience research at US multi-national health care giant Johnson and Johnson, where a ketamine nasal spray is being developed.

A Johnson & Johnson subsidiary in Europe has gone as far as mid-stage clinical trials for the nasal spray. The trial uses a slightly altered version of ketamine, esketamine, an isomer of the Class C drug and the most pharmacologically active portion in place, enabling less of the compound to be administered.

“What you do today is you admit people and lock them up before drugs kick in to prevent them from harming themselves,” Manji told Forbes

magazine. He said the idea that you can treat suicidal depression in just a day, with ketamine – known as ‘Special K’ to clubbers – is “one of the biggest steps forward psychiatry has taken in decades”.

Dennis Hartman, a patient with depression who sought help from ketamine-prescribing physicians, one of whom provided a spray, warned in *Scientific American* that news of ketamine’s ability to treat depression filtered out to social networks and the street.

“This personal friend received a ketamine infusion [from a physician],” Hartman says. “He achieved very strong relief, very similar to mine. After he relapsed, he went and sought this illegal form and he did not get the same effect.”

Hartman is involved with setting up a new web site, the Ketamine Advocacy Network, to foster activism among patients who use ketamine for depression.

If Johnson & Johnson’s esketamine trials result in a sellable drug, the company has plans to safeguard it from those who want to divert it for recreational use.

The US Food and Drug Administration has put Johnson & Johnson’s version of esketamine on a fast track for approval.

Obituary



ALAN JOYCE: 1959 to 2013

Alan Joyce, a much-loved drug user activist, was one of life’s originals – eccentric, outrageous and with a thirst for knowledge on subjects including philosophy, politics and nature. Alan was funny, compassionate, genuine – a much loved son, brother, father of two and advocate of ‘people power’, who assisted in the establishment of The Alliance, and who fought all his life against injustice.

By the early 90’s Alan had been a punk, street sweeper, squatters rights activist, master carpenter/ union rep in West End theatres and had a degree in fine art. He also needed a methadone script and began working with the Methadone Alliance to secure maintenance methadone prescriptions for addicts as a harm reduction alternative to the chaos of life on street heroin. Despite his ill health, Alan continued to write and campaign for this cause through several national organisations.

He was a major contributor to the National Users’ Network (NUN), where he could debate, dispense knowledge, reassurance and sympathy to so many who really needed it, as well as supporting NUN’s attempts to influence government policy. One of the many pleasures of meeting and working with him was seeing that light of intelligence and passion.

When he sadly and unexpectedly passed away in June, messages came from across the globe in tribute to his inspiring, empowering and often life-saving work. Alan also leaves a large collection of artwork that his family are endeavouring to exhibit.

Pin call wizard

Money donated by singer Elton John to help combat the spread of HIV among drug injectors is now making an impact in pharmacies across Ireland.

A donation in 2009 of €750,000 by the singer, through his charity the Elton John AIDS Foundation (EJAF), is being used to help set up needle exchange services in 130 pharmacies across the country.

Initially, the project got off to a slow start because there was a problem recruiting pharmacists able to assist with the needle exchanges. However since 2011 needle exchanges have been set up in 71 pharmacies in every county outside Dublin. The service will be expanded to reach a target total of 130 locations by the end of 2013.

Since the setting up of the needle exchanges, over 200 pharmacists have been trained to deliver the service. Nearly 100,000 clean needles were given out in a 10-month period from December 2011 to October 2012.

More than 1,000 clients have been referred to addiction clinics and voluntary services for treatment, addiction counselling, blood-borne virus testing (ie HIV and Hepatitis) and Hepatitis B virus vaccinations as a result of the service.

A spokesperson for the EJAF told the *Irish Independent*: “The programme is now monitored on an ongoing basis and feedback from service users and pharmacists to date has been positive.”

MAD ABOUT MOLLY

This summer a series of deaths of young people after taking the party drug Molly shocked America's resurgent rave scene. By Max Daly

"I just took six hits of Molly," 20-year-old Olivia Rotondo reportedly told paramedics after becoming ill at Electric Zoo, a three-day New York dance music festival at the end of August. Rotondo was one of thousands of young Americans squeezing the last drop of hedonism out of their summer breaks before returning to college or jobs.

A church-goer studying dance at the University of New Hampshire, Rotondo then suffered a seizure and was rushed to hospital. She was pronounced dead 45 minutes later. She was not the only one to suffer after taking Molly that day.

Within the space of a few hours, Jeffrey Russ, a 23-year old graduate died after allegedly taking the drug at the same festival. Four other Electric Zoo attendees were hospitalised because of suspected links to the drug. New York City officials decided to shut down the event, and its future now looks bleak. That same day, 200 miles to the south, 19-year-old student Shelley Goldsmith, who may have taken Molly, collapsed and died at a nightclub in Washington DC.

Molly is American slang for powder or crystal MDMA. It is viewed by drug users as a cleaner, more reliable way of getting the full MDMA buzz than the cheaper, more widespread, pill version of the drug.

However, despite its reputation for purity, not all Molly is MDMA. Forensic tests carried out last year by police in Miami, the hub of America's blossoming rave and Molly scene, found the vast majority of white powders being sold as Molly were instead methyline. And while Rotondo's toxicology test showed she had taken MDMA, Russ's 'Molly' was actually a mix of MDMA and methyline.

In the US, Molly has witnessed an explosion in use among young people and the metropolitan elite in cities such as New York, Boston, Miami and Seattle. Its rise is closely linked to the growth in popularity of America's big money electronic dance music (EDM) scene. Think UK rave culture on steroids – packed out football stadiums with state



MOLLY HAS WITNESSED AN EXPLOSION IN USE AMONG YOUNG PEOPLE AND THE METROPOLITAN ELITE IN CITIES SUCH AS NEW YORK, BOSTON, MIAMI AND SEATTLE

of the art visual shows and star DJs such as David Guetta.

Molly appears to have had the ring of celebrity endorsement. In March 2012 Madonna famously went on stage at the Ultra Music Festival in Miami, the largest event on the EDM calendar, and shouted to the audience: "How many people in this crowd have seen Molly?" She was later lambasted as a "funky granny" by dance music DJ Deadmau5 who accused her of cynical attempt at promoting her new album, coincidentally called MDNA, by name-checking ecstasy.

The Molly-fuelled European house music sound adopted by the American EDM scene has infiltrated the pop charts and has been used in hits by Rihanna and Katy Perry. The furore over Miley Cyrus's twerking while singing her new single *We Can't Stop* at the MTV Video

Music Awards disguised the fact that organisers had to bleep over her line "We like to party/Dancing with Molly". Molly has popped up all over the Billboard 100 charts. Jay Z mentioned it in *Empire State of Mind*, while Kanye West, Lil Wayne and Nicky Minaj have also included references to the drug in their lyrics.

According to the *New York Times*, Molly has experienced a renaissance in mainstream America because it has "re-branded" its reputation as a "cleaner" version of ecstasy.

The most likely explanation for the recent number of Molly deaths in the US is not a bad batch of drugs, but the sheer numbers of people taking Molly during such a concentrated period of time. Although rarely lethal on its own, the use of MDMA or methyline can cause acute overheating and dehydration, often because of the circumstances in which the drug is taken. August 31 was one of the busiest days of the American summer holiday calendar, with thousands of young people going on one last celebration before returning to work or college. And so the chances of someone being the unlucky Molly user were greatly heightened.

■ **Max Daly** is author of *Narcomania: How Britain Got Hooked on Drugs* (Windmill) October 2013



Vivienne Evans OBE

Ten years ago, the ACMD published *Hidden Harm* a landmark report on the impact of parental drug use on children. We asked Vivienne Evans OBE, Chief Executive of Adfam, to what extent children's lives have been improved since. Interview by Harry Shapiro

Can you explain Adfam's role in the Hidden Harm agenda?

Adfam was originally set up by the mother of a heroin user and at that time the main focus was mutual aid and peer support, usually for parents whose son or daughter was a heroin user. Over the years, there has been an increasing awareness of the impact that drug misuse can have on other people, not just on the individual. From Adfam's perspective, once we became an umbrella body, I was very keen that we broadened the focus and that inevitably involved child protection – for example, we were training workers on the Family Interventions Programme (which the later Troubled Families programme built on), raising awareness of drug issues and how they related to child protection.

What were the limitations of the Hidden Harm report?

It is important to say that this was an area that had never received any attention and it wasn't just about those children on the 'at risk' register. But because of the ACMD remit, it was squarely focused on drugs, whereas of course now, alcohol has very much come

up the agenda. That said, you could argue that focussing on drugs was a big enough project in itself and it made the work more contained in the terms of the development process. And there was specifics about drugs that could directly impact on children; being in an environment of illegal activity, drug dealing, violence and so on.

But I've always taken the view that the biggest problem for children is neglect; chaotic household, lack of attention because the parents are focussed on other things – fractured parenting.

And there is a view that the actual substance is really of secondary importance; children themselves don't make the distinction between the behaviours associated with drugs or alcohol.

There was a follow-up report three years later, wasn't there?

Yes, I chaired that, but to be honest I think it was too soon. When Mao Tse Tung was asked about the impact of the French Revolution he said it was too early to tell! So ten years would have been better, which is what we asked for in the report we published this year:

Parental substance misuse; through the eyes of the worker.

So what has been the impact of Hidden Harm in your view?

It is very hard to say. It had the clout and the resources to present a national picture of around 250,000 children affected by parental drug use, but it hasn't been updated. There has been a lot of work going on in this area with reports from The Children's Society, Alcohol Concern, Addaction, 4 Children, Turning Point and the NSPCC. But none of this has had the broad, robust and independent scope of *Hidden Harm* because as you would expect, these reports focus on the constituents of the agency concerned.

So we don't have much of an idea where we are now in terms of figures?

That's right – and alcohol muddies the waters as to what is or isn't a significant impact – how much parental drinking is too much? During its time, the NTA were getting much better at releasing parental

data from NDTMS, but the calculation on affected children was rather 'back of envelope' – how many people in treatment, what the average number of children they are likely to have plus some Donald Rumsfeld knowns and unknowns, including all those parents not in treatment and the impact of alcohol.

The issue is of interest to a lot of different organisations and professional groups, but one of the reasons it didn't really get off the ground was that there was no national lead. And although the government accepted all the recommendations bar three, one of those it rejected was the one about pre-qualification for social workers, which is pretty crucial and if it had been accepted, would most likely to have had the biggest impact over the long term for the largest group of professionals coming into contact with families.

And you have to ask the question, 'where does it sit now?' Department for Education? Department of Health? Communities and Local Government with the Troubled Families brief? It is everybody's business, but nobody's responsibility. The work needs to be driven from the highest possible level, with an embedded culture and training otherwise it is left to individual champions at a local level and the personal and professional relationship they develop. If they leave, there is no guarantee that whoever comes next will be willing to step into their shoes.

So is there any good news?

It would be churlish to say that nothing is happening, although we do often fall back on the same examples of good practice. In particular, identification of children at risk has got much better and those who work in drug and alcohol services who we have spoken to say that they do now have a child safeguarding focus and that family work has become part of their work rather than 'somebody else's' and they are prepared to ask the difficult questions and deal with the answers, whether its referral or developing in-house parenting programmes. They are more confident about dealing with the issues

To what extent do you think that this has come about because of all the anxieties about child safety in recent years?

The Lord Laming report into Victoria Climbié came in the same year as *Hidden Harm* and there is no doubt that all the various terrible incidents since like Baby P have highlighted safeguarding issues.

If you look at the people who came on our courses – working with complex families – they came from schools, social work, childrens' centres and probation as well as drugs workers. Ten years ago, it would probably have just been drugs workers.

There have been lots of structural changes, central guidance on working together to safeguard children. Since the Coalition came to power, there have been a lot of initiatives and *Hidden Harm* touches on a number of popular governmental priorities. But it is never mentioned specifically or centrally which is very frustrating.

If you look at the Troubled Families initiative for example, when it began the issues it covered were very broad including substance misuse. But by the time it was whittled down to the PBR scheme it became, it was all about school attendance, getting a job and reducing anti-social behaviour. Substance misuse was relegated to an optional local extra.

The Department for Communities and Local Government have been quoted as saying that it is 'incredibly hard for families to start unravelling their problems'. Which poses the question, what is the role of recovery in all this?

We're got some funding from Alcohol Research UK for some scoping work around the idea of 'what does recovery mean for children?' The premise is that children who grow up in a family with substance misuse problems, where there is inconsistent parenting, get used to coping and can become quite resilient. They become attuned to the family dynamic that exists. Then if one or both parents are in recovery, the dynamic changes. The child may be dealing with a 'new person', somebody who is

now trying to impose boundaries and discipline, but who may also relapse. So how do children deal with this new situation? How do they understand lapse and relapse? Any change in parenting, even positive, can be very confusing for children.

How do you deal with the potential organisational tensions of focussing on child protection and development while at the same time not stigmatising parents as 'bad people'?

This piece of work helps that because we will be speaking directly to young people themselves about the lives they are leading, so that will provide the evidence base for what we want say. Organisationally, Adfam starts with the family member and their experiences, so that isn't really a tension for us. But there is a tension in the whole *Hidden Harm* agenda; family focussed treatment which addresses parenting skills is not the same as supporting children. Their needs are not necessarily in parallel and you can't assume that improvements in one will be reflected in improvement in the other. So for example, if a parent's recovery is going well, but they are struggling to regain the parenting role, that can have a detrimental impact on the child.

Supporting parents in treatment is reasonably well-developed with a variety of different programmes, but work supporting children is patchy, under-developed and under-resourced.

So what is the way forward?

It's what we've been saying for years; parental drug and alcohol use is mixed in with so many other vulnerabilities, that nothing other than a whole partnership approach will actually get it done and that needs leadership both at a national and local level. Just knowing what else is available is a basic professional training issue, but it rarely happens.

Most of the delegates at our *Hidden Harm* conference were social workers, which from our point of view was great; it is clearly a concern for social work. But the challenge remains to bring social work and drug/alcohol work together.



AN EYE ON THE CHILDREN

Joy Barlow, one of the initiators of the Hidden Harm report, on what has been learned and what remains to be done

Anniversaries are not just a remembrance of an event that happened in the past, but provide an occasion to reflect on what has happened since. On the tenth anniversary of the publication of *Hidden Harm*, we have an opportunity not only to look back at the inception of this important policy, but also at the difference it has made and what should be done to develop its future.

Hidden Harm was a seminal report from the Advisory Council of the Misuse of Drugs (ACMD) and its Prevention Working Group (PWG), of which I was a member. This group had already worked over a number of years on reports about education, drug misuse and the environment and drug-related deaths. The focus of the ACMD had up until the turn of the millennium been, quite reasonably, on the individual drug user. However, a number of us on the PWG felt the time had come to consider the needs of the children of those affected by drug use. Thus *Hidden Harm* was born.

In line with its usual practice, the PWG took oral and written evidence,

as well as carrying out literature reviews and engaging in a great deal of discussion and debate. In June 2003, the resulting report, *Hidden Harm – Responding to the Needs of the Children of Problem Drug Users*, was published. It estimated there were between 250,000 to 350,000 children of problem drug users in the UK.

The report's key messages were that parental problem drug use can and does cause serious harm to children of every age from conception to adulthood and that reducing the harm to children from parental problem drug use should become a main objective of policy and practice. It said effective treatment of the parent can have major benefits for the child and that by working together, services can take many practical steps to protect and improve the health and well-being of affected children. With its 48 recommendations, the report became a seminal work and a catalyst for necessary change in practice.

From various perspectives, things needed to change. In research terms

the UK was largely dependent on literature from the US, which, while useful, was self-evidently different in culture and often in methodology. What was evaluated in largely black or Latino projects in downtown Chicago may not have resonance in Liverpool or Dundee.

Since the publication of *Hidden Harm*, a significant amount of research has been produced in the UK into the impact of parental problem drug use on children, with suggestions on how we might intervene. Notable among these has been the work by Barnard and Barlow (though I say it myself!), Kroll and Taylor, Harbin and Murphy, Harwin and Forrester, Templeton et al, to name but a few. We have the research evidence on the impact of parental problem drug use on children, but it is of concern that there is not enough hard evidence on the efficacy of intervention.

There were structural issues, described very well by Michael Murphy as a 'gulf' between substance misuse services and the child care system. On one hand we had health and adult

oriented systems, and on the other child-focused social services systems. *Hidden Harm* called for structural bridges to be built between the two systems, so that an interface of policy and practice could be established. We have come some way towards that, but still there remain challenges to be overcome.

We also know from the work of Cleaver et al. that other psychological conditions frequently co-exist with problem drug and alcohol use, and that these can further impair a parent's capacity to parent. The child living with parents experiencing a multitude of psychological and physical problems, often with associated domestic violence, might echo the words of Claudius in *Hamlet*: "When sorrows come, they come not single spies but in battalions."

And what of children? We know from their own testimonies how horrendous life can be: keeping secrets, caring for parents, experiencing physical and emotional pain and falling foul of the justice system. Yet through it all, many would echo the words of one of the young people whom Marina Barnard and I spoke to: "For all that they did to us 'cos of the drugs, they were our mum and dad and we knew they loved us and we were scared of being separated from them and going into foster care."

With our increased knowledge and understanding and better communication, learning and development for the workforce has progressed. A worker speaking to me the other day reminded me that before *Hidden Harm* children were literally unheard of in adult service provision. This led STRADA (Scottish Training on Drugs and Alcohol) to begin its work on writing protocols to support the practice interface and on training in their implementation. One of the participants in that training, a drug squad officer, shook my hand and thanked me for helping him be a better practitioner, because now he said he knew what it was like to be both a child and a parent overwhelmed by drug use.

So how far have we come? We have a somewhat better handle on the prevalence issue, but we still need to know more about numbers, especially at the local level, so that service provision can be optimised. We do now know more about the impact on children and we have enhanced the treatment options for parents – or at least we should be doing so.

In most parts of the United Kingdom, children's concerns have become major areas of policy. In Scotland this was expressed in *Getting Our Priorities Right*,

Good Practice Guidance for Working With Children Affected by Substance Misuse, a policy document published at almost the same time as *Hidden Harm*. It provided the policy context for all that has followed, and has just been updated. We have all been trying to work in a much more collaborative and interagency fashion, realising that we do not have the answers in one agency.

Projects for parents and children together and separately have flourished, specifically in Scotland with funding from the Scottish government and other partners, administered by the Lloyds TSB Foundation for Scotland – Partnership Drugs Initiative. Across the UK we have recognised that children need space to play, talk, receive respite, and harness their inner resources of resilience. To quote a mother, now off the drugs of dependency that blighted her life and that of her children: "It's no fun being a junkie's wean."

WE NEED TO BE BETTER ABLE TO ASSESS RISK AND IMPROVE OUTCOMES FOR CHILDREN AND THEIR FAMILIES. CHILDREN CAN BE IN NEED AND AT RISK IN THE SPACE OF A FEW HOURS

Yet there is still more to do amid a time of increasingly limited resources. We need to be better able to assess risk and improve outcomes for children and their families. Children can be in need and at risk in the space of a few hours.

We need to fully understand the importance of information sharing, and not hide behind the 'cloak' of confidentiality-sharing can save a blighted life.

We can better identify ways of intervening earlier to prevent the tragedies happening. From serious case reviews into child protection concerns we know all too well what familial characteristics are profoundly detrimental to a child's wellbeing and safety. These should be supported for improvement or as professionals we should carry out our duty to act in the child's best interests when the parents cannot.

But on the brighter side, we do have ideas of what might work in interventions: a 'whole family' approach; parenting support; child-focused services; strengths-based approaches

for both parents and children; solid therapeutic relationships; and staff with not only technical competencies but also behavioural ones and emotional intelligence. However, we do require more work on the evidence of putting research into practice for current and new interventions.

On the structural and strategic side, we need strong leadership, partnership working and resources for implementation of policy and practice. Roles and responsibilities should be explicit, so no-one can say "it's not my job".

Resources may be diminishing, but that means we need to be smarter at working together. Well-supported community resources like mentors and volunteers can give children the break they deserve. A strangled cry of "we haven't got the money" will not help those who need the help most. Innovative thinking comes with straightened times.

Finally, two areas not yet mentioned. The first is alcohol, which was hardly mentioned in *Hidden Harm* because of the limited statutory responsibilities of the ACMD. However, all that was said in *Hidden Harm* on illegal drugs is applicable to alcohol. The Children's Society, Alcohol Concern, Alcohol Focus Scotland and Children First, to name but a few, have illustrated the importance of the needs of children affected by problem alcohol use.

The second area is the impact on a child of a parent's recovery from drug and alcohol problems. We need to better understand the result of this positive change on a parent's life, because some of it may not be so positive for a child. Do children know what recovery means? How does the change in the family dynamic affect them? How do they view their new status, for example from a virtual carer to being a child again? And there is always the threat of relapse, with some children waiting for it like the sword of Damocles hanging over their heads. New ways of support may well be needed.

To close, as we should, with the words of a young person, quoted in Marina Barnard's book, *Drug Addiction and The Family*: "I'll be there for my mum all the way...she's coming off drugs just to get me back...that makes me feel good 'cos I know my mum's going to go through a really, really hard time, just to get me back".

■ **Joy Barlow** is Strategic Advisor of STRADA (Scottish Training – Drugs and Alcohol)

A CRACKED MYTH

New research suggests fears that a generation of ‘crack babies’ would become create havoc on America’s welfare and criminal justice systems have been greatly exaggerated. Researchers **Maureen Black** and **Stacy Buckingham-Howes** report on their latest research into prenatal cocaine exposure.

Our recent review paper into prenatal cocaine exposure, published in the latest issue of *Pediatrics*, found that the ‘crack baby’ scare of the 1980s was a myth. Thirty years ago when scientists realised that cocaine use by pregnant women crossed into the bloodstream of the developing fetus, the fear was that cocaine-exposed babies would be born addicted to cocaine and face lifelong problems.

Cocaine-exposed babies are at increased risk for prematurity and low birth weight. But the expectations were that they would experience poor academic performance, emotional and psychological disturbances and require special educational services, becoming a major burden for the educational system, service providers and ultimately the justice system.

The resulting national panic included calls to prosecute pregnant women who used cocaine, claiming that they were maltreating their unborn fetuses to remove prenatally exposed infants from their families of origin. It was anticipated there would be unprecedented demands on the foster care system.

Adolescence is a critical time to study the long-term effects of prenatal cocaine exposure. Not only is adolescence characterised by the development of sophisticated cognitive processing skills, but it is also a time of complex social demands and exposure to opportunities to engage in risk behavior. The review, which included 27 studies involving



more than 1,300 adolescents who were prenatally exposed to cocaine and more than 1,500 non-exposed adolescents from similar backgrounds, found few differences in academic performance or behavior.

Although there are individual examples of cocaine-exposed children who have major emotional and academic problems, systematic comparisons of children who vary only on cocaine exposure did not find an increased incidence of problems among children with cocaine exposure.

In our review, we found subtle differences that may be associated with cocaine exposure. Almost two-thirds of the studies that focused on behavior and three-quarters of the studies that focused on cognitive and school performance found associations with cocaine exposure. But the differences were often too small to be meaningful. In many cases, scores in both groups could

be attributed to poverty. For example, both exposed and non-exposed groups had cognitive and school performance scores that were either deficient or at the lower end of normal limits, consistent with the negative effects of poverty on cognition and academic performance.

Prenatal cocaine exposure rarely occurs in isolation. Many children with prenatal cocaine exposure are also exposed to alcohol, tobacco and marijuana – substances that are known to adversely impact children’s development. The context of poverty, addiction, and violence that often accompany parental drug use can disrupt the consistent and responsive caregiving that children need to develop healthy relationships. Indeed we found that children exposed to alcohol, tobacco, or marijuana or raised in conditions of poverty, addiction or violence are at risk for both academic and emotional problems, often leading to their involvement in risky behavior.

However, longitudinal research conducted using rigorous scientific methods to adjust for environmental differences has shown that in spite of the multiple threats to children’s development, there are few meaningful differences in children’s behavior or cognition/school performance that can be attributed to prenatal cocaine exposure.

Children’s development is influenced by environmental interactions, beginning prenatally and continuing throughout

life. Early interactions are particularly important because brain growth is both rapid and specific during the early years. As the methods of studying brain development have become more sophisticated, researchers have begun to look 'under the skin' to understand whether there are processing differences related to prenatal cocaine exposure.

Several labs, including our own, have used functional magnetic resonance imaging (fMRI) to study brain activity. When a specific area of the brain is activated, blood flow to that area increases and oxygen is created. Because oxygenated and deoxygenated hemoglobin behave differently when pulsed with a magnetic field, this contrast in oxygen can be mapped onto consecutive 'slices' of the brain and detected by the MRI scanner.

We have used the fMRI procedure with teens with varied levels of prenatal cocaine exposure. We gave the teens tasks such as memory games to perform while in the scanner and we observed which areas of their brains were activated. Although many of the neuroimaging studies included in our review reported differences in brain structure and function between exposure groups, the differences rarely translated to performance differences. The next step is to link activation patterns to behavioral or cognitive performance.

In experimental situations, we examined whether adolescents' response to stress (like having to give a talk in front of an audience or playing a game that is impossible to win) varies based on prenatal cocaine exposure. The hypothalamic-pituitary-adrenal (HPA) axis coordinates the response to stress through multiple mechanisms resulting in the release of cortisol. Under normal conditions, the expected diurnal pattern of cortisol release is temporarily disrupted in response to stress. It appears that children who have been prenatally drug exposed either have blunted responses to stress – their physiological response does not happen – or their physiological response is in overdrive – does not return to normal.

Regulation of cortisol is important for the development of emotion, learning, memory, attention, and impulse control. In our review, studies examining physiological responses did not yield consistent findings. However, each study demonstrated an altered response to stress among the prenatally cocaine exposed group. Again, the differences between the exposed and non-exposed groups were small. Research is currently

underway to better understand how prenatal cocaine exposure relates to children's behavior and cognition and their response to stress.

There are several areas to direct future research efforts in order to enhance our understanding of the development of people prenatally exposed to cocaine. First, neuroimaging is a promising area of research. The next steps would include relating structural differences to behavioral differences and model replication. Second, mechanisms should be examined to determine if there are indirect relationships linking prenatal cocaine exposure with adolescent behavior and cognitive/academic performance. Third, although many of the subtle differences found between cocaine and non-cocaine exposed youth are within the normal limits of development, it is unclear if they are associated with the increasing responsibilities and decision making skills expected of older adolescents.

THE FINDINGS OFTEN POINT TO SMALL AND SUBTLE DIFFERENCES IN BEHAVIOR AND COGNITIVE FUNCTIONING. BUT WHAT IS FAR MORE EVIDENT ARE THE PERVASIVE EFFECTS OF POVERTY, REGARDLESS OF PRENATAL COCAINE EXPOSURE

Finally, researchers have looked into the physical and social environment of cocaine exposed youth, but have paid relatively little attention to parental relationships beyond the preschool years. Early in life, supportive parent-child relationships can mitigate the effects of prenatal cocaine exposure on child functioning.

There are several possibilities for intervention with families of prenatally cocaine exposed youths. When women with addiction problems become pregnant, threatening to prosecute them for abuse or neglect or threatening to remove their children may be counterproductive and increase the likelihood that women will refuse prenatal care or help with their addiction.

In contrast, offering services to deal with addiction and with other problems, such as domestic violence, and getting

access to good food, housing, medical care, child care and job training, may reduce the likelihood that the infant is born prematurely or with low birth weight and exposed to a lifetime of stress associated with maternal drug use. After cocaine exposed babies are born, mothers and other family members may benefit from addiction services, training in responsive parenting, and access to early intervention services and childcare.

The field of prenatal cocaine exposure has advanced significantly since the 'crack baby' scare of 30 years ago. Not only are researchers using more rigorous methods by controlling for exposure to other prenatal substances and the external environment, but assessments of brain imaging and physiological processes, such as children's response to stress, are employed to understand the mechanisms linking prenatal cocaine exposure with behavioral and cognitive functioning.

As the children in longitudinal research cohorts have reached adolescence, the findings often point to small and subtle differences in behavior and cognitive functioning that can be attributed to prenatal cocaine exposure. But what is far more evident are the pervasive effects of poverty on adolescent cognitive and academic performance, regardless of prenatal cocaine exposure.

Children recruited into longitudinal studies of prenatal cocaine exposure in the 1990s are now approaching adulthood. Little is known about how prenatal cocaine exposure impacts their ability to accomplish the developmental tasks of adulthood, such as employment, financial independence, interpersonal relationships, raising a family and responsible citizenry. Conducting follow-up studies of adults who were prenatally exposed to cocaine to examine not only their current level of functioning, but also the mechanisms underlying their functioning, will contribute to our understanding of children's resilience to prenatal cocaine and possibly to other early exposures to stress.

■ **Maureen Black** PhD is a professor in the Department of Pediatrics and the Department of Epidemiology and Public Health at the University of Maryland School of Medicine.

Stacy Buckingham-Howes PhD is a post-doctoral fellow in the Department of Pediatrics at the University of Maryland School of Medicine. Their work was supported by grants from the National Institute on Drug Abuse.

ACE in the hole

The ground-breaking Adverse Childhood Experience (ACE) study demonstrated a clear correlation between childhood trauma (including parental substance misuse) and later ill-health – not least addiction. By Harry Shapiro

It all began in the 1980s in San Diego with the Permanente Medical Group's twenty week Positive Choice Weight Loss Program, treating men and women most of whom weighed at least twenty stone. The programme used a pretty extreme technique called supplement absolute fasting where the person consumes nothing during that period other than water and a nutritional supplement called Optifast. Those who stuck to the programme shed significant amounts of weights. Yet, much to bafflement of those running the programme, they were also the ones most likely to drop out. Why?

A detailed exploration of the life histories of around 300 drop-out patients was undertaken; the striking finding was that most people had grown up in dysfunctional households, and moreover, been subject to childhood sexual abuse. The clinicians concluded that for these people, over-eating was an attempt to find a solution to dark secrets which remained hidden by shame, guilt and social taboos. The indulgence in 'comfort food' is well named, but by the same token, 'it's hard to get enough of something that almost works' was actually painted on the wall where the weight loss programme was conducted. In other words, maybe the next bar of chocolate or doughnut will do it.

The research team led by Dr Vincent Felitti, then wondered if the same search for comfort to self-medicate childhood trauma, could be found in those with drink, drugs and smoking problems

and could such trauma also increase the likelihood of a range of other mental and physical diseases?. After all, drinking and smoking is associated with relaxation and reducing anxiety and you could interpret the action of 'having a fix' as an attempt to repair something that's broken. So was born the Adverse Childhood Experience (ACE) study which began in 1995 and is still running.

The 17,000 strong cohort was selected from patients who attended the Kaiser Permanente private healthcare facility in San Diego. They were middle class with fully paid up health insurance, an average age of 57, most had been to college and 80% were white.

The research team designed a simple questionnaire which asked the patients if they had any childhood experiences of the following – and the response levels are indicated in brackets:

- Recurrent and severe physical abuse (11%)
- Recurrent and severe emotional abuse (11%)
- Contact sexual abuse (22%)
- Growing up in a household with:
 - An alcoholic or drug user (25%)
 - A member of the family being imprisoned (3%)
 - A mentally ill, chronically depressed or institutionalised member (19%)
 - The mother being treated violently (12%)
 - Neither biological parent present (22%)

Emotional neglect was studied in a second wave of the study.

A simple scoring system was devised; for every 'yes' answer, the patient scored 1 point irrespective of how many times the adverse event (e.g sexual contact) occurred. The results were startling and unambiguous; for all the physical and mental diseases that accounted for patient presentation from addictions to depression and heart disease, there was a direct correlation with the scores logged. So taking adult alcoholism as an example, just over 2% of those with a score of 0 had become alcoholics compared to 16% for those scoring 4 or more. For smoking there was a 250% increase in the likelihood that somebody scoring 6 would be a smoker and if as a child you could score 6, there was a 46 fold increase in the chance of you becoming an injecting drug user.

The results shed possible new light on one of the most famous studies into the nature of addiction, conducted by Lee Robins of returning Vietnam soldiers in the mid 1970s. It was well-known that many soldiers out in the war zone were using heroin and there was great concern that treatment services would be overwhelmed by returning heroin addicts. However, Robins discovered that after 10 months back home, only 5% of the study group were still using. For the first time, this blew apart the standard medical and public belief that 'once an addict always an addict', suggesting that even chronic drug use could be linked



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entirely to traumatic experience which can be overcome once the fear no longer exists. The ACE study results suggested another possibility; that the 5% who were still using might have scored highly on the ACE questionnaire compared to the others.

In one of the many papers to come out of the ACE study, Dr Felitti wrote that the results of the study strongly indicate that most theories of addiction should be side-lined in favour of “one that explains it in terms of its psychodynamics; unconscious although understandable decisions being made to seek chemical relief from the on-going effects of old trauma, often at the cost of accepting future health risk. Expressions like ‘self-destructive behaviour’ are misleading and should be dropped because, while describing the acceptance of long-term risk, they overlook the importance of the obvious short-term benefits that drive the use of these substances.”

These findings could easily be used as a platform for anti-stigma work. Some years ago, Barnado’s produced a controversial poster depicting a baby with a syringe sticking in its arm. The charity was criticised for sensationalism, but in light of the ACE study, they might have had a point and one could see how addiction could be framed in the light of childhood trauma.

While there has been plenty of intellectual interest in the findings (invitations to present the world over), the team have found it much harder to

encourage practitioners to incorporate them into clinical action. Dr Felitti told *Druglink*, ‘we heard all the excuses like, ‘there’s no time to ask all those questions’; ‘you can’t ask questions like that, patients will be furious and they won’t tell you the truth anyway’; ‘if I’d wanted to be a shrink, that’s what I would have done’. And of course, doctors weren’t sure what to do with the information once it had been revealed. And the answer to that is – it depends. It can be hugely beneficial for people to have a major release from the unconscious stress that affects their life often very profoundly. They can share the worst secret of their lives and still not be judged. What often determines visits to the doctor is not just illness, it’s fear of illness’.

And the ACE team were able to demonstrate this in a very practical sense conducting a prospective study, looking at what happened to people having revealed what was previously hidden. There was a 35% drop in doctor visits and an 11% drop in A&E hospital visits a year after the evaluation. In the words of an old BT advert, ‘It’s good to talk’.

Since 1998, trauma-oriented questions were incorporated into the routine health appraisal carried out at Kaiser Permanente. Once the routine medical testing has been completed, along with a questionnaire that the patient had filled out at home – they would then be seen by an examiner who had all the notes in

front of them and would know how to move from initial niceties to discussing the difficult questions. Dr Felitti says that in only a few months, the staff became effective askers and listeners to the many patients who were only too willing to have somebody listen sympathetically to stories of childhood trauma.

Dr Felitti concluded in his paper, “the evidence supporting our conclusions about the basic cause of addiction is powerful and its implications are daunting. The prevalence of adverse childhood experiences and their long-term effects are clearly a major determinant of the health and social well-being of the nation. This is true whether looked at from the standpoint of social costs, the economics of health care, the quality of human existence, the focus of medical treatment or the effects of public policy.”

But the findings were not necessarily welcomed – and not just from a practical point of view – as they support, ‘old psychoanalytic views especially Freud [emphasis added] and is at odds with current concepts, including those of biological psychiatry, drug treatment programs and drug-eradication programs. Our findings are disturbing to some because they imply that the basic causes of addiction lie within us and the way we treat each other, not in drug dealers or dangerous chemicals. They suggest that billions of dollars have been spent everywhere except where the answer is to be found”.

NEW AGE AUSTERITY HIGHS

In the 1980s heroin use rocketed alongside spiralling deprivation. So why, now we have returned to an era of austerity, is heroin use falling?

Steve Wakeman and Toby Seddon have some answers.

Thirty years ago, in the early 1980s, the social and political outlook in Britain was bleak: economic recession, public spending cuts, youth unemployment and inner-city disorder. Making a bad situation worse – most notably in the post-industrial cities of the North and Scotland such as Liverpool, Manchester and Glasgow – arrived cheap, brown heroin. It spread like wildfire amongst young people in the most deprived neighbourhoods. Many commentators claimed this heroin ‘epidemic’ to be a symptom of the country’s wider socio-economic malaise.

Rather depressingly, much of this is familiar today in the austere climate that

has followed the global financial and banking crisis, with deep cuts in public services, a flat-lining economy and the 2011 riots all echoing the troubled times of three decades ago. However, there is a curious exception here: heroin. Contrary to the expectations of many, according to NTA’s statistics, the number of heroin users, far from exploding, appears to be falling, as is the use of crack. The accepted wisdom that there are strong connections between drug problems and deprivation suddenly no longer seems quite so secure.

Faced with this puzzle, we have been attempting to re-evaluate the use of heroin in today’s ‘austerity Britain’ through an ongoing ethnographic research project on a housing estate in North West England. And, we have made several small but significant observations that provide some clues as to what might be going on. We focus here on one of these emerging findings: the sharp rise in the use of two prescription-only painkillers, pregabalin and gabapentin.

As anticonvulsants, these drugs are primarily used to treat neuropathic pain,

but like most pharmaceuticals they have multiple uses. While robust and reliable national data regarding prevalence of their use in heroin-using communities is non-existent at present, in the locale of our research we have observed it to be commonplace, with considerable demand developing for these drugs.

Recently, whilst waiting for a heroin dealer to arrive, ‘Ryan’ (a long-term heroin and crack user in his early forties) explained the current situation:

Ryan: People can’t get them [pregabalin] as much as they’d like to really. I can, but I keep that quiet, you know? If everyone gets on them they’ll [the doctors] stop giving them out. It’s like there’s more demand than supply just now.

SW: So how much do they sell for then?

Ryan: Depends on the tab, the 60mg ones not much, they’re not that good, you need quite a bit of it you see, but the 150mg ones, they’re like a quid a pill or something like that, you can do alright with them if you’ve got loads.

This particular individual was prescribed pregabalin as a result of pain caused by methadone withdrawal, but



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he has subsequently started sourcing them from elsewhere too (mainly from a non-heroin-using amputee prescribed pregabalin for 'phantom' pains in an amputated leg).

Despite his claim to be 'keeping things quiet', we have witnessed the use and sale of these two drugs spread across the whole heroin-using population on this estate. They have quickly become established components of the drug market here, especially pregabalin, and this – in our estimation at least – might represent a significant development regarding the real nature of reported falls in heroin use.

As we will explain, it is possible that the use of drugs like pregabalin is affecting the recorded rates of heroin use. Our interviews and observations suggest this drug has been adopted so feverishly because of its 'dual utility'. Pregabalin *enhances* the desired effects of heroin in that it helps the user 'gouge out', but it also has the capacity to *reduce* the undesirable effects of withdrawal symptoms too. That is, for the heroin users we have been spending time with, pregabalin maximises pleasure and minimises pain *concomitantly*. Illustrating this, 'Anton' (a male heroin user in his early thirties) gave the following response to a question about the effects of pregabalin:

They do the job, they smash me right in. On top of a smoke [of heroin] like, they're like being pissed, except you know what you're doing and that.

However, during a subsequent meeting whilst he was attempting to withdraw from heroin (again), he was still consuming pregabalin (in large quantities too). When asked about whether or not this 'worked', he responded:

It's not perfect, but nothing's ever going to be is it? It does do the trick though in a way, it deffo helps, like really helps you know? One of the main things for people is the cramps and twitching legs and that, and it really helps with them, but also with sleep, I'd say that's the main thing for me, it lets me sleep – if I take enough of them that is.

So pregabalin has attractive qualities on two fronts; this is not simply a matter of pleasure seeking, or pain-avoidance, but *both at the same time*. Whilst pregabalin is not the cheapest black-market pharmaceutical in circulation, it is not the most expensive either, and it has become highly sought after in this area – a regular supply like Ryan's is something to be coveted. It is clear that developments such as this – as marginal as they may be at present – have implications for the ways in which local

drug markets are structured, and in turn, for what we know about them and the levels of drug use they contain.

Despite national estimates indicating a decline in 'problem drug use', our research suggests there may be more going on here than first meets the eye. Based on our observations, there is a case for considering the role of substances like pregabalin in the reported falls in heroin use, especially because of its dual functionality for users. The use of pregabalin to enhance the effects of heroin means one requires less heroin to maintain a habit.

FAILING TO MONITOR NEW PATTERNS OF DRUG TAKING BEHAVIOUR DOES NOT MEAN THEY DO NOT EXIST

But this does not necessarily equate to less problematic drug use. At the same time, on a number of occasions we have witnessed heroin users utilising pregabalin's opposite capacity by detoxing themselves at home with an illicitly sourced supply. We leave aside the question of whether or not this 'works'. What is critical here is that this behaviour can preclude a user's contact with treatment agencies and as a result, their appearance in treatment data. We certainly acknowledge this is speculative at the moment, but if similar shifts are happening elsewhere then a potential distortion of national drug trend data becomes conceivable at the very least.

In other words, what appears to be a *decline* may actually be a more complex process of *diversification*. And, given the fact that there are currently no accurate quantitative measures of this diversifying picture, we have no way of knowing whether drug markets as a whole are growing or shrinking. All we can say is that our own qualitative observations actually run counter to the quantitative measures we do have. If we also consider the fast-moving market in 'legal highs', only some of which are on the policy and monitoring radars, then reports of a shrinking drug problem seem less than convincing. It may be more plausible to suggest that our monitoring systems are simply falling behind rapidly evolving drug markets.

Our findings resonate strongly with earlier studies on the 1980s heroin epidemic, *Living with Heroin* and *The New Heroin Users*.^{1,2} We have found heroin to be an important commodity within the informal economy on this estate (an economy that is flourishing in these

times of economic hardship). However, our project reveals more complex intersections between *illicit* drugs proper and various pharmaceutical drugs that are being used and sold *illicitly*, than those that went before it.

This presents an obvious challenge for conventional approaches to policing and law enforcement, which are predicated on more clear-cut divisions between legal and illegal commodities. There may also be implications for health. The problems associated with the illicit use of benzodiazepines and other similar drugs are well documented; it is possible that what we are looking at with pregabalin is the start of something similar. On a number of occasions users have expressed to us their belief in the 'harmlessness' of pregabalin due to it being 'non-opiate'. Whilst it is true that it is not an opiate-based substance, we are less convinced it is necessarily harmless, particularly when used in the quantities we observed and alongside other substances. From a public health perspective, this has the potential to be problematic.

What are we to make, then, of this emerging picture of heroin in austerity Britain? It seems to us, first of all, that politicians (and others) have been far too hasty in celebrating drug policy 'successes': failing to monitor new patterns of drug taking behaviour does not mean they do not exist. We would suggest that any complacency now would be ill-judged and irresponsible – David Cameron's assertion in December 2012 that "we have a drug policy that is actually working, drug use is coming down" may be more like political wishful thinking than it is an evidence-based fact.

Announcements of the death of the drugs-deprivation link may also be premature. Our research suggests that illegal substances remain important commodities circulating within the 'shadow' economies that thrive in the most disadvantaged neighbourhoods, and that they grow in stature and appeal in close correlation with the decline of legitimate economic opportunities. What is now urgently needed is further ethnographic research in areas such as this to build our understandings of their rapidly evolving local drug markets. Only then will we be able to develop policies and services that can fix today's problems rather than yesterday's.

■ **Steve Wakeman** is a criminology PhD candidate. **Toby Seddon** is Professor in the School of Law at the University of Manchester

The treatment matrix

A new, all-encompassing database gives practitioners and commissioners unprecedented power to pinpoint key areas of best practice in the drug and alcohol field.

Mike Ashton reveals its secrets.

In some ways a child of the now deceased library of the Institute for the Study of Drug Dependence (ISDD) – one of the two agencies which merged to form DrugScope – the Matrices fill a gap in evidence base resources so obvious that you may wonder why it was left unfilled until May this year.

Since 1997 *Drug and Alcohol Findings* has made 'what works' research accessible and understandable to UK

practitioners, so they can use it to substantiate and improve their practice. Additions to its in-house library – at 17,000 documents, now the largest live drug and alcohol library in Britain – feed the growing Effectiveness Bank database holding over 900 analyses. New deposits in the bank are brought to subscribers' attention via a mailing list and DrugScope's daily news service.

That service answers one need – to

bring research to practitioners – but at the same time poses another: from all these riches, can we somehow identify the major documents practitioners in Britain should read even if they read nothing else?

In relation to adult treatment, just such a discussion took place in a subgroup of the Substance Misuse Skills Consortium, the sector-led partnership that aims to develop the substance

misuse treatment workforce in England. Drug and Alcohol Findings participated and undertook to complete the task, the plan for which included one fundamental innovation.

Before listing important documents, a map would be created of the evidence base universe in relation to treatment and allied topics. It would be divided in to territories that reflect logical and practical divisions in the delivery and organisation of services and in the roles of practitioners, regardless of whether there were any documents worth signposting within each division. Only then would a search be conducted for documents to fill the gaps. Some territories would have only rarely and partially been explored, others are relatively well mapped. As well as signposting the achievements, the exercise would expose the gaps in the evidence base.

Findings had already constructed a matrix for the consortium which mapped the treatment evidence base, though for a different purpose. Funded via the National Treatment Agency for Substance Misuse, *Findings* undertook to develop this framework into matrices presenting the most important documents and resources for treatment practitioners and commissioners concerned to understand the evidential basis for their work and to implement its most important lessons.

The level of ambition involved can hardly be overestimated. Despite the obvious need, no agency, no matter how well funded or how expertly staffed, from multi-million dollar US government institutions to the UN's World Health Organization, had attempted such a project.

In Britain it could only be envisaged within a reasonable time frame and limited resources because for the past 16 years, *Drug and Alcohol Findings* had been monitoring and collecting evaluation research, assessing the studies, and selecting and analysing those of greatest relevance to the UK. Along the way, seminal research had been identified and analysed in its own right (the Old Gold series in the *Findings* magazine – see <http://tinyurl.com/EfB-cdl-6>) and as the backdrop to understanding more recent work. Reviews were collected and read to help understand the significance of each individual study and guidance documents to help make sense of what they might mean for the UK. On this foundation could rapidly be constructed this ambitious superstructure.

In May this year the result was the Matrices, one for harm reduction

and treatment of problems related to the use of illegal drugs, another for brief interventions and treatment of alcohol-related problems. The best way to envisage them is of course to go see. Across the top are five columns, moving from the intervention itself – is it feasible? does it work? how does it work? – out to the contexts within which interventions are implemented: by practitioners, who are managed, work in organisations, which coalesce in to whole treatment systems, all of which affect the treatment's feasibility and impacts, contexts variously of greatest interest to front-line staff, supervisors and managers, management committees, and commissioners.

INSTEAD OF SIMPLY LISTING IMPORTANT DOCUMENTS, A MAP WOULD BE CREATED OF THE EVIDENCE BASE UNIVERSE IN RELATION TO TREATMENT AND ALLIED TOPICS

Intersecting the contexts, down the side are five rows. Choose whether your interest is harm reduction (drugs only), brief interventions (alcohol only), cross-cutting treatment issues, medical treatments, psychosocial therapies, or criminal justice work.

For both drugs and alcohol, the result is a 5x5 grid totalling 25 cells. Within each cell are the major historical and contemporary research landmarks in that territory, reviews offering a panoramic view, expert guidance based on this research, and an option to yourself explore beyond these dozen or so selected documents by searching the Effectiveness Bank. Each document entry can be clicked on to access the original document either directly or via the Effectiveness Bank's analysis of the study.

Arrangements have been made to update the Matrices on an annual basis, piggybacking on the work Drug and Alcohol Findings continues to do to identify and analyse documents for the Effectiveness Bank.

What can you do with the Matrices? As a manager, they list the documents you could advise new staff to read to help them understand the basis

for addiction treatment, commend to existing staff to advance their professional development, and you too could interrogate for practice-improvement clues from the world's leading researchers. They will help practitioners understand the most important foundations of their work and how to build on those, and help commissioners appreciate the different ways they can influence effectiveness. Familiarity with these relatively few documents could be seen as an indicator of an important dimension of the quality of an organisation and its staff – an appreciation of the key evidence on which practice has been built and can be improved.

■ **Mike Ashton** (editor@findings.org.uk) editor of Drug and Alcohol Findings (<http://findings.org.uk>), a national UK collaborative project involving the National Addiction Centre, DrugScope and Alcohol Concern. Supported by Alcohol Research UK and the J Paul Getty Jr Charitable Trust. Thanks for their involvement and support to the Substance Misuse Skills Consortium, co-owner of the Matrices, and to the National Treatment Agency for Substance Misuse which funded the initial work.

Find the Drug Matrix at: <http://tinyurl.com/EfB-cdl/download.php?file=dmatrix.htm>
the Alcohol Matrix at: <http://tinyurl.com/EfB-cdl/download.php?file=amatrix.htm>

Thanks to Lifeline's FEAD video bank web site (<http://www.fead.org.uk>) you can see and hear the Matrices' developer explaining their genesis and construction at: <http://www.fead.org.uk/video618/Mike-Ashton:-'The-DoDo-Bird-Effect'-overview---from-the-Editor-of-Drug-and-Alcohol-Findings.html>

An updated version of the presentation's slides is available at: http://tinyurl.com/EfB-cdl/download.php?file=Chafetz_ME_1_presentation.pdf

This drills down to one study in one cell of the Alcohol Matrix – a seminal study from the 1950s which demonstrates that such work still has considerable current relevance.

VAPOR TRIALS

The booming e-cigarette trade has thrown down the gauntlet to the tobacco industry. Yet if the new, safer smokes are classed as a medicine, the battle could be over before it even begins.

By Clive Bates

The World Health Organisation estimates that on current trends one billion people will die prematurely from diseases arising from smoking tobacco. For every death there is also a burden of illness, poor health and wellbeing and various impacts on non-users through passive smoking.

The tobacco business is a powerful, stable oligopoly striding the globe. The six largest firms had revenues of \$350 billion and profits of £35 billion (2010). However, the basic product of this industry, six trillion cigarettes annually, has not changed that much in 50 years. But that is all about to change.

If smoking is so harmful, why do people do it? It's an often-denied fact, but nicotine, like any drug, provides functional benefits to the user. In fact is a 'good drug' in many respects: it provides a calming of mood, relief from anxiety and it can improve concentration and cognitive abilities. It is thought to provide relief to some psychotic symptoms. It is also widely understood to be 'addictive' for some users, as characterised by withdrawal symptoms and the early morning imperative to smoke.

Drugs do not become addictive unless they provide rewards – and nicotine definitely does. Nicotine use is fuelled by behavioural ritual and its association with cues and particular moments that

punctuate the day. Nicotine has other 'positive' characteristics for the user: it does not cause intoxication, because users control their intake and start to feel nauseous if they take too much. The development of tolerance and need for ever greater doses is limited.

Nicotine itself is wrongly maligned as the dangerous agent in tobacco, yet it isn't really harmful at all. Nicotine is relatively benign, with a risk profile analogous to caffeine. It is often said that people 'smoke for the nicotine but die from the smoke'. And this is right: it is the mix of smouldering particles of tobacco and the hot toxic gases and vapours drawn deeply into the lungs that does the damage.

E-cigarettes have the potential to create a decisive change in the trade-offs facing smokers. They allow the user to retain the benefits of nicotine use, and provide much more effective delivery than nicotine replacement therapy (NRT) products. They mimic closely the behavioural aspects of smoking. They remove practically all the long and short term health and other negative impacts, and cost less. They have negligible impact on surrounding people. Moreover, they allow a user to move away from the dangers of smoke inhalation without suffering cravings and withdrawal, and with no great personal effort.

It is this dramatic change in the choices now facing smokers that make e-cigarettes a disruptive technology. The investment bank Goldman Sachs regards e-cigarettes as one of eight significantly disruptive technologies, and a leading analyst at Wells Fargo Securities, Bonnie Herzog, is forecasting that e-cigarettes will overtake cigarette use in the United States with a decade. If that happened and became a global trend it would be a wrenching disruption of the cigarette-based business model of the tobacco industry, and it would make dramatic inroads into avoiding the one billion deaths forecast by WHO on current trends.

But are e-cigarettes safe? No-one is claiming they are 100 per cent safe – very little is. But a common-sense consideration of what is in them and how they work should tell us they will be very much safer than cigarettes themselves. They contain three main ingredients: nicotine, flavouring and an excipient to create vapour when heated, typically pharmaceutical-grade propylene glycol or glycerol.

The ingredients are vaporised at relatively low temperature rather than burnt, so there are no new products of combustion. By contrast, tobacco is a complex organic material with toxic substances formed during growing,

curing and then as products of combustion. The physics and chemistry of e-cigarettes mean that it is common sense that they will be much lower risk. This is backed by studies showing many tobacco toxins are not present at detectable levels. The few that are present, are at levels many times lower than in cigarette smoke. It is possible that prolonged exposure will cause irritation or that some flavourings might be harmful, but the total risk is likely to be around 99 per cent lower than smoking. Obviously, we can't know the long term effects until the long term has passed, but everything about the products suggests it is far less harmful.

Some health activists claim that e-cigarettes are unregulated. While it is true that at present there are no specific regulations covering e-cigarettes, it is not true that they are unregulated. They fall within the scope of 17 European directives, regulations and decisions that apply to all products. These cover general safety obligations, pan-European safety and defect notification, electrical safety, packaging and labelling of hazardous substances, weights and measures and fair commercial practices. Together these could be purposefully applied and enforced to remove defective or unsafe products from the market, apply a range of safeguards and to prevent false or misleading claims.

The European Commission, several governments including the UK, the pharmaceutical industry and many health campaigners want e-cigarettes to be classified and regulated as medicines. This would be done through a revision to the EU directive on the manufacturing, presentation and sale of tobacco products currently under consideration by the European institutions. Article 18 of the proposal would apply the medicines directive 2001/83/EC to e-cigarettes above a very low threshold of nicotine content.

Regulating e-cigarettes as medicines would mean that only products that had been granted a marketing authorisation by a medicines regulator would be allowed on the market. To achieve that, they would have to prove the safety, quality and efficacy of the products to standards determined in medicines regulation. This is an audacious bid for control of the emerging new nicotine market by medicines regulators and their allies in the prohibitionist wing of the health lobby.

There are five main objections to regulating these products as medicines. Firstly, these products are not medicines, they compete with cigarettes. E-cigarettes are not for treating or

preventing disease or for any other therapeutic purpose. They are not sold as medicines and the people buying them do not regard themselves as in treatment. They are legal lifestyle drugs like cigarettes, alcohol or caffeinated drinks. Medicines regulation will require pharmacokinetic testing and establishing a system of pharmacovigilance – neither is necessary and neither required of the cigarette manufacturers. There is a further fundamental difference – medicines require prior authorisation to be placed on the market – cigarettes do not. There is no sense at all in allowing regulation to tilt the playing field in favour of cigarettes, providing *de facto* protection from competition. The likely effect of medicines regulation is legal challenges – there have already been four successful cases – so it doesn't even provide legal certainty.

THIS IS AN AUDACIOUS BID FOR CONTROL OF THE EMERGING NEW NICOTINE MARKET BY MEDICINES REGULATORS AND THEIR ALLIES IN THE PROHIBITIONIST WING OF THE HEALTH LOBBY

Second, it will dramatically limit the choice of products on the market. The UK regulator says that no products currently on the UK market would meet its standards. Yet they have been used by 1.3 millions users, many very satisfied, and there is nothing wrong in practice with these products – they just don't meet arbitrary and unnecessary standards. Many firms produce several hundred flavours and strength combinations. Each would require a lengthy and expensive marketing authorisation process. That simply will not happen. Good products will be banned *de facto* simply because it will not be affordable to go through the licensing process.

Third, regulatory burdens slow innovation. Pharmaceutical innovation involves spending years on drug discovery and then exploiting a patent-protected market for 10-15 years. The innovation model in fast moving consumer goods is very different, more like the short product cycles seen in the personal technology market. Expensive, burdensome and slow authorisation regimes work against this, even if they work for pharmaceuticals.

Fourth, complete reconstruction of the supply chain will be required. Medicines regulation requires that manufacturing and distribution comply with an exacting quality standard known as Good Manufacturing Practice (GMP), which requires pharmaceutical grade facilities, automation, process controls and qualified staff. The existing facilities, many based in China, do not meet these standards and will probably never comply. Nor do they need to – we should recall that the vast majority of recreational nicotine is delivered through toxic smoke at present. There is an acceptable standard between this and pharmaceutical standards. The current companies would have to rebuild their supply chains from scratch. Few have the deep pockets necessary to make the investments and incur financial strain while this overhaul takes place.

And finally, retail access will be limited. This is not so much of a problem in the UK, but in the other major countries in the EU, sales of medicines are restricted to pharmacies or other specialised settings. This not only means users can't access e-cigarettes when and where they want them, but that tobacco retailers will lose revenue as pharmacies gain, creating a negative political lobby against e-cigarettes. Again, it makes no sense to have regulation that makes cigarettes more available than safer alternatives.

The overall effect of medical regulation will not be to raise standards, but to cause an abrupt restructuring that will drive out most of the existing firms. From the users' perspective it will have the effect of banning products they are already using as alternatives to cigarettes. Medicines regulation will force the industry towards a small number of large players, primarily from the tobacco companies, selling a narrow range of more expensive commoditised products in fewer places.

The whole philosophy of tobacco policy is grounded in control – it even goes by the name of 'tobacco control'. The instinct is to control the products that exist and close the door as far as possible to new products. That is an out-dated mind-set. We have products that are many times less harmful than smoking that are good substitutes offering comparable experience. We should be actively encouraging them, not choking them in red tape for no good reason.

■ **Clive Bates** is head of Counterfactual, a public interest consulting and advocacy practice

A noxious business

When teenager Sophie smoked a legal brand of synthetic cannabis she expected to get high. But it turned out to be a nasty experience that the sellers and websites promoting the brand refused to acknowledge.

During the college holidays when I was 17, my boyfriend and I took some Bubblegum Kush – a synthetic cannabis which is completely legal. I had tried the same product before and we had experienced no negative effects. It was just like cannabis but stronger and faster acting. However, the most recent time I used it, the effects were very different.

One morning we had nothing to do so we decided to smoke some using a bong. As soon as I took it I knew it didn't feel like the last time. I was sick. I remember having my head over a bag trying to get the stuff out of my system. My heart felt like it was speeding up. My boyfriend felt my heart and told me it was going at about 300bpm. I could feel this beat all around my body and a pulsing in my head. I tried to focus on the TV but it was too difficult. All I could concentrate on was how my body was feeling. I was shaking all over, my hands, legs and even my head was shaking.

I kept being handed water and told to drink but I could barely hold the cup and bring it to my mouth. All my movements were slow and I had to focus so much just to reach out my hand. My head felt heavy and I also felt really hot. The worst thing was having this overwhelming urge to close my eyes and sleep, but being convinced that if I closed them I would die. I remember picturing articles in newspapers with headlines like 'Legal high girl dies'. Apparently I was extremely pale and "looked like death". I kept saying that I would be all right as I didn't want my boyfriend to worry, although I know this was stupid. He remembers that my voice was very quiet and my speech really slow.

He was just about to call the ambulance when I began to feel better.



THE WORST THING WAS HAVING THIS OVERWHELMING URGE TO CLOSE MY EYES AND SLEEP, BUT BEING CONVINCED THAT IF I CLOSED THEM I WOULD DIE

I think the whole scenario lasted only about 15 minutes, but it felt like much longer. Although my boyfriend had took the same kush (just a tiny bit less) he did not have a reaction anywhere near like mine, although he said that he didn't like the feeling he got. One of my friends had an even worse time than me, with another legal synthetic cannabis called Evolutions (now banned). They had a terrible experience including hallucinations, sweats and vomiting.

I felt I had a duty to report what had happened to Red Eye, the head shop in Brighton where I had bought it, so that they could remove it from sale or at

least warn people when they buy it. As I began to explain what had happened, the man interrupted saying that I had misused the product and that it was a "novelty collectors item". It is true that on the packaging it says "not for human consumption", but I know this is complete rubbish: people buy them to get high.

I noticed that the online reviews scored Bubblegum Kush very high. After having the bad experience both my boyfriend and I wrote negative, one star reviews for it, stating that it was dangerous. These reviews were sent for moderation but months later they are still not up on the site.

I feel that these products should not be sold. The people working at the shop where I bought it know full well what people do with the products, but they just churn out pre-prepared phrases to cover themselves. They are happy to take people's money and defend themselves as an honest business, but there are not taking any responsibility and have no interest in the safety of their customers. And I'm pretty sure this is not the only one.

Before I took Bubblegum Kush, I very naively assumed that as it was legal, it was safe. But now I realise that it is only legal because it is yet to be made illegal. Ever since I was in year 6 (aged 11), I have heard horror stories by speakers coming into my school about illegal drugs. But I had never been informed about the dangers of legal highs. I think that had I been warned and informed about legal highs, I could have made an educated decision when I took them, and I may well have decided not to.

I know I will never take any legal highs ever again and I have urged all my friends to never touch them.

This survey, conducted by DrugScope on behalf of the Recovery Partnership, aims to take a snapshot of the current conditions for and adaptation of the drug and alcohol treatment sector in England. The survey will help establish a narrative of change in the sector – both for services, and the people who use them.

The survey is primarily for local managers although anyone can participate if they are able to provide information about an individual service, and ideally we would welcome just one response per project or service. We are keen to hear from providers from both the National Health Service and Voluntary and Community Sector. This survey is aimed at residential and adult community services; the Recovery Partnership is planning separate research focused on other sectors, including young people's and prison-based services.

Following the initial online survey, we will be contacting some agencies for short telephone interviews to gain more detailed information in response to the questions here – the survey asks whether or not you agree to take part in a telephone interview. The results will inform the priorities of DrugScope and the Recovery Partnership over the coming year.

In the final part of the survey we ask for your contact details, which will be kept completely confidential to DrugScope. We intend to publish a report in late 2013 exploring the findings of this research, but no services will be named or identified: at the end of the survey you will be asked to choose the level of anonymity for your responses: completely anonymous, by Public Health England region, or by local authority.

This survey consists of 46 questions and we estimate it should take around 15–20 minutes to complete. Your contribution will be invaluable in helping us to build an accurate picture of the 'state of the sector' to enable us to provide an informed voice for the sector and to influence policy.

THE STATE OF THE SECTOR SURVEY

[GO TO ONLINE SURVEY](#)



If you have any comments, queries or would like to discuss the survey before you take part, please contact:
Charley Stamp
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BROKEN DREAMS

Between 2004 and 2009, 1.5m people from Eastern Europe came to Britain looking for a better life. But for some, the adventure has ended in unemployment and addiction. Meanwhile, hard hit services brace themselves for a new wave of migrants from two of Europe's poorest countries. Report by **Andrew Craig**

Gathered outside a drab terraced building in Bradford's city centre, a group of young people laugh and shout at each other in Polish, a language that has become the second most widely spoken in Britain. One of them offers up a light for another's cigarette before stepping inside the door, and into Bradford's Day Shelter.

The shelter provides refuge for people who are street homeless or living in poor quality accommodation, offering free meals, hot drinks and laundry facilities. It provides a focal point of contact for those facing other complex problems and is the gateway to the Migration Impact Project, whose substance support team are becoming increasingly stretched as their workload has ballooned since their inception in 2011.

Throughout the recent downturn in Britain's economy, increasing numbers of migrants from Eastern Europe have found themselves out of work, homeless and using drugs or alcohol.

Between 2004 and 2009, when citizens of eight Eastern European countries were given full access to the UK job market, an estimated one and a half million people from Eastern Europe came to the UK. According to the Office for National Statistics, some 669,000 people from the 'A8' Eastern European countries – the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia – were working in the UK as of 2011, with half a million from Poland alone. Although the majority of Eastern

European migrants have settled into life in the U.K. and made a significant contribution to the economy and culture, others have not been as fortunate or have been less able to adapt, and some have engaged in drug and alcohol misuse as a consequence.

Accounts from service users attending the Migration Impact Project show that many have multi drug and alcohol misuse problems. Some having histories of substance abuse and others developed them after arriving in the UK. Problems around trafficking, language difficulties and exploitation in the job and accommodation markets can lead to disillusionment and produce the mindset that makes substance abuse more likely.

Kuba's plight has become an increasingly familiar one among this community. Born in Poland to alcoholic parents, social services removed him from the family home when he was four years old. As a teenager, he returned to live with his mother but began using amphetamines and went on to use most illegal drugs. His use of amphetamines endured into adulthood which, combined with his daily intake of beer and vodka, became problematic. In an attempt to change his life, he started work as a labourer in Poland, before moving to West Yorkshire

Having family in Wakefield, he moved in with his sister and began to look after her child. However, his brother-in-law was also used amphetamines. Kuba

picked up where he had left off and resumed his habit. Even so, he managed to obtain work as a packer on nights in Wakefield and used amphetamines to help keep him awake through the long shifts. Eventually he lost the job, and his family ties were broken as a result of his drug and alcohol use. He was forced to move into private rented accommodation from where he was later evicted due to a drunken attack on his landlord. Now 30, he has recently found accommodation in a hostel in Bradford with the support of the Migration Impact Project but, unable to speak English, he still struggles with life in Britain.

Another service user is Maksim, a 32-year-old Russian, who grew up in Latvia. He began using heroin when he was 18 after mixing with, what he terms, "the wrong crowd" and spent some time in prison as a result. After completing a detox on release, Maksim managed to stop using completely by the age of 23. Over the following years, he led a transient lifestyle and left Latvia in 2007 to seek work in Holland, where he trained to become a mechanic after settling in Rotterdam. During his time there he remained drug free. His life took another turn when he discovered that he had contracted Hepatitis C, leading to him getting depressed and using again. He moved to Paris and then onto England in 2012 after being encouraged to do so by his partner's friends who were living in Bradford.

Maksim immediately found work

in a food manufacturing plant. During his first week there, he worked 50 hours for which he received only £175. Realising he had been cheated, he left the job and has not been able to secure employment since. However, with a heroin and crack habit to fund, he has found himself committing crime and now has two convictions in Britain for shoplifting. Maksim is now temporarily accommodated by a housing association and reducing his methadone. He hopes to become completely drug free and find work as a mechanic once more.

Twenty nine million Bulgarians and Romanians (A2 countries) will gain the right to live and work unrestricted in Britain from the January 1, 2014 under European 'freedom of movement' rules. Some forecasters predict that it could lead to a significant number of new arrivals, as it did when Poland and other Eastern European countries gained these rights in 2004. But the scale of migration from the A2 countries is likely to be high, as the ramifications of Europe's economic difficulties unfold. Bulgaria is the poorest country in the EU, and both countries have falling populations due to emigration – a trend which seems likely to continue for the foreseeable future.

Although available data indicates that the prevalence of illicit drug use is low in Romania compared to other EU Member States, drug use of most substances appears to be on the rise. Studies there indicate an increase in the lifetime use for all types of illicit drugs from 1.7 per cent in 2007 to 4.3 per cent (including new psychoactive substances) in 2010. While the majority of problem drug users are said to use heroin, the proportion of those who inject new psychoactive substances (NPS) has increased and may constitute around a third of all problem drug users. In Bulgaria, estimates provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicate that there were 31,316 problem drug users in the country in 2010, around 0.6 per cent of the adult population, with amphetamines being the second most widely abused drug after cannabis.

There is anecdotal evidence that stimulant use among Eastern Europeans has increased over recent years as more young people turn their backs on heroin. Again, after cannabis, amphetamines appear to have become the narcotic of choice for Polish drug users. According to the EMCDDA, methamphetamine accounts for two thirds of problematic drug users in the Czech Republic – the highest rates in Europe. The EMCDDA also reports that stimulant use in



HE MANAGED TO OBTAIN WORK AS A PACKER ON NIGHT SHIFTS IN WAKEFIELD AND USED AMPHETAMINES TO HELP KEEP HIM AWAKE

Hungary has led to twice the number of people seeking treatment for addiction over the last decade, while reports from Latvia also indicate high levels of abuse of these drugs.

In addition to drug misuse, drug and alcohol services in the UK are treating increasing numbers of Eastern Europeans with severe alcohol problems.

'Jack' is Polish and has been working in Western Europe since Poland joined the EU in 2004. After a short period driving trucks in Italy, he was invited to England by a friend living in Bradford. He had promised Jack that there was a job waiting for him. Jack travelled from Italy on the train after being told that he would be met at the station. On arrival, and with nobody there to welcome him, he called his friend who then sent someone to meet him. He was introduced to his accommodation, where he was to share with two recent arrivals from Poland, and had money taken from him for rent. The job did not materialise, his friend disappeared and Jack was left to his own devices to find work.

Having started to drink after his marriage broke down in Poland, he had managed to control it while working in Italy. During his initial three months in Bradford, he began drinking more frequently until he was drinking daily. Despite this, he found work in various low-paid roles until 2011, but has been unemployed since then. Jack continued to drink heavily throughout this period and has been in treatment for his alcohol use on and off since 2011. Now 42, he lives alone in council accommodation and with no friends or family, feels completely isolated.

Marzena Peron-Lapinska of the Migration Impact Project is frank in her appraisal of the situation in Bradford. The service was initially established to support Eastern Europeans with non drug-related issues, such as human trafficking, housing and benefits. But the project soon realised that many people in the area were battling drug and alcohol issues, yet were not engaged with treatment services.

"We have many service users that already have addictions when they arrive in this country but some do develop them while they are here. The service has developed and grown to accommodate the increasing number of people we see. We also have clients that are involved in criminality and are on the run from the authorities in their own country. These people are often caught and subsequently deported."

Migrants from Eastern Europe have settled all over the UK, but only certain agencies in some towns have established support services that are sympathetic to their needs. With the predicted influx of more young people from this part of Europe in 2014, it seems likely that demand for drug and alcohol treatment for migrants will grow.

It is clear that people are disadvantaged if they face linguistic or cultural barriers which prevent them from accessing specialist services. But with their budgets being squeezed, many drug and alcohol treatment providers are losing more services than they are gaining and are forced into making uncomfortable decisions when allocating resources. Unless support agencies are provided with funding to offer services tailored to their needs, it is certain that growing numbers of Eastern Europeans will be left to battle their addictions alone – and the social costs of this can only escalate.

■ **Andrew Craig** is a freelance writer and commentator on international drug issues

Artificial paradise

This year New Zealand introduced radical new drug laws in an attempt to deal with the confusion over legal highs.

Mike Power on a brave experiment that hopes to marry business, science and politics.

The place New Zealanders call the 'dairy' occupies a space in the national psyche somewhere between the pub and a 1950s British corner shop. A place of convenience and conviviality, perhaps incorporating a post office in more isolated rural areas, the dairy acts as community hub, as much as a grocery store.

But the mayor of Timaru, on the eastern pacific coast of the south island, Janie Annear, told politicians this month: "Once upon a time the dairies used to be the family friend...now they're our drug dealers."

From around 2010 onwards, as well as selling Mrs Mac's Pies and Tip Top ice cream, many of these corner shops started selling exotic novel psychoactive substances (NPS). These included cannabinoid receptor agonists such as JWH-018 and AM-2201, blended with herbs and sold as legal marijuana, as well as so-called 'party pills' – various piperazine mixes that emulate ecstasy or amphetamines.

It is hard to think of a more illustrative example of the way the NPS market has infiltrated everyday life in many parts of the world. Far-flung New Zealand has been a market leader in the legal highs business thanks to its isolation, and to one of the world's most infamous legal high entrepreneurs.

In July this year, New Zealand introduced a new law that bans the sale of legal highs unless manufacturers can provide clinical evidence that they are safe. Its stated purpose is "to regulate the availability of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances." An

interim licence system has allowed a list of drugs, mainly cannabinoid receptor agonists, to remain on sale in licenced shops. Some chemicals have been granted licences, and may be sold under certain restrictions (<http://www.legislation.govt.nz/act/public/2013/0053/latest/DLM5042921.html?src=qs>).

Peter Dunne, who was the health minister with responsibility for writing the legislation, told Drugscope: "I am very proud of what we have done. It may well become – though I'm not advocating this – the blueprint for how we deal with illicit drugs – but I think that's a way off."

Some people saw the law as a clampdown, others saw in it a glimpse of a rational drug policy that would end the legal-highs merry-go-round, and others yet saw a business opportunity.

Matt Bowden, New Zealand's self-styled 'godfather of legal highs', is the biggest domestic player in the market. Known also by his stage name, Starboy, Bowden nowadays plays the European rock festival circuit leading a steampunk glam-rock group, with added circus tricks.

"I think what we need to do is look and see what is it that humans need that drugs deliver, and see if it can be replicated without the risk profile," he says.

Bowden was responsible for the first wave of legal highs to hit New Zealand in 1999 – in the form of BZP (benzylpiperazine) pills. He says he was motivated to do this after a cousin died from an ecstasy overdose and when he saw the effects hard drugs were having on his community. "The cocaine boat doesn't stop in New Zealand," he says across a Skype video chat. "And ecstasy

here, near the South Pole, costs 10 times what it does in the UK."

So self-reliant Kiwis, he says, went DIY. "They just made their own methamphetamine from pseudoephedrine from the pharmacy. So instead of a normal clubbing population going out and partying, you had people messed up for days, addicted," he says.

Bowden set up Stargate International, and started selling BZP in 1999. He says he chose BZP after spotting an article in the European Journal of Pharmacology from 1973, which said the drug had been trialed on amphetamine addicts. It was also the metabolite of an established antidepressant, and so it had been through clinical trials and had an established risk profile.

The drugs sold fast, around 5 million pills a year by 2007. He left the drug trade last year when one of his products, a marijuana substitute called Kronic, was banned. Now the law has changed, he's back with a brash, entrepreneurial chutzpah and is among the industry backers of a new organization, the Star Trust, an NGO that advocates for drug law reform.

Bowden rattles off rapidfire harm-reduction policiespeak, but Peter Dunn says the new NZ policy was driven by political, not industrial pressure. "He was certainly consulted by my officials fairly frequently, but he was at arm's length from a lot of the policy decisions. He was more than on the fringes because he is the key market player here. He was supportive, but he was very much someone who was responding to initiatives we were proposing."

It's easy to imagine Bowden, in 2005, challenging the New Zealand

government over its decision to ban the products he was selling, citing constitutional violations of his human rights to consume and sell what he called 'social tonics'. Now, he reframes policy reform as a health and safety issue.

"If you put up signs saying 'no swimming', people are going to do it anyway. So what we do is draw a line and at the end where there are rocks we say 'stay off the rocks' and where there's a riptide, we say it's dangerous, and where it's safe we put up a flag and a monitor and we say: 'Swim here, this is the safe area'. We manage risk in other areas of society and governance. Why not this? We need to build a regulatory system."

But what about a drug like ketamine? Evidence of bladder damage did not emerge for years. The New Zealand system does not set out any requirement for any longitudinal, population-scale trials. What harms does Bowden aim to examine? "We looked at likelihood of lethality, neurotoxicity and organ damage and addictive potential. With medicines, they test for carcinogenicity, mutagenicity, organ damage and neurotoxicity. Those are the same tests that will need to be done on these products."

All drugs, it could be argued, have a toxic effect: that's the point. This is a key issue for the NZ legislation: set the harm threshold too low, and it's prohibition redux. Too high and dangerous substances can be sold legally.

Harry Sumnall, professor in substance use at the Centre for Public Health at Liverpool John Moore's University says he believes no standardised benchmarks have been defined. "It takes pharmaceutical companies hundreds of millions of pounds to create a new drug, a large proportion of which comprises rigorous safety and developmental phases, not to mention post-marketing monitoring. It seems that the safety threshold [in New Zealand] has been set much lower for NPS than traditional pharmaceuticals."

Professor Dave Nichols has worked in the development of psychedelic drugs at Purdue University, Indiana since the 1970s. He has seen much of his legitimate scientific research hoisted into production in China by the research chemical scene, with drugs such as 6-APB and the NBOME-series. He is dubious the NZ system, requiring firms to fund safety research will work.

"Who's going to do that? In the US, to do a test on humans you have to do a test on two animal species, and give them the drug chronically for 28 days.



Matt Bowden: self-styled 'godfather' of legal highs

Then you have to slice them and dice them and see what damage has been done. Only then do you get approval for phase 1 trials.

"I can't see anybody in the business of making research chemicals saying: 'Maybe we got a doozy here. Let's invest so we can make it legal in NZ.'"

I THINK WHAT WE
NEED TO DO IS LOOK
AND SEE WHAT IS IT
THAT HUMANS NEED
THAT DRUGS DELIVER,
AND SEE IF IT CAN BE
REPLICATED WITHOUT
THE RISK PROFILE

"Testing will cost \$2m NZ per product," says Dunne. "Some people fear vendors will come back with all sorts of new products. They might, but we also have to look at the economics. If they're going to spend that much bringing it to market they have to A) be pretty certain that it will pass, and B) recoup that investment pretty quickly. In some cases that work; in others, the economics will work against them."

Ultimately, the real indicator of the success or failure of this trial lies in the hands of the customers. Will they buy in? Professor Sumnall believes drug users simply choose the very illegal drugs that the new, mild, legitimate

'social tonics' seek to replace. "I have yet to hear of an NPS which produces equivalent entactogenic properties to MDMA, prosocial effects to cocaine or reflective and hallucinogenic qualities to psilocybin. I acknowledge the difficulties governments face with regards to international drug conventions and treaties, but perhaps a truly innovative policy would also consider the licensing of illegal products such as these?"

And back at the Kiwi dairies, the new law banned the stores from selling any kind of drugs at all. They were given a day's grace before the July 10th deadline to bin their products. Meanwhile, sex shops and other licensed premises were allowed to sell compounds under interim licenses. The Timaru Herald reported in August that two local dairies had simply converted into licensed sex shops – where minors are not allowed.

Jackie Wang, owner of the R18 Store Lincoln Rd, previously the Lincoln Road Dairy, said his new drug-dealing venture had been open one week, and said the new business was "better than the dairy shop", because competition among dairies was stiff. He can now sell bags of herbs laced with AB-PINACA and AB-FUBINACA and (S)-N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1H-indole-3-carboxamide, the latter under permanent licence, without any legal issues whatsoever.

■ **Mike Power** is a journalist specializing in drugs and author of *Drugs 2.0: The Web Revolution That's Changing How the World Gets High* (Portobello Books, 2013)

Magnificent seventh

Reviews

■ **Blaine Stothard.**
Prevention specialist and Druglink's book review editor

We can probably assess how long someone has been in the UK drugs arena by knowing which edition of *Living with drugs* is on their shelves. Mine's the fifth, bought and read on publication, when I was extending my horizons beyond the school-based 'prevention' activities I'd previously focussed on. So it's a tribute to the quality and comprehensiveness of Michael Gossop's text that it's newly available in a seventh edition, ready to inform and inspire those now joining the field.

There is constancy and consistency in the book's contents – the chapter headings are identical in this and the two previous editions – and this book is a reminder that the wider cultural, psychological and socio-economic factors affecting drug use are frequently discounted in public debate.

Media coverage of the ACMD's May 2013 open meeting concentrated on the numbers of 'new' drugs being reported. It failed to mention the silence of HM Government following its receipt three years ago of the ACMD's report on foil use and heroin; the dis-investment in drug and alcohol services already becoming apparent since the ending of ring-fencing of drug and alcohol funding; or the 'disengagement' of the Department for Education from inter-departmental work on drugs. The immediate – and the sensational – have taken over from the important.

The opposite is the admirable characteristic of Gossop's book. His reflection on new psychoactive substances is that they are a predictable result of the prohibitionist approach to drug use. To ban is

to challenge suppliers to re-formulate their existing products. More regrettably, the moves to ban newly emerging substances and compounds are frequently linked to media coverage which is all too often partial, inaccurate and misrepresentative. Gossop lets us draw the conclusion that such activity at the edge of the drug use spectrum gives an impression of 'doing something' which ignores or disregards wider realities and contexts, and focuses on symptoms, not causes.

LIVING WITH DRUGS

Michael Gossop
7th edition, Ashgate, 2013

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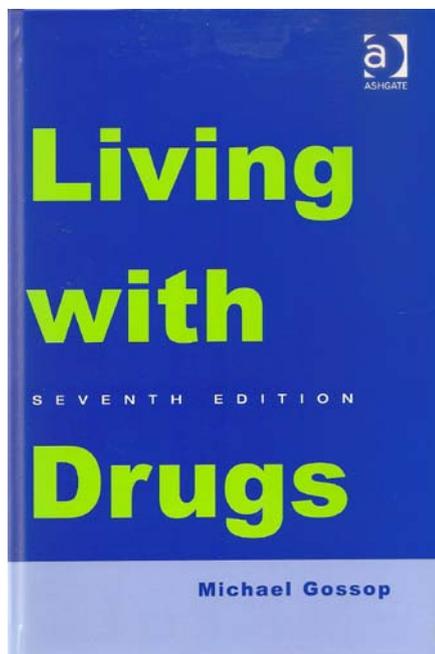
Gossop recognises the different narratives existing around drugs, at one point acknowledging that what – and how – he is writing will not be well-received or accepted in some quarters. And he ends his seventh edition, as before, with the statement: 'Drug taking is here to stay and one way or another we must all learn to live with drugs.' His patient, well-argued and non-judgemental style leads up to this summarising statement, but clearly – and at times explicitly – he rejects the prohibition approach and the 'war on drugs.'

HIS REFLECTION ON NEW PSYCHOACTIVE SUBSTANCES IS THAT THEY ARE A PREDICTABLE RESULT OF THE PROHIBITIONIST APPROACH TO DRUG USE. TO BAN IS TO CHALLENGE SUPPLIERS TO RE-FORMULATE THEIR EXISTING PRODUCTS.

Apart from the patient and thoroughly argued style and content, what can the reader – lay and professional – expect from *Living with drugs*? Tellingly, the lengthiest chapters are those on alcohol, tobacco and the control of drugs – with some provocative mention of sugar.

'Junkie myths' includes discussion on anti-drugs campaigns and propaganda. His examples range from the well intentioned, the misinformed and misinforming, to the grotesque, mendacious and xenophobic. Here too is discussion on the impact of stigma about drug use and drug users, willingly, it seems, encouraged by much of the media. The conclusion that is hard to resist is that the majority of the harms arising from drug use has social and not chemical origins. The role of governments in perpetuating rather than countering myths is implicit here, reinforcing the claim of the Norwegian criminologist Nils Christie: 'The most dangerous use of drugs is the political.'

Those established in the drugs field will look to see what's new in this seventh edition and find the discussion and argument retained. There is careful, thoughtful and comparative exposition of all factors, including historical and geographical drug use and production, with relevant inclusion of recent developments around drug control and new psychoactive substances. Those whose copies have wandered will want to replace them. New readers, as they say, could do a lot worse than start here. Prepare to have your knowledge extended and preconceptions challenged!



Social injustice

Drugs, Crime and Public Health focuses on evidence and its role in policy making. Having ‘heard and read a lot of nonsense’, Alex Stevens aims to challenge conventional wisdom on such matters, something he is well placed to do as Professor of Criminal Justice and an experienced drugs researcher.

By way of scene-setting, Stevens dismisses free-market ‘solutions’, which he argues would likely increase drug-related harms, and distances himself from the ‘Foucauldian position’ because of its tendency to see all public health initiatives as exercises in disguised coercion. Insisting on the primacy of human rights, Stevens maintains that public health interventions may promote freedom and protect people’s health by facilitating informed choices. This leads him to a ‘political economic approach’.

By focusing on such arrangements, Stevens challenges ‘blinkered discussions’ that ‘close off consideration of social issues that are at the root of many of the harms for which drugs and laws have been blamed.’ While drug use does not seem to be linked to deprivation, Stevens shows that dependence and associated harms are, forming one of the ‘afflictions of inequality’. This evidence is then used to challenge prevailing notions that drugs cause crime, as it is noted that such claims cannot explain the social distribution of drug-related harms.

As an alternative, Stevens develops the notion of ‘subterranean structuration’, incorporating individual motivations, while also helping to explain why drug-related harms are concentrated amongst those ‘who have suffered most from deindustrialisation and the advance of socio-economic inequality.’

Having identified the social conditions associated with drug-related harms, Stevens documents how they are routinely silenced and suppressed. Through his experiences as a policy adviser on a placement within the UK civil service, he identifies practical, professional and political barriers to the translation of evidence into policy. Although evidence had a certain cachet among his civil service colleagues, Stevens argues it was routinely air-brushed to remove ambiguity and support ideologically favoured positions. In particular, the need for ‘totemic toughness’ resulted in ‘selective policy stories’ that talked up the drug-crime link, while minimising the inequality-harm link.

The distorting influence of politics is further illustrated in a series of case studies, which show how evidence is used to support a particular world-view. By dividing drugs and their users into the ‘safe’ and the ‘threatening’, this view militates against ‘a more fully rational use of evidence’ and supports the greater penal exclusion of some drug users. The result is ‘a sorry picture. Millions of pounds wasted. Thousands of people deliberately harmed.’

Turning to the international evidence, Stevens

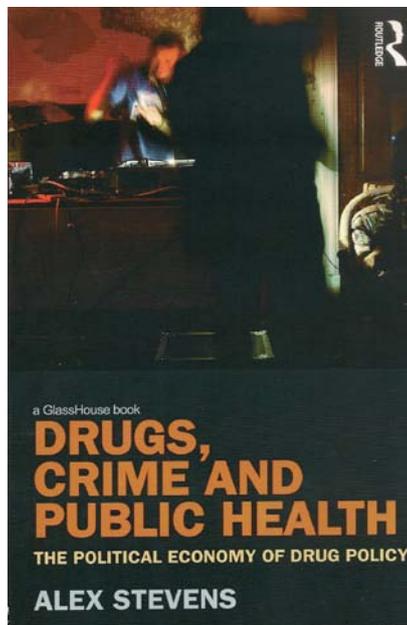
Reviews

■ **Michael Shiner**
Senior lecturer in social policy and criminology, London School of Economics and Political Science.

DRUGS, CRIME AND PUBLIC HEALTH: THE POLITICAL ECONOMY OF DRUG POLICY

Alex Stevens
Routledge-Cavendish, 2011

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concludes that drug policy appears not to be the most important determinant of drug use or related problems. Inequality and social support, he argues, are probably more important in alleviating such problems. If governments have the drug problems they deserve ‘it is not because they have neglected to enforce their drug laws, but because they have failed to protect their citizens from the malign effects of inequality.’ While drug policy may accentuate harms, it follows that long-term solutions lie elsewhere.

As a way forward, Stevens points to reduction of inequalities, reform of international law, and ‘a gradual, evidence-dependent shift towards the decriminalization and regulation of currently illicit drugs.’ While recognising the apparent remoteness of some of this, Stevens insists that ‘justified scepticism’ about political uses of evidence should not prevent us from creating and using knowledge to improve drug policy. Such action should, however, ‘complement initiatives to create wider social justice’ by ‘building coalitions between drug users, researchers, campaign groups, unions and politicians in ways which build support for greater equality and reduce the perceived electoral dangers of less punitive drug policies.’

Drugs, Crime and Public Health provides a powerful diagnosis of the drug problem and is a must-read for anybody seriously interested in the subject. The analysis is thoughtful and nuanced, yet refreshingly concise and clear-sighted. Rather than academic dissembling, the political implications are laid bare, though the call for ‘more reliable evidence on which to build drug policy’ is tinged with irony. Stevens’ own analysis suggests the evidence he presents will be unpalatable to those best placed to act on it and will almost certainly be subject to the processes of selectivity and silencing he describes. That said, the call for a progressive coalition has an air of realpolitik about it, encapsulating what might be taken as the book’s core manifesto – drug policy is inevitably political, but is too important to be left to politicians and their advisors.

Opening up addiction

Reviews

■ **Paul Wells**
Independent commentator on drug policy, with over 25 years' experience of managing statutory drug services.

My initial thought when I saw the title of this book was that it would turn out to be another imported manual on how to do drug and alcohol work. But while there have been publications of dubious quality and relevance to working with addiction, this is not one of them.

It is refreshing to read a book of quality that is not only relevant to the UK but is also authored by a UK clinical practitioner. Frank Ryan has produced a thought-provoking book that critically analyses existing cognitive approaches to treating addiction, and which proposes a new framework to improve outcomes. In doing so he acknowledges the reduced therapeutic gains that cognitive therapy has had in addiction, compared to the outcomes in anxiety or depression. The book integrates findings from cognitive neuroscience research with cognitive therapy practice, so that some of the underlying shortcomings identified when working with addictions are better understood.

Users of addictive substances frequently do not achieve their stated goals and this is due in large part to an impaired cognitive control where attentional bias plays a major role. Ryan proposes a therapeutic framework he calls 'CHANGE' (Change Habits and the Negative Generation of Emotion) – as a means of improving cognitive control to improve outcomes. Within the CHANGE framework he identifies four key stages: motivation and engagement; managing urges and cravings; mood management; and maintaining change.

The timing of this book is particularly apposite because of the recovery culture currently dominating drug and alcohol services, especially when combined with payments by results. Against a background of competing accounts of the nature of addiction, Ryan clearly takes the position that rather than being compensatory, addiction is essentially rewarding, or 'appetitive', and that these appetitive cues have a competitive advantage in influencing cognitive control.

The application of the CHANGE framework and issues such as the role of implicit cognition and cognitive bias influencing treatment outcomes are explored using case studies that integrate with other existing interventions.

So, who is going to benefit from reading this book? Commissioners of drug and alcohol services for sure. They need to understand that setting payment by results targets for recovery for an in-treatment population is not as simple a proposition as it may first appear. This book identifies the cognitive barriers to achieving this, and the barriers to preventing relapse. It is not possible to have all drug users identified in prevalence data in treatment, nor is it possible to achieve meaningful recovery for a defined proportion of the

treatment population within a given time. However, commissioners are not the primary audience for the book.

The most important beneficiaries from the practical application of the model described in the book are those receiving treatment from workers in the addiction field. Their expressed desire to change may not be manifested or sustained without an adequately trained, competent and supported workforce, able to deliver high-quality clinical interventions. There is a requirement for a high degree of competence, in delivering the cognitive therapies identified in the book, to those using drugs and alcohol.

As the case studies within the book demonstrate, clinicians face significant challenges in dealing with what can feel like intractable problems. These require skills that may not always be present in services that have been recently commissioned.

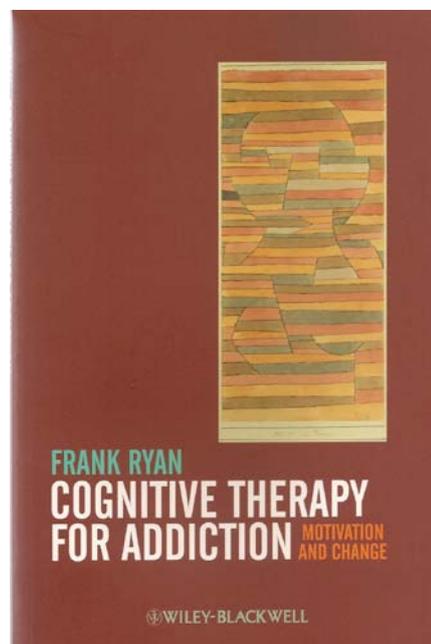
This book is written by a clinical psychologist working within the NHS. However, as a result of the many changes in services in recent years, the numbers receiving treatment within NHS services, where highly trained clinicians are involved in their treatment, have reduced by 55 per cent in the past 5 years.

The challenge for this book is for it to become an increasingly popular, used and essential text for those clinicians, with the appropriate key skills, working with addiction. Hopefully those numbers will increase but the current situation doesn't auger well for the future.

COGNITIVE THERAPY FOR ADDICTION: MOTIVATION AND CHANGE

Frank Ryan
Wiley-Blackwell, 2013

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Heavy metal

It has been a long time coming, but in July the government finally saw the logic in providing foil at drug services: to promote transition from injecting to smoking heroin and cocaine. **Mike Ashton** on the long route to foil provision.

On July 4 Home Secretary Theresa May told the House of Commons: “The government has accepted the advice of the Advisory Council on the Misuse of Drugs (ACMD) to allow for the lawful provision of foil by drug treatment providers subject to the strict condition that it is part of structured efforts to get people into treatment and off drugs.”

Cloaked in the guise of recovery and abstinence, thus a key extension to harm reduction became acceptable. Just what that ‘strict condition’ means remains to be seen. It may be enough that simply providing foil in the context of a needle exchange or drug help service will bring drug users in to contact with services who previously had no reason to attend.

Politically it was a minor and pain-free adjustment, evidenced by the lack of action against Exchange Supplies or against its customers when in 2007 the company started supplying foil for needle exchanges. If in the end logic, expert opinion and evidence held sway, perhaps it was because the issue was neither morally nor politically charged. That year, after Exchange Supplies put its head above the parapet, the ACMD decided to address the issue of foil “after a growing body of evidence of its potential benefits and also its distribution from drug services.” In 2010 came the ACMD’s report, *Consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin and cocaine*, which eventually the government acceded to.

At first, it was not enough to convince government. The following year it asked for more evidence on the health risks of smoking drugs on foil. This further investigation did not change the council’s mind. At the end of 2011, in a revised report, the

ACMD reiterated their belief that “foil, as an intervention, can support an individual’s treatment journey towards recovery...there is a strong case that foil is exempted”.

FOIL, AS AN INTERVENTION, CAN SUPPORT AN INDIVIDUAL’S TREATMENT JOURNEY TOWARDS RECOVERY

For the ACMD a major consideration had been its conclusion in its report on hepatitis C – that “ultimately we need to stop injecting to reduce the risk”. Two small UK studies suggested foil might further that ambition.

Distributing foil from needle and syringe programmes (NSPs) to promote transitions from heroin injecting to chasing: an evaluation, was published in 2008. It analysed data from four needle exchanges and interviewed injectors at one of them. It found that packs were taken when available, that offering them could prompt discussions about ways of reducing injecting risks, and suggested that supplying foil could reduce injecting in areas where there was already a culture of ‘chasing’ heroin.

Because foil was being provided, the needle exchange saw 32 new heroin smokers through its doors – drug users who would presumably otherwise not have made contact. At the second visit, all but two of the 48 needle exchange users interviewed said they had used the foil, and 41 said that as a result they had smoked when otherwise they would have injected.

The same year a UK needle exchange report said foil provision had reduced injecting and promoted less risky alternatives. Foil was utilised by 85 service users. Most had recently injected, but 12 per cent had not used the service before. A third provided feedback: nearly all said their injecting had reduced as a result of using the foil.

Another source of evidence was the Netherlands. Looking at its experience convinced the ACMD that foil can provide a platform, “when coupled with harm reduction messages and appropriate service provision”, for transition away from injecting.

A review of more than 15 years of Dutch experience in switching injectors to foil concluded: “The availability of aluminium foil seems to have played a significant role in the transition process”. The main downside was the common and sometimes severe respiratory complaints among drug smokers. Inhaling the fumes of street heroin or crack cocaine or inhaling hot vapour in general is not a good idea, but the ACMD judged this considerably less dangerous than injecting.

ONLINE

See the ACMD website for all documentation relating to the provision of foil

<https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs>

See Drug and Alcohol Findings Effectiveness Bank for the full story with more information, citations and links visit: <http://tinyurl.com/EfB-cdl/download.php?file=DL12.php>

Headspace

...drugs from the left field

Feeling is everything

The addict *feels* the world, bits at a time. The addict's cognition, his or her executive functions such as reason, planning and choice, are subordinate to the emotional act of using drugs, and its consequences. The addict is moved by emotion, and feels his or her way through the macabre of his or her addicted behavior.

The addict, in moments of clarity, reaches out for help and receives treatment, only to become a victim of a world-view created by the 'mind-body dualism' (that thinking is separate from emotion) philosophy of Descartes. The one-size-fits-all treatment model borne from this world-view forms the basis of the cognitive behavioral therapies (CBT), developed by American psychologists A. Ellis and A.T. Beck; the cognitive modules of the Hazelden foundation, which are ubiquitous in treatment facilities; and the Narcotics Anonymous and Alcoholics Anonymous fellowships. Unwittingly, cognitive-behavioral models neglect the

wherewithal of the emotional-feeling aspect of the addict, and treat him or her like a commodity, alienating them even more.

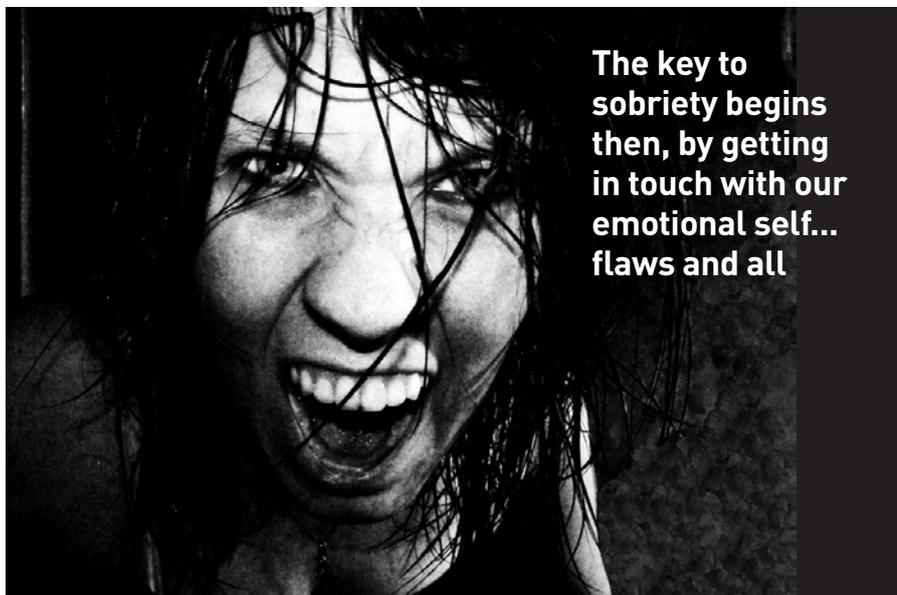
When treating addiction, addiction specialists have placed the carriage before the horse. Until recently, the addiction treatment field did not even recognise this strong emotional component that is so worthy of fresh research. As Antonio Verdejo, from the Department of Clinical Psychology & Institute of Neuroscience at Universidad de Granada, Spain and Antoine Bechara, from the Brain and Creativity Institute, University of Southern California, said: "Growing evidence from neuro-scientific studies shows that core aspects of addiction may be explained in terms of abnormal emotional/homeostatic guidance of decision-making. Behavioral studies have revealed emotional processing and decision-making deficits in substance abusers."

When identifying the addict's

dilemma, the addiction treatment field is in what I call a Counter Dark Age. The Dark Age (500BC to 1500AD) kept people from exploring the mind as a thinking, reasoning entity; imprisoning and executing anyone who said otherwise, and science suffered as a result. It was a religious time, an emotional time to say the least.

Today, it is reversed: science and its preoccupation with cognition as a thinking, reasoning entity keeps us from the true nature of the problem of addiction – the emotional, feeling person underneath all the bad choices and harm caused. There are as many different kinds of addictions as there are people. Twenty-first century addiction treatment professionals must move away from the rational, one size-fits-all-disease-model, and look at the dynamics of the emotional individual and the relational event. It is not the individual addict, nor the drug itself, it is these relational events that should be defining the concept of treating addiction.

We focus on the choices we make and their consequences, because the dark truth of looking too deep into the amygdala's memory will show nothing but a reflection of the looker. So we distract ourselves with a consciousness full of everything else save the truth, focused on the appearance and the phenomena of addiction, rather than the cause. We are set right smack in the center of the universe again. This was equally true for the church in the Dark Age. It used a lot of rituals, prayer beads, confessionals, and the like to stay above the surface of it all. The robotic world-view we've created keeps us at the surface, and in an emotional darkness where we are safe from *feeling*. The key to sobriety begins then, by getting in touch with our emotional self... flaws and all.



The key to sobriety begins then, by getting in touch with our emotional self... flaws and all

■ Sal Ventimiglia



Pills, Thrills and a Bellyache

Would a gun to the head make an alcoholic put down the bottle? Maybe. Would surgically removing an addict's veins prevent them injecting drugs? I guess so. But do either of these things promote a healthy recovery? Absolutely not. Yet methods of cutting alcohol and drug consumption by force and biological manipulation, rather than by volition and personal agency, are on the rise.

Figures released by the Health and Social Care Information Centre show that the number of prescriptions dispensed to treat alcohol dependency in England have risen by 73 per cent in nine years. The drugs monitored in the study included Acamprosate, prescribed to reduce cravings, and Disulfiram, which causes adverse effects, such as vomiting if the patient touches alcohol. The latter can, in severe cases, cause heart failure, convulsions and even death.

The same report reveals that of the 823,500 hospital admissions last year, where the primary diagnosis was alcohol-related disease, the most common primary reasons for hospitalisation were mental and behavioural disorders.

Yet neither of these medications addresses the mental or behavioural aspects of addiction. Prescribing Disulfiram is like saying to the addict: "Don't drink, or else". Acamprosate may reduce short-term cravings, but it doesn't help the addict address the long-term problematic thought processes that lead to relapse.

Addiction is marked by desperation and delusion. It is perpetuated by faulty thinking, and an inability to tolerate distress and to make level headed, long-term decisions. If threats of harm, or painful consequences, stopped alcoholics from drinking, no addict would ever reach the point where they lose their job, home, family, sanity and even their life.

Worryingly, patients in hospital are now more likely to be prescribed Disulfiram than Acamprosate. When someone is at the mercy of a mental state so skewed that they've have already drunk themselves into a hospital bed, is this the time to force them into a do-or-die situation?

The trend towards pills for treating addiction continues into the realm of drug treatment. Money is poured into researching medications that stop psychoactive drugs from working, yet which do nothing to treat the addict's underlying thinking patterns, nor to promote healthy behaviour. In the news, I read of scientists proudly presenting their latest findings. Vaccines to prevent cocaine thrills from reaching the brain. Drugs to stop the heroin addict achieving his high. Researchers report that addicted rats given these medications show less drug-seeking behaviour. But addicts aren't rats. They have complex relapse-inducing emotions and lives to deal with, not just a physical dependency.

When someone is at the mercy of a mental state so skewed that they've have already drunk themselves into a hospital bed, is this the time to force them into a do-or-die situation?

Sobriety alone is nothing without recovery – and recovery is not brought about by duress. It is brought about by addicts learning to deal with their emotions and the ability to be happy without substances.

There may be mutterings of 'safety nets' and 'stabilisation', but just look at the (sometimes lifelong) handcuffs of methadone prescribing, where addicts become addicted to something legal, rather than dealing with life. Look at the adverse side effects of medication. Some pills which block the brain's opioid receptors, block natural endorphin production too, leading to increased anxiety and depression.

While working on the imbalanced, addicted brain seems like a solution, addicts can condition their own brains against relapse more effectively by retraining their thoughts. Someone who has built mental resilience, who sees the silver linings, who learns to be accepting of life and grateful for sobriety, is far less likely to relapse. Not because of threats, or chemical policing, but because their thoughts serve them better than that.

These responses can be trained to become automatic, long-term responses through methods such as dialectical behaviour therapy and mindfulness. The only side effects are increased contentment and happiness – and the results don't wear off.

I am not completely anti-medication, but nearly £3 million was spent on Acamprosate and Disulfiram in 2012, and there is a finite amount of money available for treatment. It makes no sense to pay for sticking plasters, when we could be directing more of that funding into teaching people to look after their own brain and wellbeing.

Addiction is a progressive mental health condition, and not giving addicts the tools to deal with their disorder forever is greatly under-serving them. Giving addicts the fishing rod, rather than the fish, is a sensible long-term strategy. Maybe the field needs to develop some good long-term thinking of its own.

■ **Beth Burgess** Author of *The Recovery Formula* and *The Happy Addict* and teaches Dialectical Behaviour Therapy and other solution-focused methods. www.smyls.co.uk

Game on: drug and alcohol services and the new local players

Connaught Rooms, Great Queen Street, London WC2B 5DA

6th November 2013 9.45am – 4.30pm

It has been a long time coming, but now it is here. As the National Treatment Agency rides off into the sunset, over the hill comes Public Health England and with it a whole new landscape in which drug and alcohol services need to operate. So we have speakers that reflect the new dynamic as well as those reporting on developments in drug use which may well impact on services.

Plenary and workshop topics include:

- The changing scene from the perspective of local authorities, police and crime commissioners and public health
- The challenge to services of alcohol and new drugs
- Commissioning
- Payment by Results
- Update on new drugs/legal highs

Confirmed speakers and workshop leaders include:

- **Rosanna O'Connor**, Public Health England
- **Dr Andrew Howe**, Association of Directors of Public Health
- **Dr Owen Bowden-Jones**, Royal College of Psychiatrists
- **Sophie Howe**, Deputy Police and Crime Commissioner, South Wales
- **Dr Marcus Roberts**, Director of Policy, DrugScope
- **Dr John Ramsey**, St George's Hospital Medical School
- **Tom Woodcock**, Commissioning Lead for Lancashire
- **Debbie Holt**, Independent consultant on commissioning
- **Katy McLeod**, Crew 2000 Scotland
- **John Jolly** – CEO Blenheim/CDP
- **Steve Broome** – Director of Research, Royal Society of Arts
- **Councillor Stephen Bedser**, Birmingham Health and Wellbeing Board

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Booking form at:

www.drugscope.org.uk/events/drugscopeevents/gameon.htm

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