VOL 28 | ISSUE 1 | **JANUARY/FEBRUARY 2013**

# Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- Hamid Ghodse
- Sex work
- Stateside legalisation
- Alcohol debate

## The Paul Hayes Interview

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# Druglink

# My big fat drug report

They've been coming thick and fast; first the Home Affairs Select Committee, then the UK Drug Policy Commission followed by the All Party Parliamentary Group on Drug Policy Reform and most recently, weighing in at a whopping 341 pages is the BMA Board of Science report on the role of the medical profession in dealing with dependence. The BMA report does not make any policy recommendations, but does headline the idea of 'encouraging debate on the most effective approach to preventing and reducing the harms [of drug use]....based on an independent and objective review of the evidence'. The other reports pretty much sing from the same hymn sheets concerning the need for policy reviews and law reform. The response from the Government has been a resounding 'no' and a refusal to engage in the debate.

When drug use was soaring in the late 1980s and early 1990s, change was unlikely on the grounds that we risked making a bad situation worse. Now, an improving picture is cited as the reason not to review policy on the grounds that we must have got it right.

But now is exactly the right time to review policy. While use of traditional street drugs has been going down, it is likely that with the rise in the use of new drugs like mephedrone, the drug scene is in transition rather than long term decline. Depending on a number of upstream factors such as the state of the economy, we can't rule out another drug panic in the future. But currently the political waters are relatively calm. So now is the time for some clear thinking and rational political debate. We don't need any more hefty drug reports.

**Harry Shapiro**
Editor and Director of Communications and Information

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

**DrugScope**
Asra House
1 Long Lane
London SE1 4PG

**Telephone**
020 7234 9730
**Email**
info@drugscope.org.uk
**Web**
www.drugscope.org.uk

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

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**DRUGLINK STAFF**
**Editor** Harry Shapiro
**Editorial Assistants**
Ruth Goldsmith, David Ader
**Online** Jackie Buckle
**Book Reviews Editor**
Blaine Stothard
**Director of Communications and Information**
Harry Shapiro

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**Design**
Helen Joubert Design
helenjoubertdesign.com

**Print** Holbrooks Printers Ltd, Portsmouth PO3 5HX

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

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ISSN 0305-4349

## News



## Features



## Regulars

### London gay drug scene concerns

The high prevalence of drug use on the gay scene is well known. But a new report in *The Lancet* raises concerns that the injecting of drugs such as crystal meth and mephedrone – known as slamming – is driving up rates of HIV among men who have sex with men (MSM), both due to unsafe injecting and sexual practices. In 2011, there was a record high of 3010 new HIV MSM infections in the UK of which nearly half were recorded in London. The numbers injecting are also rising dramatically; in 2011, around 30% of those using mephedrone and crystal meth presenting to the CODE clinic in Soho were injectors; in 2012 that figure leapt to 80% of which 70% were sharing needles. David Stuart of London Friend called the increases 'staggering and frightening'. He pointed to the ease of buying the drugs and internet information on hard-core sex party locations as the main drivers.

### Consensus on medicine addiction

The Royal College of General Practitioners and the Royal College of Psychiatrists have issued a consensus statement aimed at reducing patient addiction to medicines such as tranquilisers and painkillers. However, trying to ascertain the overall prevalence of addiction is difficult; there are no official statistics concerning those in receipt of prescriptions together with many anecdotal reports of people becoming addicted to painkillers bought over the counter without a prescription and also increasingly over the internet. In 2009, the All Party Parliamentary Group on Drug Misuse published a report which highlighted the problems and expressed concern as to the general lack of support for people who have become dependent on drugs prescribed to them by doctors. There is little evidence that this paucity of help has improved.

# UK opposes Bolivia on coca chewing

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The UK was one of several countries who opposed the demand of Bolivia for a special exemption from the Single Convention on Narcotic Drugs to allow its indigenous population to chew coca leaves. Most of the countries who objected including the US, Russia, Italy and Sweden are long time opponents of any reform of the Treaties, although the objection of the Netherlands is perhaps more surprising. In its submission to the UN, the UK said that it, 'acknowledges and respects the cultural importance of the coca leaf in Bolivia', but added that the UK was concerned that the exemption 'could lead to an increase in coca production and crucially – the amount of coca diverted to the cocaine trade'.

That coca ever made it into the Single Convention at all was due to one highly controversial UN enquiry into coca in 1949. According to the Transnational Institute report *Coca yes, cocaine no?: legal options for the coca leaf* (2006), the UN report (based on a brief UN mission to Peru, the major grower of coca for the pharmaceutical industry) was "sharply criticised for its arbitrariness, lack of precision and racist connotations. The team members' professional qualifications and parallel interests were also criticised, as were the methodology used and the incomplete selection and use of existing scientific literature on the coca leaf". The result was that Peruvian growers lost their legal business and eventually they began to supply criminals instead, giving birth to the illegal cocaine trade.

In signing the Convention in 1964, the right of indigenous communities in the Andes to chew coca was removed. But under the terms of the agreement, Bolivia was given 25 years to implement the ban. This expired in 1989 and has been a matter of dispute ever since. Having legalised coca growing, in 2011, Bolivia withdrew from the Convention, the first country ever to do so, but reacceded in January this year on condition that it was exempted from the coca chewing ban. Despite objections, this was agreed.

# Professor Hamid Ghodse CBE 1938-2012

The recent death of Professor Hamid Ghodse is a huge loss to the global field of drug misuse. His achievements in areas of academia, research and international policy development to reduce the harm to individuals and cost to societies locally and across the world, are legion. But to many, including myself, the loss is also a great personal one.

I am very privileged to have had Hamid as a colleague for nearly 30 years – from 1978 when he was appointed Consultant Psychiatrist to St Georges Hospital Drug Dependence Clinic and to the inpatient drug unit at Tooting Bec Hospital, in South London, to his retirement from the NHS in 2005. In those early days St Georges DDU was typical of the London clinics which had opened in the late 1960s. It was sited in cramped accommodation in an old building (Clare House) on the edge of the general hospital, with its own entrance – no doubt to protect "respectable" patients from having to share facilities with the addicts who were often regarded with fear and suspicion. Staff resources were few and Hamid would often joke in later days how we together managed over 100 patients with just half a nurse and a part time secretary whose office was smaller than the average toilet!

Treatment then was not much more than open-ended, unstructured methadone prescribing,and for those severely dependent on barbiturates, repeated inpatient admissions for detoxification. It was this unsatisfactory 'revolving door' of detox that prompted Hamid to research polydrug use in London leading to the establishment of City Roads Crisis Intervention project. It quickly became apparent that Hamid was determined to see that drug misusing patients were accorded the highest standards of care and respect. By negotiation (and sometimes by stealth) our staff team expanded and our occupation of Clare House spread along corridors and up stairs. He was at the forefront of innovations, which are now the norm, such as therapeutic or contingency management contracts, multidisciplinary working, liaison work, service user involvement, family support and a tool for structured regular six monthly progress reviews – decades before TOPS !

In 1988 after the closure of Tooting Bec inpatient unit, Hamid ensured the staff affected could transfer to the new unit at Springfield Hospital – which comprised both an acute treatment ward and a recovery ward allowing much longer admission for patients with complex conditions or dual diagnosis. Today a service closure such as Tooting Bec would result in at least some redundancies, but Hamid's concern for preserving valuable expertise for the benefit of future patients, as well as for the welfare of staff of all disciplines, was typical of him.

He was passionate about student education and he saw offering clinic placements as the opportunity to promote positive attitudes towards substance misusers at an early stage in medical and nursing students' careers. Throughout his tenure he fostered and supported numerous doctors in training, nurses, social workers, psychologists and other practitioners, so that many have gone on to have careers in UK treatment services and government departments. This is but one of his many legacies.

In short, Hamid Ghodse was a clinician of extraordinary skill and charisma. He was genuinely as pleased by the positive progress of an individual patient in South London, as much as he would be – in his capacity as President of the International Narcotics Control Board – in having advised and helped another nation to develop rational and humane drug control policies and treatment services. At his NHS retirement function I was told it brought tears to his eyes when I presented him a card signed with many touching tributes from current clinic attenders.

No tribute to Hamid would be complete without mentioning the generous hospitality of him and his wife Barbara in opening their home for many a staff gathering complete with delicious home prepared Iranian fare. He was devoted to his family and leaves Barbara, three children, four grandchildren – and many, many friends and wonderful memories.

**Dr Jill Tregenza**. (Previously Associate Specialist, St George's & South London Mental Health NHS Trust)

# STREET WISE

**It's six years since Stephen Wright was convicted of murdering five Ipswich prostitutes. Concern about access to drug services was one of the issues raised at the time. Jeremy Sare looks at what has happened since.**



The murders of Gemma Adams, Tania Nicol, Anneli Alderton, Paula Clennell and Annette Nicholls prompted local partnerships to make a fundamental re-assessment of what police, local authorities, voluntary sector, health and housing associations were doing to help women who had turned to the street sex trade to fund their drug habit.

The Ipswich Street Prostitution Strategy included all stakeholders and was launched in 2007 with support from senior police and councillors. It was a five point plan addressing supply and demand sides with a combination of creating incentives to move out of prostitution, community action and sustained enforcement against kerb-crawlers.

Figures contained in a report compiled by the University of East Anglia showed 128 kerb crawlers were arrested in 2007. This figure fell to just 14 in 2008 and there were none in 2009 and 2010.

The main organisation which the community and street workers cite as instrumental to change is the Iceni Project led by Brian Tobin. He said, "What was critical was to show patience and compassion to the women. The needs of all the community had to be led by a ground-floor organisation which could slowly build up the necessary trust." Paula Clennell had made an appointment with Iceni the day before her death.

The Iceni project offered the women treatment for their drug use (mainly heroin and crack cocaine) and paths away from exposure to the dangers of sexual attack and other forms of physical violence. In the short term, Iceni bought them mobile phones for security, paid rents and utility bills, delivered food parcels, even children's Christmas presents. They then treated their addiction mainly through methadone, identified safer housing and helped women gain employment. Brian Tobin said, "Our approach is to address the whole person, and consider the underlying psychological issues as well as the socio-economic ones. Most of the girls were severely damaged people. Sixteen were from statutory care system; most had been raped and abused. They were also bereaving the loss of five of their friends."

Former street worker, Jade, who now works with women's groups said, "My friends were murdered and it shouldn't have taken that but it was the catalyst. Before we were criminals and after we were victims. Iceni in particular gave us the support and strength to stay off the drugs and not go back."

Six years on, the more proactive interventions of education, housing and debt management are still firmly in place to prevent the emergence of a new generation of vulnerable street girls. The new structures created by the 'Make a Change' team targeting sexual exploitation and the creation of Suffolk's Multi-Agency Risk Assessment Conference (MARAC) ensure the problem of drug using street workers is now close to negligible.

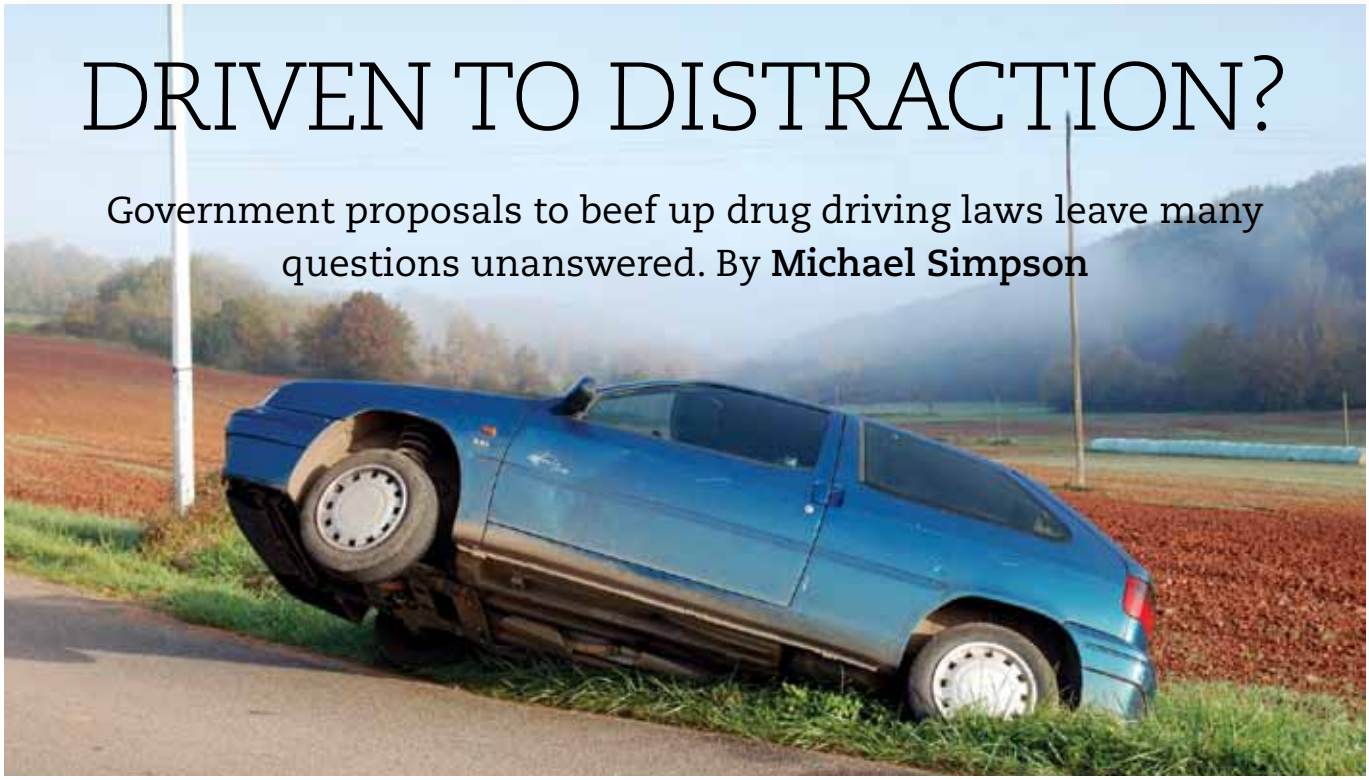
Getting all senior police and councillors backing to the strategy was critical to a successful outcome although they may also have been driven by the desire to diminish the reputational damage to the area from tabloid headlines such as 'Town of Fear.' The Drugs and Alcohol Team (DAAT) found it hard initially to build trust and credibility but the first step was to treat the women as the victims.

Simon Alders, Head of Suffolk DAAT said, "Previously there had been something of a laissez faire attitude – considering these girls' lifestyles as their personal choice. But following the murders, we took a much more assertive stance. We had to develop a 'good offer' for them and abandon the old model of just handing out condoms and needles. We gave them all the help we could to stop them finding a reason to go back to putting themselves at such extreme risk on the streets." There were fears that the women would simply transfer to off-street sex trade but it did not materialise. There has also been a concerted programme of prevention in schools which was "critical" to stemming the flow of new street workers.

Members of the 'Make a Change' team were invited to share their conclusions at a higher Government level and in other regions but so far there has been little application of the Ipswich experience elsewhere. *See also feature on p16-17.*

# DRIVEN TO DISTRACTION?

Government proposals to beef up drug driving laws leave many questions unanswered. By **Michael Simpson**





After being initially announced by the Government at the beginning of 2012, proposals to strengthen enforcement powers to combat drug driving were introduced in the Crime and Courts Bill published in December 2012. Taking on some of the recommendations of the North report, a major review into the prevalence of drug driving published in 2010, the bill proposes a specific sanction police can apply to drivers they suspect of being under the influence of drugs. Separate to the bill, in anticipation of the development of a saliva-based roadside testing kit, a working group of experts has been set up to assess the levels at which a number of different substances impair driving.

While roadside test kits should, in theory, be able to detect certain substances, it will take a blood sample taken in the police station to ascertain the specific amount of a given drug in the body, and accordingly the levels of impairment. As it stands, forensic physicians (doctors), are required to administer the tests. The North report also recommended that nurses, many of whom will already be employed in police station custody suites, could perform the task.

However, Sir Peter North also noted that people driving under the influence of drugs were likely to be also impaired by alcohol. With the penalty the same for the two offences, and a breathalyzer yielding an instant result, are police likely to go to the effort of also testing for an illicit substance? What motivation would they have for doing so? The Department for Transport has been clear in stating that the proposals are first and foremost a road safety issue. The police are likely to see their role as enforcing the new law, not studying drug use patterns among drivers.

Nonetheless, and as the North reported noted in 2010, the level of evidence on drug driving is poor. Estimates from 2008 put the number of casualties attributable to impairment from substance misuse at 263, 56 of which were fatal. This, in North's words, is all out of proportion with the perceived scale of the problem. While his report urged the Government to commission a study to improve the evidence base, nothing, as yet, has been announced.

The European Monitoring Centre for Drugs and Drug Addiction recently produced a report that attempted to assess the extent of drug driving across parts of Europe. While the UK along with France and Germany did not take part in the study, it does provide some clues to what substances might be prevalent among drivers on British roads. THC, cocaine and amphetamines were the most commonly recorded, and were found in 1.3 per cent, 0.4 per cent and 0.08 per cent of drivers respectively. That 3.6 per cent of 15 to 64 year olds across the whole of the EU and Norway have tried cannabis in the last month, a figure which obviously includes a number of people too young to drive, gives some indication of the potential number of drug drivers in the UK, where cannabis use is among the highest in Europe.

It would be wrong to assume that cannabis detected in the system necessarily leads to impairment. The drug can stay in the body for a number of weeks. While the proposed roadside testing kit will be designed to only detect the impairing element in cannabis, how accurate the device will be remains to be seen, and does raise the prospect of false positives.

There are also questions around how the proposed new powers will be applied. Stop and search powers, particularly in London, have led to a disproportionate number of arrests among young ethnic minority people. If some police decided to use the new powers to extend stop and search to 'stop and test', this would further erode community relations in areas where this is already fragile.


FROM THE DOCUMENTARY 'EVERGREEN'

# UNHOLY ALLIANCE

Washington (with Colorado) became the first state in the USA to legalise the recreational use of cannabis. But along the way, Proposition I-502 faced some unlikely opposition. By **Harry Shapiro**

The voters of Washington State made legal history voting in a 55/45% split to allow the smoking of cannabis in private by those over 21. Yet the campaign to legalise cannabis was opposed not only by the usual suspects of law enforcement agencies, but both by the medical cannabis lobby and some groups who had for years been campaigning for cannabis law reform.

The campaign got off the ground in mid-2012, backed by some heavyweight supporters most notably Seattle's elected City Attorney, Peter Holmes. The group worked frantically against a tight deadline to gather 241,000 signatures, from among the State's voting population, the number needed for the measure known as Proposition I-502 to be put before the State Legislature. That body can decide either to pass the measure straight into law or put it to the people. Given the controversial nature of I-502, no politician wanted to publicly back it in the Legislature, opting instead to let the people decide.

However, as the campaign got under way, there was vociferous opposition from the medical cannabis lobby. The crux of the problem was that I-502 included a provision that set a THC blood level for driving under the influence of cannabis which patients, who often had high levels of THC in their blood without any obvious driving impairment, feared would mean that many would now face prosecution for Driving Under the Influence (DUI). The reform campaign had included this provision in order to head off opposition from public safety groups like Mothers Against Drunk Driving (MADD) who had lobbied hard against a similar legalising proposition in California in 2010 – but which had no such testing provision – and successfully saw it off.

Groups in favour of legalisation also opposed I-502 on the grounds that it was too restrictive. They didn't want to see a cannabis law on the statute book that still prohibited use by those under 21; that still prohibited growing for personal use and smoking anywhere other than in private. This prompted the Seattle Times in an editorial (20th August 2012) to tell such opponents to 'get real' and not scupper I-502.

By contrast, supporters came from equally surprising quarters, none more so than right-wing Christian evangelist Pat Robertson who said, "I really believe we should treat marijuana the way we treat beverage alcohol. " And of course, the ability for Washington State to earn valuable tax dollars in a time of recession was an argument that probably helped sway those who might not be natural supporters of drug legalisation. Underpinning the support of somebody like Robertson would also be the libertarian opposition to government intervention in the lives of people especially when a 'victimless crime' such as cannabis smoking is concerned.

More controversy surrounded the campaign funding of the reformers; they managed to attract $5m in donations, a substantial chunk of that coming from Peter Lewis, the CEO of Progressive Insurance. Conspiracy theorists suggested that if the new law resulted in soaring rates of DUI convictions with consequential hikes in insurance premiums for convicted drivers, maybe Progressive Insurance had a stake in the proposal becoming law. In fact, Peter Lewis has a long track record of supporting cannabis reform efforts and was arrested himself in New Zealand in 2000 for cannabis possession.

One might have thought that in America, a well-funded national anti-reform lobby including faith groups and others would have weighed in against I-502. But this simply didn't happen. Nils Cowan, producer and writer of a documentary currently in production, *Evergreen: the road to legalization in Washington* says, 'the No camp told us they only raised $6800' compared to the $5m war chest of the Yes campaign.

The situation with cannabis supply right now in Washington is intriguing. It is legal to buy and smoke cannabis for recreational purposes, but there is nowhere legal to buy it from. This means a sales bonanza for cannabis dealers, both from State residents and the inevitable influx of drug tourists, while the officials sort out the licensing and quality assurance arrangements which will involve the setting up of a body similar to the State Liquor Board. Officials are calling the medical marijuana dispensary who joined with medical lobby in opposing I-502, to ask for advice on how to set up a state-run cannabis business. If they cooperate, this could be the turkeys voting for Christmas. It is well known that many of those in receipt of medical cannabis prescriptions gained them on the most spurious of pretexts; new state-run outlets will be in direct competition with these private businesses. On the quality assurance side, the State will have to be careful not to be too proscriptive on what can be sold for fear of driving customers back to the illicit market.

All of which begs the question as to how the Federal authorities will react, in particular the Drug Enforcement Administration (DEA). Another provision of I-502 was that there should be no sales within 1000 feet of a school zone. The DEA responded in August last year by writing to every medical cannabis dispensary (technically operating legally anywhere it likes) threatening them with closure if they violated this provision.

President Obama has made a public declaration that targeting individual smokers was not a government priority, possibly a coded message to the DEA not to kick in doors of those who had democratically voted for the repeal of a law that was still a Federal offence. However, he was silent on the issue of the retail outlets that would spring up and the creation of a cannabis licensing authority. Should the DEA try and arrest a state or city official on a charge of conspiring to break Federal law by issuing a cannabis retail licence, then Washington State will be on collision course with Washington DC.

**To find out more about the forthcoming documentary go to: www.evergreendocumentary.com**

# Cannabis and health

Two new reports underline confusions over the impact of cannabis on health.

A recent paper on the link between cannabis and schizophrenia co-authored by researchers from Bristol and Cardiff Universities (and in line with ACMD analysis) have concluded that the evidence is not strong enough to make a direct causal link between the two. In particular they state that ' ecological studies have found little association between the increase in the cannabis use in recent decades and incidence of psychotic disorders; public health models suggest that cannabis use may need to be treated and prevented in many thousands of users in order to prevent one case of schizophrenia'

Another new report has cast doubt on US data published in 2012 by the Duke Transdisciplinary Prevention Research Center which suggested that those who used cannabis heavily as teenagers saw their IQs fall by middle age. The new analysis by Ole Rogeberg, a Norwegian economist, suggests that socio-economic factors may play a role, for example, poorer people have reduced access to schooling. The data from the States came from the now famous Dunedin study in New Zealand where around 1000 people born in 1972-73 were tracked to age 38 and beyond. This

data showed that those from of lower socio-economic status were more likely to being smoking cannabis as teenagers, more likely to become dependent – and this argues Rogeberg, coupled with the schooling issue, could account for the correlation between cannabis use and IQ. In response, the US researchers said they took all this account and concluded that the decline in IQ cannot be attributed to socioeconomic factors alone.

*Nature* commented that it is hard to say which research outcomes are correct because the researchers have taken the same data set, but studied it in different ways and each has merit.

# Paul Hayes

Always a controversial figure, Paul Hayes has nevertheless been a tireless champion for treatment. With the NTA shortly to fold into Public Health England, he reflects on the political realities of establishing and maintaining the treatment system in this specially extended interview with **Harry Shapiro**.

### Can you remind us of the political background to the setting up of the NTA?

The NTA was the idea of the tsar's office (more Mike Trace than Keith Hellawell) – and the Home Office. The government believed that if you could get people into treatment, that would make a major impact on crime. They didn't trust the NHS to spend enough money on drug treatment, even if they gave it to them. They thought the NHS would nick it and use it for hip replacements and they almost certainly would have done. What they wanted was a mechanism that would oversee the spend. The early period from 1997-2001, the new Labour government was tied to the previous government's spending plans, so there was no additional money. They then decided to increase investment across the whole of the public services and the increase in the treatment spend was part of that whole package. Given that crime was the main driver here, 'tough on crime, tough on the causes of crime', they didn't want Milburn (Health Secretary) siphoning it off and spending it on other things that were more important to the NHS. So the birth of the NTA, unique among health bodies, was announced by Jack Straw, the Home Secretary, not by the Department of Health.

The NTA was announced before the 2001 election but didn't start until after the election by which time David Blunkett was the Home Secretary. The tsar had been shunted off to do international stuff, the tsar's office had been closed down in the Cabinet Office and moved into the Home Office. That was the point at which the Home Office took control of drug policy. Everybody thinks the Home Office has always controlled drug policy, but they didn't until 2001. Prior to that, starting from the first drug strategy – John Major's Tackling Drugs Together – control of the drug policy had been in the Cabinet Office. The Home Office have always had an interest, but they weren't the lead department until 2001.

### Did you share the same view as government, that the NTA was essentially there to deliver reductions in crime?

We saw the NTA as multi-faceted; the theme of speeches at the time was 'three for the price of one'. There was the motivation from the government: what justifies it to the taxpayer is reduced crime, benefits to society of people getting back into work, reduced benefit payments and all that. But you've also got the investment that comes off the back of the crime link; it enables you to invest in harm reduction services to prevent public health risks and thirdly gives you a big enough treatment system to enable you to provide decent services for individual users. Wider societal, public health and individual benefit as long as you meet the government's objectives on crime. If you do that, you trigger all the rest, otherwise the money tap gets turned off and you can't do anything. You might then be ideologically pure, but you would be back to where we were when we came in which is people waiting months, most people being outside the treatment system, most of those coming in dropping out again in the first few weeks, drug related deaths escalating and so on.

### How would describe your relationship with government over the period?

Relations with ministers were mostly good, but it always goes up and down. The key thing politically was the relationship with the Prime Minister. The

Blair government did business through dedicated funding streams, targets and what they called Prime Ministerial stock takes. So for an issue that was important like drugs, there was a quarterly meeting at number 10 with the PM that I went to with cabinet ministers, Home Office, Health and the Foreign Office. You'd sit around the table and talk about supply, about Afghanistan, and you'd talk about treatment. And the focus was usually on treatment; what we were doing, how well we were doing, and in the early days, they had to take an awful lot on faith. There wasn't any NDTMS, there was no way to actually account for what was going on, we had to lash up systems in order to count waiting times with some degree of approximation and it wasn't until NDTMS properly came on stream in 2005-06 that we were able to account with some clarity and confidence and appropriate speed as to what was happening.

Ministers are always impatient for delivery, they always want more than you can give them. But generally, the PM was very supportive and he demonstrated that support through continued investment. DIP came out of one of the stock takes; we pitched the notion of joining the different bits of what we were doing with the criminal justice system; we had arrest referral, Drug Treatment and Testing Orders (as they were then). But people were still being referred from arrest referral to the back of the queue. The pitch was that we should join all the different bits of the system together; we could then identify a much bigger pool of resources and expand the treatment system itself, not just the routes in.

**And in the process, gave birth to the notion of the two-tier treatment system where it was perceived that the best chance of getting into treatment was to heave a brick through a window?**

Yes. That's where that myth came from. I spent years saying to people 'find me somebody who has looked on the Home Office website, found where the intensive DIP areas are, has worked out that there is a trigger offence that isn't going to get them sent to prison, looked where the beat bobbies are going to be and then gone out and timed it so he gets nicked in order to get into treatment.' Nobody did. And that has ceased to be an issue, because we levered in the extra DIP resource, which meant the entire system grew. So then everybody was getting into treatment in a few days. And that was always the whole point, to use the criminal justice resource to drive up the treatment system.

**So the personal involvement of the PM was a critical factor then?**

Absolutely. The drug sector owes Tony Blair a lot. It gave us leverage with officials because they don't often see the PM and particularly in the Blair government, much of the business was run from number 10. So I could say, 'I'm about to see the PM next week' or 'Last week I saw the PM' and credibly show that you knew what the PM wanted.

The only problem we had was once we had NDTMS up and running, we were the only people who had any numbers. That gave us clout, but it also meant that everything focused in on us. If there are no numbers that anybody trusts about supply or crop eradication in Afghanistan and if the evidence base around prevention is weak, more attention is focused on treatment because it is the place where the evidence base is strongest, the place where the investment is going. I would go to massed ranks meetings in Whitehall to discuss the progress of the drug strategy, and they would gloss over everything else in five minutes and spend the entire meeting with the Permanent Secretary from the Home Office giving me a grilling for an hour on what we were doing with drug treatment because there was no other game in town. Here was something they could performance manage. If you haven't got numbers, you can hide. You have these important people from Foreign Office talking about Afghanistan, shrugging their shoulders and getting away with it – partly because they were important people from the Foreign Office and partly because everyone knew they would get nowhere with it.

We set up NDTMS because we wanted to improve stuff, not just to demonstrate things were improving but to actually drive improvements and NDTMS, I think, is probably the most important legacy. The target in the 1998 strategy had been to double the number of people in treatment, pre-NTA. We inherited that target; it quickly became apparent to us that it had been framed as it was because nobody knew how many people were in treatment, nobody knew what the baseline was, nobody had defined treatment, and there were half a dozen different definitions of what 'in' meant as in 'in treatment'! If you are going to start allocating money, start trying to work out if people are getting better, are they doing as well in Manchester as they are in Leeds, you have got to understand what's going on and define it in some detail. You've then got to collect data to support that.

**And does this partly account for the often fractious relationship between the NTA and the treatment sector?**

Everybody screams about bureaucracy, but without the means to count anything, you are handing out £700m a year for people to do what with? Look, nobody likes to be told what to do. I don't think the NTA could have had anything other than a fractious relationship with some in the sector because a lot of the sector was letting service users down. There is a potent myth being propagated that pre-2001, treatment was difficult to access but of high quality for the lucky few. Anyone who thinks that should read the Audit Commission's 2002 report 'Changing Habits', which paints a damning picture of the reality. So when we came in, people were waiting an average of nine weeks to get in, the quality of interventions in many places was very poor, leading to very high early drop out. I knew that because I had worked in and around the sector for many years, as had most of the other people working in the NTA. And we talked to service users and they told us what was happening – too many people in the sector were happy with that, were complacent. They told us 'you can't get people in quicker'. There was a big row that waiting times have to be that long. And there was a row that once we had people in, we couldn't retain them – because you can't have a big open door and keep people in. Some people in the sector resisted every single improvement we tried to instigate. Some of them because they didn't like central direction, but some because they were quite comfortable being left alone to provide a terrible service to people that no-one else gave a toss about.

## Can we talk about 2007 which was something of an *annus horribilis* for the NTA?

Peoples' memory of what happened that year is often wrong. The interviews that myself and Dawn Primarolo [Health Minister] gave to the BBC came first and that was about an NTA report on contingency management. The Mark Easton thing about treatment data came afterwards.

But just stepping back; the story of 2007 really starts in 2005. That year we unveiled something that now everybody's forgotten about called the *Treatment Effectiveness Strategy*, launched by Tony Blair at a high profile event in Alan Milburn's constituency (some blogger accused me of making it all up, well if I did, I did it big time!). We said in 2005 that getting everybody in isn't enough, that what we need is a system that has a back door as well as a front door because if you don't, we will very soon silt up and we then either need shedloads more money – which even before the credit crunch we knew was not sustainable – or we have to shut the front door and we are back where we started. We got nowhere with that; nobody wanted to know. The doctors were saying that the key is to get people in and retain them, and yes a trickle will go out the back door but that's not the point. Commissioners were OK with that because it was delivering a system they wanted; fewer people dying, crime was down, so the cops were happy with it, the politicians were happy with it, everything was aligned to access and retention, not completion. What we wanted eventually came out in the Strang report [in 2012] – which made it clear that heroin users should not be parked indefinitely on substitute drugs and all prescribing treatments should be regularly reviewed. But the *Treatment Effectiveness Strategy* was five years too early, the sector was not prepared to go there.

The big mistake we made was to frame it as a management problem, 'we'll run out of money, we need to build a back door'. The service users were still stabilising; the doctors wanted to protect maintenance, which had only been formally endorsed by the Department of Health as late as 1997, and quite rightly too. If we had aligned it more with service user aspirations we might have had more chance, but then again the service user movement at that time was more focused on access and retention and having the right dose of methadone. Maybe we should have revisited it a bit earlier, but that's why the 3% furore of October 2007 was so potent. We thought it should be the next big thing and we were right, but too early.

## So what happened in 2007?

The train wreck interview focused on a report that we published on contingency management that I had never seen. There is this myth that if you are doing a job like mine, you see every bit of paper. Mark Easton starts asking me detailed questions about this stuff and I didn't know. So instead of me taking the flak for government, which was the way it was supposed to work, Dawn Primarolo had to come on the Today programme and take the flak for me. Later she made it clear that that wasn't going to happen again! What that did was to damage the NTA's reputation with the media and that made us more vulnerable for what happened later that month.

There were no interviews with us at the time of the Mark Easton piece about the 3% drug-free figure, that was all done by emails and phone calls because Mark Easton had misinterpreted the numbers which he subsequently admitted to us privately. You can cut the data to come up with the 3% figure, but the actual figure was more like 6%. No-one is saying there was not an issue with the system – which is why we were raising it in 2005. The whole 'parked on methadone' thing is simplistic, but the system had not been as ambitious as it should have been and that's the whole basis of Strang – and the 2008 drug strategy says the same thing. Unfortunately it was the case that you could come into treatment and be actively dissuaded from leaving by the people delivering the treatment and we have heard that from far too many service users for it to be a total myth.

But you can understand how that happens. Many drug workers have become dazzled by the mantra of the chronic, relapsing condition and of course that can be true in a lot of cases. Keeping people scripted on methadone is the cheap and easy option especially if you have a service where the workforce is poorly managed and trained, yet you are expecting them to approach each client, day in and day out as a fresh opportunity demanding their highest professional skill and motivation. The sector grew very quickly, and suffered in terms of quality because of that, not as able to respond to these subtleties and complexities as we would have wished. This meant that we got criticised for building the system too quickly, but given the thousands of people out of treatment and all the misery and chaos that was causing, we had a moral duty to open the door as wide as possible – and then try and drive up the quality. So it would have been morally wrong, for us to just to build a pristine system for 25% of the people and say the rest of you can get stuffed.

## So apart from the deep divide that opened up in the sector, what were the political repercussions?

The 1998 strategy had run its 10 years. The 2008 strategy presented the opportunity to say that Mark Easton was wrong in the specifics but right in the thrust. So the message to the sector was 'if you don't want the 'parked on methadone' critique from the Centre for Social Justice [CSJ] to lead to abstinence only, you have to respond to the bits of it that are right.' And we persuaded ministers of that.

Another reason for the lack of traction we got in 2005 was we didn't have as much access to ministers then as we had in 2001. Firstly, because we had been a success and had therefore slipped down the priority list. And Blair was distracted by foreign affairs, so he couldn't drive it as much and it was seen to be going in the right direction. At the time, there was John Birt's thing to make consumption illegal and have compulsory treatment for all heroin users which was seen off by Blair, Blunkett and John Reid because they said we are backing the NTA to deliver this for us, so we don't need this radical stuff – and more resources had been committed to it following the 2005 election.

Come to 2008, ministers were re-engaged because the Tories had made it a political issue. The CSJ had undermined the Labour argument that they had got a grip on the drugs problem by using treatment to drive down crime. The CSJ were saying this is the wrong kind of treatment and people aren't being enabled to recover. The benefit of this to us was that it re-engaged ministers, enabling us to rework the 2005 treatment effectiveness strategy for 2008, now with ministerial support.

## So how did the political landscape for drug treatment pan out between 2008 and 2010?

While the word recovery doesn't appear in the 2008 strategy, the aspirations of it are very similar to 2010. The key difference is that 2008 is focused on societal benefits/harms; and these are addressed by helping the individual. The 2010 strategy is driven by the individual, so that by helping the individual, there are wider benefits for society. But back in 2008 and 2009, the doctors still weren't buying into it. I had a very angry meeting up in Manchester where I genuinely felt physically threatened because I was saying to them, that they were not doing the best for every single patient they saw, which caused great resentment. Our concern was that if they didn't voluntarily buy in to recovery, we ran the risk of an unevidenced, ideologically driven, abstinence-only agenda being rammed down our throats which was doomed to fail. Two years later, with both psychiatrists and GPs having new politically astute leadership, they are signing up to Strang which is saying much the same thing. After the election, they finally got real and realised they had to start delivering in line with the evidence, otherwise they would be faced with delivering something driven by ideology not evidence. We were able to go to the new ministers and demonstrate how we were going forward with this. To their credit, not only did they keep the money going, in very difficult financial circumstances, but were willing to have a conversation that took the 2010 drug strategy to a different place than you would have anticipated on the basis of some of the things that were being said before the election. From the ideological purity of opposition, ministers have to adjust to the reality of being in power; you are privy to information you didn't have before, you've got pressures on you to make it work. Then you have to work with people to decide how you deliver the essentials rather than the froth in a way that will work and is consistent with the evidence.

## So what about the future?

Opportunities and risks – and they are the same things; payment by results, localism, local authority leadership and Public Health England (PHE). Local authority leadership has a great opportunity to deal with issues like jobs and houses which we have never got right. Local authorities as 'custodians of place' which is their jargon, are more interested in playing the long game. But that has to be traded off against political short-termism and increases in democratic accountability. Similarly with the Police and Crime Commissioners; a real opportunity to champion the criminal justice benefits of treatment and therefore retain the investment. The crime agenda hasn't gone away; our analysis together with the Home Office is that ready access to treatment keeps the lid on just under five million crimes a year. Now if you are Home Secretary, you don't want to take that lid off. But if you are a Director of Public Health, you might be very interested in diverting drug spend towards alcohol or obesity; drug addiction doesn't kill many people compared to alcohol or tobacco. If you are going to spend money from a narrow public health perspective, you are not going to spend money on drug treatment. So we still have to talk about those broader issues of unemployment and crime, inter-generational transmission – selling the societal benefits but more localised. And if you don't, then the money will dry up. It can't just be seen as a health problem otherwise you are at the back of the queue – and you can talk about stigma until the cows come home, but you'll still be at the back of the queue. Without a sense of drug addiction as a threat to the rest of society, the rationale for spending money on it is much diminished. People don't like that; and that's why we have been happy to defend ourselves against all the aggro. And that goes back to where we started; the NTA would not have been created if not to fill that space. From Day 1, we knew there would be pressure from both sides on that, from the politicians and the sector. So we didn't need to harden ourselves; that was part of our fitness for purpose.

Increasingly in terms of the political agenda around drugs, it will become less important what the Home Secretary or the Health Minister thinks and more important as to the views of the leader of local councils – and local media are going to matter more. There is a tension though; governments tend to like localism in opposition and early in the Parliament. The extent to which the government will allow local areas to go to hell in a handcart and be accountable to their electors for that will be interesting to see. And PHE, for example, will be in that space. It will have an entirely legitimate role to say, for example, to Leicester, 'you're doing this, but they seem to have sorted that out better in Derby, do you want to have a word with them?' That's hardly micro-management, but it is keeping a watching eye on what's going on, having an influence, being able to enable people to learn from each other. None of that is undermining the local authority's ability to spend its money and make its own decisions. But it is giving them a wider range of better informed choices. And to a large extent that's how the NTA has always done business. We have never been a formal part of the NHS management structure, so we have never actually been able to tell people what to do. We just persuade them forcefully. Somewhere between a gentle reminder and a money-driven instruction, the new world will land.

Treatment still needs advocacy; whether it needs protecting is another matter. And there will still be a body of people advocating strongly both for drug and alcohol treatment within PHE. The risk is that they won't be able to be as focused because it will be an over-arching public health approach. And my big fear is this phrase, 'narrow public health', focussing on the five big killers. There is nowhere in the public health mindset that thinks crime and welfare dependency. And that for us is core business, and if it ceases to be core business, then we cease to justify the investment because in strict health terms you cant justify spending four or five times more money on drugs as you do on alcohol. Alcohol has had to survive in an NHS-driven environment – and how did it do? Badly. How would drugs do in the same environment? Even worse. If I talk to PHE people, they get it and they genuinely commit themselves to a broad public health perspective embracing poverty, crime, employability etc. But the default 'narrow public health' mindset is powerful and resilient, particularly when no one with a drug/alcohol perspective is in the room. The treatment sector and the service user and carer movements need to stay active to keep local authorities and PHE alive to a world that isn't part of their mental map.

# Endangered species

While by no means extinct, the traditional drug squad officer is one of a dying breed. **Matthew Bacon** spent two years with two drug squads studying the changing landscape of drug law enforcement.

Drug squads are specialist detective units mandated to police drug markets and drug-related criminality. They have been a key element of drug law enforcement since around the 1960s, when media and political uproar about the taking of drugs by young people prompted a dedicated and specialised police response to the novel and increasingly notorious 'drug problem'. As half of the first full-time two-man drug squad in the north-east of England, Malcolm Young has subsequently written that he was 'tasked with defining and dealing with the new social aberration of "flower power", "the counter culture", and the "psychedelic trip"'. Up until this point in the history of drug control, drugs had been policed in a relatively routine and haphazard manner, as and when police officers stumbled across or were called upon to do something about suspected drug offenders in their area. As drug problems worsened in the 1980s, an era when 'war on drugs' rhetoric was reverberating on both sides of the Atlantic, the enforcement approach came to dominate drug control policy, accounting for at least two-thirds of the spend. Although they differed significantly in terms of their organisation and operations, by the late 1980s, all of the police forces in England and Wales had drug squads in place.

Over the past decade or so, however, there has been a substantial decline in the number of drug squads operating at both force and district level. To further investigate this largely unreported sea change in drug policy, I set out to examine the culture and daily activities of plain clothes drug detectives working in two contrasting constabularies: one metropolitan area in the south, which I call 'Metropolis', and a small town in the north, 'Smallville'.

Before fieldwork commenced in Metropolis, I learned that the drug squad had become the firearms squad a few years earlier, and while the detectives employed in the squad remained the primary drug law enforcers of the district, their focus was now on firearms offences. Towards the end of the fieldwork period their mandate changed to gang-related criminal activity and the firearms squad was rechristened the gang squad. As for the situation in Smallville, plans were put into motion to disband the drug squad as my research project was coming to a close, with the intention of merging the separate squads of the proactive investigation department into a generalist crime squad.

The Smallville detectives did not react terribly well to the pending demise of the drug squad. It provoked them into questioning the motivations and competencies of their supervisors and chief officers. Signs of anger and frustration were regularly displayed as they told me about how management 'didn't have a clue' and would 'end up regretting their decision'. The detectives were convinced that drug dealers would take advantage of their newfound freedom and in turn there would be more drugs on the streets and more drug-related crime. They truly believed in the importance of their work, so not only did the decision to disband the squad deprive them of their territory, it also challenged their sense of mission and made them feel devalued and dejected. From their perspective, the police service no longer considered the control of drug supply to be a priority and this was a huge mistake. The Metropolis detectives said they remembered reacting similarly when the drug squad became the firearms squad, but they soon accepted the decision and the need to concentrate on dealing with the most harmful criminal elements of the drug trade, seeing as 'it is impossible to deal with them all'.

This downgrading of drug policing can probably be attributed to a combination of three factors: resources, results and realisation.

At the organisational level, police managers have to decide how to prioritise the deployment of limited resources to enforce the law and perform other policing tasks. Within this constraint – common in many policy realms – further decisions about the appropriate use of the law and the suspects against whom it should be used were made. 'Drugs have always been and will always be a priority,' the police frequently assured me. Yet albeit an official priority, during fieldwork it was found that drug law enforcement had been unofficially deprioritised and was downplayed when there were deemed to be more serious and pressing issues to deal with. In the words of the senior officer who made the decision to

refocus the detectives of Metropolis onto firearms: 'If all other crimes somehow go down, if we can get rid of all the serious crime, all the shootings and stabbings, the terrorist threat, then maybe drugs will become a priority again.'

Police managers regularly asserted that they struggled to justify using their limited resources to enforce drug laws when there were victims of crime in need of police services. In addition, they told me that, since the Updated Drug Strategy of 2002 had removed drug offences from the national performance indicators, it had become practically impossible to continue to prioritise drugs and meet targets. During interview, one Detective Inspector from Metropolis said: 'We could choose to ignore drugs if we wanted to, because it's victimless and isn't performance managed anymore… In the police there's a saying: "you only have a drug problem if you look for it". The more we police drugs the more problems we find, and management don't want us to go out and find any more problems – just look outside, we've got enough work on.'

Furthermore, the officers I studied acknowledged that their efforts could only ever have a marginal impact upon the drug trade, whether they were to police drugs through routine police work alone or in combination with a specialised response. This much is evident in the following quotations from both areas studied:

'One thing you quickly come to realise in this job is that no matter how many dealers you put away there's always someone out there selling.'
Detective, Smallville

'The fact of the matter is millions of people commit drug offences every year – what are we supposed to do about that?! Apart from the ones that cause people harm, I'd say no one expects us to do anything.'
Detective, Metropolis

These findings can be interpreted as being connected to the pragmatic dimensions of police culture and the need for managerial efficiency. They also suggest that drug law enforcement is more of a symbolic police priority than an actual priority, which represents their values and sense of mission rather than their true objectives and practices.

So what are the more important implications of the study?

The decline in the number of drug squads and the deprioritisation of drug law enforcement strongly suggests that both the government and the police have started to move away from the heroic but quixotic drug war towards a more realistic management approach to dealing with drug-related problems. If anything, the recent public sector budget cuts will force them to walk even further down this path and become even more minimalist in their interventions.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The aforementioned changes might, on the one hand, result in enforcement initiatives being aimed solely at reducing the most socially harmful problems that are caused by and associated with drug distribution. Such an approach would lead to a reduction in the number of people entering the criminal justice system for relatively harmless supply and possession offences. On the other hand, seeing as officers carrying out routine patrol and response tend only to encounter users and street dealers, it could equally lead to the over-policing of the lower levels of the market. Whatever happens, the CID will continue to investigate drug dealers and uniformed officers will continue to police drugs in their neighbourhoods. Devoid of drug squads, however, the police will inevitably mount fewer investigations, from which one can infer that dealers – especially closed-market retailers and middle-market distributors – are at less risk of being detected and arrested.

Taking a selective approach to enforcement can be criticised for flying in the face of the rule of law and to some extent condoning the buying and selling of certain drugs in certain contexts. But if one works on the assumption that the drug trade is a constant and that policing is a marginal activity, there are few alternatives if drugs remain situated within a criminal law framework. Given that drug law enforcement is under-resourced and the drug trade is increasingly under-policed, it is time to seriously start thinking about alternative policing methods and policies for dealing with drugs.

■ **Matthew Bacon** is a Lecturer in Criminology at the University of Sheffield.

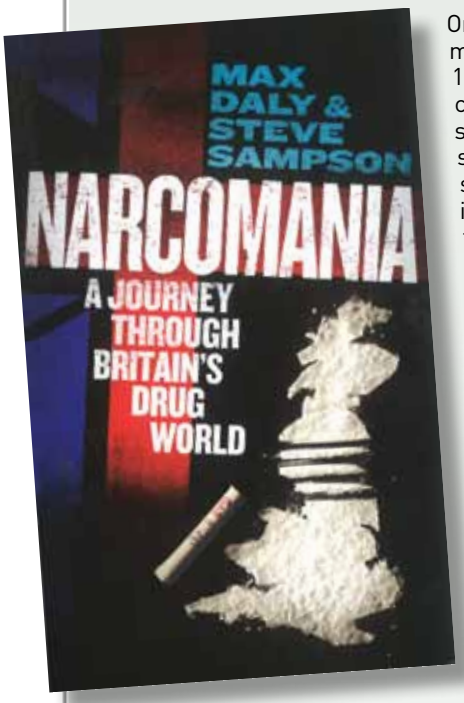
**In 2011, the UK Drug Policy Commission published *Drug enforcement in the age of austerity* based on a survey and workshop covering both regional constabularies and local command units.**

**The key findings were:**

- Drug-related policing expenditure and activity is expected to decrease and there is a perception that it is faring worse than other police activities
- Proactive work related to the detection of drug supply is expected to decrease. Activities such as covert surveillance, test purchasing and other intelligence gathering work were most often mentioned as likely to decrease. This of course, undermines the restricting supply strand of the 2010 strategy which sought to 'make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks", although another finding of the UKDPC report was that those drug-related activities that could be income-generating, like asset seizure, could increase.
- Finally, survey respondents believed that in a time of financial squeeze, the police would focus on 'core business' and be less inclined to engage in partnership working at a local level. Ironically, back in 2009, before the real impact of the financial freefall on public services was felt, the UKDPC published a report about refocusing drug-related law enforcement to address real-life community-felt harms. In that report, they said, 'partnership working is vital to maximise the effectiveness of action to reduce drug market-related harm'.

## BOOTS ON THE GROUND

**In an extract from *Narcomania* (see review page 26) Max Daly describes Operation Audacious, a very visible exercise in community policing**




On a dark December morning in 2011 around 150 local schoolchildren, community workers and senior business leaders stood bleary-eyed and shivering in a warehouse in Manchester. Sharing the room with 1,000 police officers, many in riot gear, the locals listened to a briefing by a senior officer about what they could expect to see on the trip around some of the less salubrious parts of the city. Operation Audacious was, he said, the biggest ever operation against drug dealers in Manchester, and onlookers would have a ringside seat as officers raided the homes of one hundred suspects.

The police's guests piled into a fleet of hired minibuses to begin the slow crawl at Safari park speed behind a procession of police vans and officers on foot, into the habitats of drug sellers in Manchester, Bolton and Stockport. As the journey began, Operation Audacious, or #OpAudacious as it was known on Twitter, was launched in a multimedia publicity whirl worthy of a new pop band. A press release, Facebook page, flyers and a YouTube video, as well as the Twitter feed, were launched to promote the tour.

Senior Manchester police figures were at pains to stress that this was an action brought about as a direct result of public concerns and the wishes of the community. The biggest ever drug bust in the city's history was prompted by, witnessed by, and for the benefit of the public.

The raids began. Peering through the minibus windows, the passengers looked on as suspected drug dealers were dragged out of their freshly broken front doors in various states of undress, blinking under TV spotlights, and into the back of police vans.

Back at the warehouse HQ, a bank of huge TV screens showed the live action as officers dressed in riot gear entered a drug safe house in the suburb of Cheetham Hill.

The police have always made a meal out of drug raids, now a daily occurrence in every city and county, and in the media, thanks to the growth in cannabis farms. It is (unless the door won't budge) a dramatic visual way of showing the public that officers are doing what they are being paid to do, protect the public from drug dealers.

Some saw Audacious as a hollow publicity stunt, although it was more than that. There was a media circus, but the raids were carried out after good police work and as a response to leads provided by local people who had grown impatient with their drug-selling neighbours. Unintentionally however, Operation Audacious, with the highly visible arrest of well known drug dealers, may have provided a window onto the future of community drug policing.

During the writing of *Narcomania*, local drug officers said that a lack of resources had created some embarrassing situations. One officer was told by his bosses that there would be no further action taken after he found six men in a room with £15,000 of heroin, because there was neither the time nor money to prosecute them all. Another admitted that there was an unwritten rule not to arrest dealers too late on in the afternoon because it would be too costly as the investigation would involve several officers working overtime.

Police have always had to be selective about who they target. They can't arrest everyone. Officers know the best they can do is keep the drug trade at bay, no more, partly because the battle between public sector (the police) and the private sector (the drugs gangs) is so unevenly resourced in terms of cash and manpower.

On the streets and in council estates, the lower echelons of the drug trade – the teenage dope smokers, the small time heroin and crack users and dealers, the gofers and the runners, the low hanging fruit that police are able to grab without too much trouble, will continue to be arrested, as they always have been.

But with money drying up for drug policing across the board, and little success in curtailing the organized crime networks that feed local drug markets, police have had to become even more selective in which aspects of their local drug markets they can afford to clamp down on.

If the drug trade cannot be defeated, the next best thing is damage limitation, focusing on what can be done, rather than what cannot. Much of this damage limitation is public facing – reducing fear of drug crime, protecting communities from drug related nuisance and being seen to act swiftly in the face of public opinion. With the arrival of police commissioners to the regions, this tactic is likely to become a bigger part of everyday community policing in years to come.

If there is a specific problem that the public want to get cleared up, the police will respond. So if police get a call about dealers selling drugs in a park they will act on it. Like a request from a resident for the council to come and pick up dumped rubbish, now the police looks set increasingly to become a public service utility, to be 'called out' to deal with nuisance drug crimes. And when the dealers get swept up, it's done during a live event broadcast, like Operation Audacious, on Twitter and YouTube.

But will local police only respond to the most vocal and eloquent sections of the community? To an over-stretched, more publicly answerable modern police force, if a crackdown on dealing in a public place leads to the dealers switching their business operations to a private house, then that can be seen as a result.

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# FROM RED TO GREEN

New research reveals that many women involved in street prostitution want help to move on rather than simply support to stay in the life. By **Marcus Roberts** and **Shannon Harvey**



Anna says that she's been involved in prostitution for 14 years and doing drugs for 15 – for the past few years she's been street working 'every day' in a city in Yorkshire. When asked she says that the drugs came first when she was 17 years old and the sex work followed while she was still in her teens. She is now 32. Why does she do it? 'Just for money and that', she explains, 'and to buy drugs with – drugs and food and fags'.

Anna is on a methadone script, but she says that she thinks she will always do drugs, and is currently using amphetamines, cannabis and alcohol. It all 'takes the edge off', she says, adding that she feels 'numb' these days anyhow ('it's just a way of life, I just do it'). Her current partner says he doesn't like Anna selling sex, although he might make her a sandwich for the train journey into the city's red light area, and 'he can't get hold of the drugs and the money quick enough' when she comes home. She says that he's 'too stubborn' to engage with treatment or any other kind of support – so his dependency is driving her sex work too.

If Anna's story seems to confirm a lot of the research findings on drugs and involvement in prostitution (for example, a 2004 Home Office paper, *Paying the Price*, concluded that up to 80 per cent of street sex work in the UK was driven by drug dependency), it's texture and detail is a stark reminder that the reality of sexual exploitation is generally light years away from *Shades of Grey*. Anna reveals that she has been raped, sodomised, tied up and 'punched out'. The thing that stays with her most is 'being stripped in a car and thrown out in the middle of some fields and having to walk home and to knock on someone's door because you can't just walk home'. 'How humiliating can it get?', she asks. 'Once that happens you don't forget'.

Our research with services in Yorkshire and the Midlands confirms that experience of violence and abuse is routine among women with substance use problems who are involved in prostitution. Service providers told us the overwhelming majority of service users had been subject to violence by a client and at the hands of an intimate partner. Two thirds reported that their service users have 'often' or 'always' been abused in childhood by either a father or stepfather.

Anna has had some help. An outreach worker approached her when she was on the street and she got a meal, a shower and somewhere to sleep. A local drug service arranged for a methadone script. Social services are involved with her children, but she has no time for the social worker ('that woman has caused me so much trouble…so much misery').

Reading between the lines, engaging with Anna may be a challenge for services. Some of the things she implies about the impact of her situation on her children provide a legitimate basis for child protection concerns. Back when the homelessness service first took her in, she says, she responded by stealing a credit card, then 'legged it, maxed it out and bought some crack'. She says that she 'doesn't want counselling and support like that because at the end of the day it is all self-inflicted'. She appears to miss appointments and to disengage from services, who 'send out search parties when you don't turn up'. She fits the category for what are now called 'multiple needs', including mental health problems, experiences of homelessness and a history of crime. She doesn't feel like her family are able to be a source of support, insisting that they are 'stuck up' and 'living in a fantasy world'.

When asked, Anna says she'd need time and space if she was to make a serious move towards recovery. 'I'd have to go to rehab', she reflects, 'I can't do it on the streets…I'd have to be out of the way for a bit…I wouldn't be able to do it in a fortnight!'. And what would most motivate her to change? 'To be able to support my children and warn them not

to do this', she says, 'but even if they do, to give them support'.

Janice also talks to our peer researchers in Yorkshire. She's in her early 30s, and has been using drugs since she was 18. She is an articulate advocate for what she describes as 'recovery'. She praises a local service for sex workers for providing outreach support on harm reduction and safety, but says that the help she has had has been 'dishing out condoms and a sandwich' and not much else. The methadone script from the drug service has been helpful, but she is apparently still using crack on top, and complains that they 'didn't have a look at why I was using' or show much interest in 'getting you to move on'. 'I've heard things are changing now', she says, 'but when I started it was just about a script and maintenance. They don't do much about actually reducing down…it should be about the service user having a choice and the doctor not making all the decisions'. When asked about her aspirations and what would help her most she talks about housing (including relocation to a different area), education, employment, counselling and a better life for her son.

Who she talks to is important for Janice – particularly given the 'guilt' and 'shame' that she feels about both her drug use and involvement in prostitution. She says she hasn't felt comfortable talking to a 'normal key worker' about her sex work and would never disclose to a male worker. She is also adamant that 'I wouldn't want to go to my family because they don't know anything about it… well they might have some idea, but I certainly haven't admitted it to them'. Janice feels particularly uncomfortable discussing the issues with younger and less experienced workers. 'Now I've got a bit older', she confides, 'I'm sitting with someone who might be ten years younger than me, and they've just come out of college or whatever, and then it feels like I'm being judged'.

This raises the issue of the role for peer support for women involved in prostitution. We explored this issue with a group of service providers in Yorkshire and the Midlands. Four per cent said peer support was 'always positive' and 68 per cent that it was 'mostly positive'. Twenty eight per cent said that they were 'neutral' about peer support. One worker commented that 'peer support brings commonality, so the immense shame many women feel is broken down a bit because its shared amongst peers'. Others saw both positives and negatives. 'I have had concerns that sometimes a lack of training and supervision of peers and a lack of stability and distance from the peer's own issues can be detrimental to both parties', one front line worker told us, adding 'sometimes there is a hurry to involve women who are doing well into becoming peers; sometimes this can lead to a relapse in the peer or collusion with the client'.

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A number of the women we spoke to raised issues about the role of opiate replacement therapy in their recovery. When we asked Janice what made her first ask for help, the response was 'just the fact that I was told I'd be able to get a script so I wouldn't get the rattle'. Another woman we spoke to, Cathy, had been working in prostitution for thirty years and regularly using crack cocaine for twenty, but told us that she had never asked for help from a drug service. Why? 'I don't believe in it', she explains, 'my partner's on a script…they're giving him methadone on one hand and he's still using on the other'. Janice was positive about opiate replacement therapy in its proper place, but still critical of what she saw as a lack of aspiration for women involved in prostitution. When we asked about her experiences of drug services, she replied 'they gave me a script, which was helpful, but really they didn't have a look at why I was using, and still to this day I feel like a script was the easy solution.'. And her aspirations for the future? 'To reduce down off my script', she says, 'to get help with maybe moving, get some education, you know, so that I can go out and actually get a job at some point in the future'.

Claire had been supporting her drug use through prostitution since she was 15 years old, and had become dependent on crack cocaine. She told us about the time she'd been raped by a client and how she was 'stabbed with scissors by some guy'. The severe breathing problems that she had developed as a result of her crack cocaine use brought things to a head. 'I moved away from the area and moved away from the people I used to associate with', she told us. The availability of one-to-one support from her local service had been critical in getting her through the bad days. 'When you're coming off drugs you need someone to talk to', she told us, 'when… you don't know what to do with yourself it's nice to be able to pick up the phone and speak to someone just to take your mind off things'. When we talked to Clare she had not used drugs for two years, was no longer involved in sex work, was in employment, had recently re-married and was trying for a baby. Things, as Janice said when talking about her aspirations 'that people would say are a normal, everyday life'.

**Marcus Robert** is Director of Policy and Membership at DrugScope. **Shannon Harvey** is Stella Project Co-ordinator at AVA (Against Violence and Abuse).

*Names have been changed in this article. These interviews are part of a research project on women with substance misuse problems involved in prostitution being conducted by DrugScope and AVA and supported by the Pilgrim Trust. We will be publishing a full report in the Spring. The interviews were conducted by Kelly McSorley and Mary Marsden. We are also grateful to Ena Keco, DrugScope Policy intern, for work that informed the article.*

# The Alcohol Debate

We hear a lot these days about our growing problem with alcohol. But is the problem really getting worse – and if it is – what should we do about it? Not surprisingly **Emily Robinson**, Director of Campaigns and Fundraising at Alcohol Concern and **Mark Baird**, Head of Industry Affairs & Alcohol Policy at Diageo, a major alcohol manufacturer, have differing views.

**Emily Robinson**, Director of Campaigns and Fundraising at Alcohol Concern

**January is a good time to talk about alcohol issues.** It is a time to get people's attention after the excesses of Christmas and New Year. At Alcohol Concern we have taken the opportunity to get people thinking about their drinking through our Dry January campaign, where we ask people to give up booze for a month. January also marks one year in my role at Alcohol Concern so it is a natural time for some sober reflections on our national alcohol problem.

So let us start with some truths in the bleak mid-winter. The world is round. The earth orbits around the sun. We have an alcohol problem in this country.

One year on, I am still staggered by the statistic that alcohol is the biggest killer of young people aged 18 to 24 year olds. Over a million admissions to hospital are alcohol related and at some points in any given night the majority of A&E attendances are down to booze. That is a national emergency. I cannot believe that as a country, alcohol is costing us so much: £3.5bn on the NHS, around £11bn on crime and anti-social behaviour and around 17 million lost working days to the economy. And yet we are in a time of recession and economic difficulty. That is before you get to the personal stories of tragedy; the drink driving accidents, neglected children, the accidental poisonings, the devastating alcohol addictions. Beyond the statistics there are whole families ripped apart and lives destroyed.

This is a grave situation, it is not about whether the problem is getting worse or not, the damage being caused by alcohol right now is colossal and requires immediate action.

Last year marked a great step forward with the publication of the Government's Alcohol Strategy. Despite some obvious flaws, like the lack of action on treatment, it is, from Alcohol Concern's point of view, the best national alcohol strategy we have seen to date. There are two things that are particularly heartening about the strategy. The first is the commitment to introduce a minimum price for alcohol (MUP), the Government has accepted that alcohol is a different product to all other groceries in the shops and needs special treatment. Second, that alcohol harm is a complex problem requiring different strategies to deal with different groups of drinkers. So while MUP will have an effect on young drinkers, it is the NHS health checks which will help the over 40s. Plus of course, changes to strengthen licensing laws which could have a major impact across the board. It also, helpfully, did not put all the pressure to change on individual behaviour.

I actually do not believe this is a complex issue – quite a lot of us are

**Mark Baird**, Head of Industry Affairs & Alcohol Policy at Diageo

drinking too much and we should drink less alcohol for the good of our health. But on our own that is really tough to do without changes in availability, price and marketing.

For politicians, I can see why it is such a hornets' nest. On one side you have got a well resourced and powerful alcohol industry, whose old fashioned and inflexible business model relies on maximising their profits for shareholders. They are formidable opponents. And there is the fear – but what will the public think? I believe they are more up for change than politicians think.

One of the many interesting things about working for Alcohol Concern is just how much people love to talk about alcohol! From committed teetotallers to those who enjoy a tipple, our relationship with booze is of endless fascination and in my experience, people are more than happy to talk about it. And quite a lot of people are fed up. Fed up with their high streets becoming no go areas on Friday or Saturday nights, young people realising they have been sold a lie by flashy marketing campaigns and actually, with all this pressure to drink to show, we are having fun, it is quite nice to have a break sometimes.

We may love talking about alcohol, but now in 2013, it is time to have the right conversation. I hope you join us ■

**Does Britain have a national drinking problem?** It all depends on your definition. If 78% of us are drinking less than the Chief Medical Officer's recommendations; if underage drinking has halved since 2003 and binge, hazardous and harmful drinking are all decreasing, as are alcohol-related deaths, is that a problem on a national scale? If it is, then at least it appears to be a problem which is getting better.

However, there are areas of our country which have a higher incidence of alcohol harm than others, such as the north-west and north-east. Such areas need local, targeted and specific interventions, aimed at those who are already misusing or at risk of misusing alcohol; not unproven population-wide measures, so often favoured by those responsible for public health. Liver specialists don't employ an indiscriminate whole population approach to surgery by operating on the livers of thousands of healthy patients on the off chance that they might catch a few with chronic liver disease

So why do some persist with proposing untried approaches when I would contend that we already know what works and what doesn't? We have seven years of empirical data to refer to where alcohol consumption and risky drinking patterns have consistently fallen. In the absence of any major research project examining why this has happened, (and we should seriously question why this is the case) I would like to offer some insight. Since 2005, we have seen the formation of The Drinkaware Trust offering excellent, free, comprehensive and impartial advice and education on all matters relating to alcohol. Coupled with this we have seen more determined, sustained and targeted action by the alcohol industry in partnership with agencies including, Addaction, Mentor UK, The British Liver Trust, NOFAS, The Ascension Trust, Oxford Brookes University, BRAKE and many police forces up and down the country.

So what works and what doesn't? We know that SBIs (Screening and Brief Interventions) have a significant success rate in spotting and treating those who are misusing or at risk of misusing alcohol. We know that the Strengthening Families Programme (SFP 10-14) has a high success rate in working with families who may have substance misuse issues. We know that training midwives in how to talk to expectant mothers about the risks of drinking alcohol while pregnant produces positive results. We know that 'Lifeskills' based education programmes can avoid risky behaviour in school aged youngsters and we know that initiatives aimed at increasing safety in the night-time economy, such as Best Bar None, Pubwatch, Purple Flag, Street Pastors and Taxi-Marshalls, all reduce alcohol-related crime and anti-social behaviour. You will notice that none of these successful and proven approaches addresses price, availability or marketing – the so-called 'best buys'.

And what doesn't work? Advertising bans for one – a French government report concluded that "no effect on alcohol consumption could be established" in connection with the alcohol advertising ban, known as The Loi Evin. And interestingly, several French media reports in recent years have reported the growing problem of teenage binge drinking in French cities. In November, Denmark abandoned their 'sugar and fat tax' after just one year, admitting that the Government's attempts to engineer a healthier society through raising prices had failed, with the Minister for Food quoted as saying that "...we have to try to improve public health by other means."

And of course there are some approaches where we don't know if they would work or not; the main example being state controlled alcohol prices or minimum unit pricing (MUP) as it is better known. There is no evidence for this particular intervention as it has never been tried anywhere in the world and is based solely on the much maligned 'Sheffield Model'. We are often told by MUP enthusiasts that minimum pricing is working well in Canada when the truth is that the Canadian Model of 'Social Reference Pricing', which sets different floor prices for different drinks, is very different as it is not based on a price per unit and alcohol is mainly sold through state owned liquor stores. So why take a risk on an untried, untested, unproven (and probably illegal) policy when we already know what works.

The alcohol industry has already proven itself as a credible and successful partner in tackling alcohol misuse, including its involvement in the Department of Health's 'Responsibility Deal'. So I would urge all agencies to recognise this and work *with* the industry rather than blame it and attempt to exclude it from solution building. After all, no-one blames Ford or Toyota for road accidents or speeding or suggests putting up the price of petrol to deter irresponsible drivers ■

*See also Research p27*

# MOTHERS' MILK



High profile media stories highlight the potentially fatal consequences of children drinking methadone. What can be done to help prevent such tragedies? **Rebecca Lees** reports.

The headlines have the power to shake even the most experienced health professional. In January, the parents of Riley Pettispierre were found guilty of the manslaughter of their two-year old who died in March 2012 after he drank his mother's methadone left in child's beakers. Last summer, Bristol parents Jamie Green and Sonia Britton were jailed following the death from methadone of their son Jayden-Lee in 2011 – just a month short of his second birthday. In Wrexham, mum Nia Wyn Jones was sentenced to three years in prison for putting the substance in her baby's milk. Midwives, health workers, GPs and drugs agencies are working together to provide the best possible outcome for families with a parent who uses drugs, but is the fear of the authorities still too great for many parents to engage with them?

In 2003 the Advisory Council on the Misuse of Drugs estimated there to be between 250,000 and 350,000 children of problem drug users in the UK. Its Hidden Harm report, which examined the serious negative effects on children of drug users, recommended that every maternity unit should provide accessible and non-judgmental quality care during and after pregnancy. Almost a decade later, this need for this care was emphasised again in a serious case review undertaken in Bristol following the death of Jayden-Lee Green, stating that the clinical management of pregnant women who are using drugs or who are on opioid substitution treatment is of 'extreme importance' to safeguard the welfare of the baby.

A baby born addicted to heroin might experience Neonatal Abstinence Syndrome (NAS), suffering from withdrawal symptoms including sleep and feeding problems, vomiting and restlessness (signs also displayed by some babies born addicted to methadone). In an interview with BBC Wales, Nia Wyn Jones said she put methadone in her daughter's milk to prevent her craving heroin. "I could feel her getting hot and that," she told BBC Wales while on the run from prison in 2012. "But in the end, every time she cried, I was panicking – is she sick? It was on my mind all the time."

In the same BBC report, social care lecturer Fiona Macdonald said she would 'hope' it is difficult for mothers to hide addictions from health professionals. But there is widespread concern from mothers that their babies will be taken away if their addiction is known. Swansea Drugs Project family worker Carole Atkins says, "There is a belief that if a woman 'confesses' to drug use, social services are still that stumbling block. Hopefully the message is getting across that treatment is available but there is still a huge belief that if social services are made aware of drug use, then that

will have implications on the children."

Vivienne Evans OBE, Chief Executive of families, drugs and alcohol support organisation Adfam, agrees; "Fear of intervention by 'the authorities' is a powerful disincentive to engage with services for many pregnant drug users," she says. "Ten years ago, *Hidden Harm* said that maternity services must be accessible to pregnant drug users and be non-judgmental, and this holds true. This doesn't mean pretending that everything is fine when it isn't. But the fact is, if these women feel stigmatised and unsupported, then the relationship between them and services suffers – and so could the baby."

In Swansea, where there is a recognised heroin problem, the Substance Misuse Ante-Natal Clinic was established by the local health board two years ago to offer a structured care plan for pregnant women. Held at the city's Singleton Hospital, it comprises a consultant obstetrician, the Community Drugs and Alcohol Team, a specialist nurse and a specialist midwife, as well as working in partnership with Swansea Drugs Project.

A spokeswoman for Abertawe Bro Morgannwg University Health Board says: "Many women have told the team that they were nervous about revealing drug use in pregnancy if they were not already on a prescription for methadone or subutex. But on meeting the team, they soon realised they are there to help them to have as healthy a baby as possible, and work positively with all agencies for the best outcome for mum and baby. The team has seen a 36% reduction in babies who have 'clucked' (withdrawn from drugs) following birth and required admission to the neo natal unit."

Dr Alan Fenton is a consultant neonatologist at the Royal Victoria Infirmary in Newcastle upon Tyne, where treatment of drug-dependent mothers and their babies is tailored to their individual needs and circumstances. "Methadone is a controlled drug and not often prescribed for babies," says Dr Fenton, honorary secretary of the British Association of Perinatal Medicine. "I have no experience of the mothers who come to our clinic doing this, thankfully. We see a number of mothers each year who are dependent on a variety of substances and subsequently their babies may show signs of withdrawal when the source is cut off, and we have to manage that. When mothers are on the methadone programme, babies who show on-going severe signs of withdrawal will be given oral morphine to control the symptoms, and we would carefully wean them off this over a period of time."

"It's hard to judge why mothers are coming forward (for support). In our area, mums who are dependent on drugs know there is a clinic for them where they can access the relevant services and prescription methadone, and that encourages them to engage, but one approach does not suit everyone."

There is a distinction between the parents who give babies methadone fearing neonatal withdrawal symptoms and those who do so as a parenting method, for example to control crying or to induce sleep. But whatever the parent's reason, professionals agree that there is still an underestimation by parents about methadone's potency.

"Recent serious case reviews have found instances of parents giving their children methadone, apparently with some complacency regarding its 'safety'," adds Ms Evans. "This took some professionals by surprise, so it really is crucial that anyone working with the family understands the risks of methadone, as well as its legitimate place in drug treatment."

"Methadone is very dangerous," says Ms Atkins. "Lots of people have died from methadone overdose. When it is prescribed by the Community Drugs and Alcohol Team, who I work with, they always go out to the family home to check that there is a lockable cabinet to keep it in, which is part of the agreement."

Trevi House is a residential rehabilitation unit in Plymouth, where mothers and their babies and children up to the age of eight can live for up to six months. Residents follow a programme based on the triangle of parenting, addiction and healthy relationships, and are encouraged to examine how their life experiences are affecting their parenting.

Registered Manager Hannah Shead has never personally been aware of a parent deliberately giving their child methadone. "It is one of these very rare occurrences which get a lot of media attention," she says. "From my time in community services, we focused our attention on avoiding accidental consumption of methadone through the use of pharmacy-led supervised consumption schemes and by giving out locked boxes. We need to educate drug users about the small amount of methadone that could overdose a child. In my previous role we advised parents not to take their medication in front of children, as children imitate what adults do."

Ms Shead adds that professionals are more aware of the impact of parental drug use upon children than they were a decade ago and that this understanding informs the decision-making process about keeping families together. "Most of the children at Trevi are already in the social care system, and for some mothers, Trevi represents their only option for remaining with their child," she says. "From professionals, there is an awareness of the impact of engaging with parents much more proactively. Although there is still a way to go, there has definitely been a huge shift over the last 10 years. We talk about the time scale for the child, rather than the parent. We have a greater awareness about the impact of a child's neurological development and the need for secure attachments. The early months are crucial. Ultimately, of course we want to keep families together; that's what Trevi House is all about. We are not a cheap intervention, but then none of these things are. It is a short-term expense but the long term costs to the public purse are much improved when it works."

Ms Shead also stresses the importance of breastfeeding as a means of bonding. "We always advocate breastfeeding, including when mums have been prescribed methadone" says Ms Shead. "The evidence suggests that breastfeeding can help in the management of neonatal withdrawal symptoms. There is so much conflicting advice when you have a new baby generally, but all the latest research and evidence shows it can help with some of the withdrawal symptoms, and that the mother-child bond is so important."

The mums at Trevi are unanimous in their response that the biggest barrier to accessing treatment is fear, one saying she was "terrified that I would lose my child." But there was also positive feedback for the difference that professionals can make. One resident says that what had made a difference for her was "a drug worker who believed in me", whilst another says she has "learnt a lot from her drug worker". There is a consensus among the women that it is important to feel listened to and not to be pre-judged.

"We need to remember that not one of these mums ever set out to be a bad mother and a little more compassion in society would go a long way," says Ms Shead. "It's a social problem and we have to be prepared to play a part."

**Rebecca Lees** is a freelance journalist

# WRAP AROUND SERVICE

## **Lauren Johnston** describes Scotland's Circle of Care support programme

Circle of Care (CC) originally developed as a recommendation from Melting the Iceberg of Scotland's Drug and Alcohol Problem: Report of the Independent Enquiry (2010). A CC can be described as a group of people who meet together to support the individual achieve what they aspire to in life. Within the setting of drugs and alcohol, the circle acts as a community around the person to support them in their recovery and aims to maximise the potential of family, social networks and community resources. The term focus person is used to distinguish that individual who is seeking support from those other individuals who make up the circle.

Circle-based approaches have a successful track record in other health and social care settings including homelessness, sex offending and learning disabilities. It is important to note that the CC approach is not an intervention but an approach to improving the existing framework. A circle should above all make sense to the focus person who is in charge of deciding who to invite to be in the circle and also in the direction of the circle's energy. Circle members can include family, friends, peers and other community members who wish to make a positive contribution to the focus person.

Professionals are included in the circle to develop and sustain treatment and interventions. A facilitator is normally chosen within the circle to take care of the work required to keep the circle functioning.

CC is being delivered in six drugs and alcohol organisations in Scotland and the 'proof of concept' phase has seen a number of circles being developed. The aim of the 'proof of concept' phase is to demonstrate the strengths of CC in the field of drugs and alcohol and what can be improved for future practice.

The following case study will demonstrate how CC can be practically delivered.

Dave (not his real name) is a 30 year-old father who has been intensively involved with the host organisation for 2 years. He had a long-standing history of poly-drug use which spanned 11 years and became involved in the organisation to make changes to his life following a number of harrowing life events.

Dave is currently on 100ml of methadone and is now not using any illicit drugs. He is trying to maintain abstinence for the first time in 11 years. As a result of his long-standing drug-use, Dave had an extremely negative and poor identity, was very isolated from his family and had little positive role models. The organisation has spent time trying to change his identity, raise efficacy and self-esteem.

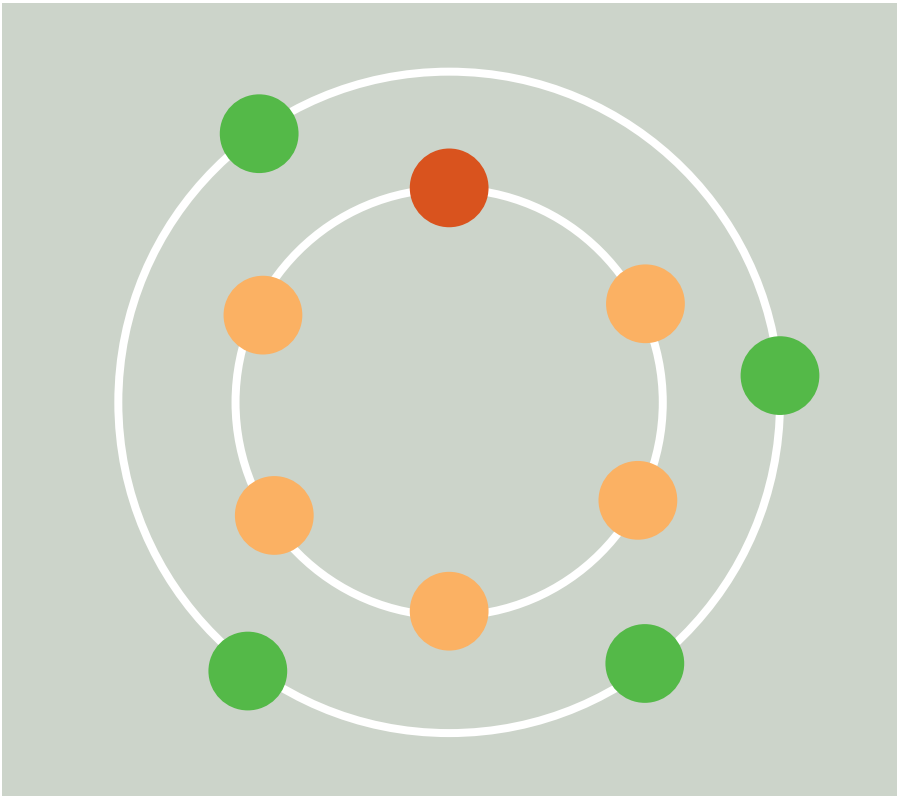
The concept of the CC was introduced to Dave who liked the idea.. The circle was, in some way, naturally already in place. Dave was given another chance at fatherhood and became the sole carer of his baby. Dave's family members started to become more involved in his life because he was clearly making steps through recovery and was making attempts to improve both his own and his child's life.

The circle currently involves Dave's sister who was providing practical child-care help and emotional support. She has now been formally invited into the circle and is willing to be part of the CC. This circle member had little previous contact with Dave; now she has contact and is a pillar of support for him. Dave's father is also involved in the circle and he provides love and positive support.

The child's foster carer was already in contact with Dave prior to the circle being developed and provided child-care help and support. Dave went to the foster carer's house with the child for a weekly dinner. A positive and helpful relationship had already developed and therefore it was natural to formally invite this individual into the CC. The foster carer is involved in the circle and is also committed to supporting the aims and objectives of the circle.

The circle also involves a father from the community. This father has been abstinent from alcohol for 4 years

## Circles of support and accountability



**The circle comprises vounteers from the community who are supported by professional staff**

**Professionals** **Core member** **Volunteers**

and has two children. He has gone through similar life events as Dave who identified him as a positive role model and someone who he could relate to. The facilitator made contact with the father and he was very eager about being involved in the circle. Dave and this circle member take their children on outings, like swimming. The circle member provides social and peer support, positive gender roles and practical support; if Dave feels he is going to relapse or is tempted to use substances, he can turn to this circle member.

The facilitator has worked hard to strengthen broken relationships and bring Dave to a place where he can identify his strengths as a father but to also ask for help and support from those people around him. Dave had little or no recovery capital but now has a strong network which he can use throughout his recovery. This circle is a good example of how recovery capital can be strengthened and built from virtually nothing and how new relationships can be identified and made.

The facilitator meets Dave weekly. Initially, meetings spent most time interacting with the baby and therefore other conversation about the circle's aims and objectives was difficult. However, this circle's focus is predominately on parenting; most of the circle members are there to support Dave in his new role as a father and so this is just a natural process of this particular circle. The circle is different from others because of the naturalistic development of the circle and because the focus is on parenting and perhaps not solely on recovery – although these two cannot be separated.

At one point Dave said he wanted to reduce his methadone prescription. Part of the circle's work might be to help him prepare mentally, physically and emotionally for this process. This crucial support is in what is missing from the recovery process. The circle can and may provide a pillar of strength at a time that is stressful for Dave, who is also taking on a complex and important role as a father for the first time.

The next stage for this circle is to formally establish the ground rules, responsibilities and expectations. This can be done through a meeting that is organised by the facilitator or through home visits to each circle member by Dave and the facilitator. Dave will lead this – explaining what he wants to gain from the circle and what he needs from each circle member.

One of the challenges that came to head when developing this circle was how to record the progress of a circle which works quite well without much facilitating support. The CC coordinator suggested the use of node-link or mind maps. However, the facilitator noted that these might not be suitable for the circle at this particular stage. Dave is getting to grips with his role as a father, new identity and maintaining abstinence. This is currently a complex circle with Dave having to manage a number of critical agendas. Extra paper-work may not be suitable at this stage. The maps can be used as topics and themes for discussion between the circle members, Dave and the facilitator at meetings and to progress the circle.

CC is an innovative and imaginative concept which is concerned with those individuals who are at the margins of society, bringing them out of isolation through building stronger communities of support around them. The concept aims to encourage inclusion, connection and integration; something which is certainly lacking and appears to be much wanted and needed.

**Lauren Johnston** is Circle Care Coordinator for STRADA (Scottish Training on Drugs and Alcohol)

# From Wootton to the World Wide Web

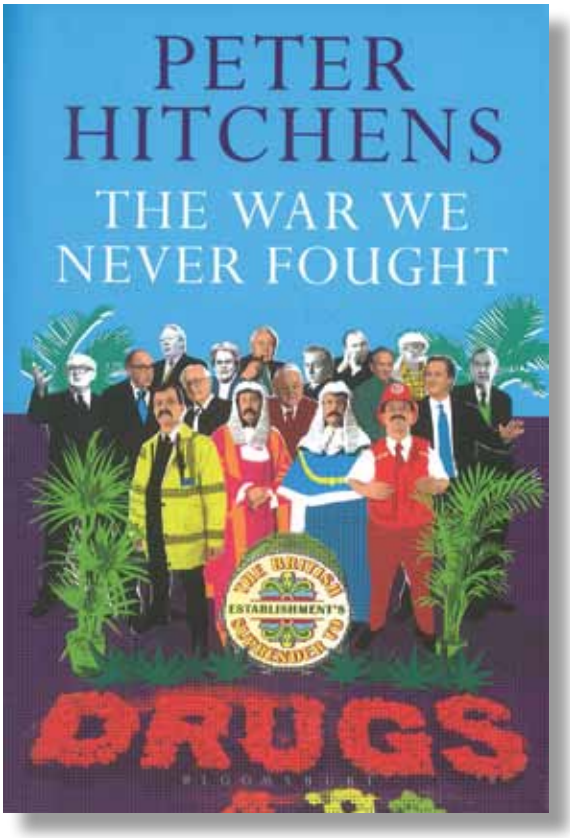
Two books look at the UK drug scene from very different perspectives. By **Harry Shapiro**

Reviews

## Sergeant Peter's Lonely Hearts Club Rant

This book is both more and less than its title. It is more than just an attack on successive government failures (as Hitchens sees it) effectively to prosecute the war on drugs. Hitchens is proud to be a Christian moralist, a puritan, who hated the sixties and all it stood for and to that extent, *The War We Never Fought* is a tirade against an era which he firmly believes sparked a collapse in the moral wellbeing of the nation.

It is also less than its title. Hitchens does not, for example, accuse the establishment of turning a blind eye to heroin or cocaine use – rather he primarily focuses on cannabis, which for him is the litmus test for the more general decline he laments – typified by the instant gratification of chemical stupor (and that for him to be fair includes alcohol and tobacco). It is instructive to scrutinise the acknowledgements to ascertain who has helped inform the thinking and provided anything approaching scientific rigour. Only two names are mentioned in this context; Kathy Gyngell formerly of the Centre for Social Justice and Dr Mary Brett. Kathy Gyngell's views will be well-known to drug policy watchers, Mary Brett less so. She is an ardent anti-cannabis campaigner and the former head of biology at a top flight grammar school, who voluntarily resigned from the education and prevention sub-group of Ian Duncan-Smith's 2007 inquiry into the state of drugs in Britain (part of David Cameron's policy overview *Breakthrough Britain*) on the grounds that she could not be objective about cannabis.




**THE WAR WE NEVER FOUGHT**
Peter Hitchens
Bloomsbury, 2012

No sensible person would argue that cannabis is a safe drug; a totally safe drug is inert – and so technically not a drug at all. But Peter Hitchens' 'evidence-base' for the dangers of cannabis is utterly compromised as demonstrated by the statement on page 139 that cannabis is' one of the most dangerous drugs known to man' – an interesting comment when he earlier accuses cannabis reformers of misleading the 'ill-informed with crude propaganda'.

In attacking the drug culture of the sixties and seventies, you might think that the brunt of Hitchens' ire would bear down on maybe the Rolling Stones, Timothy Leary, John Lennon or any one of a number of counter-cultural icons of the age. But no, those in his sights, include such renegades as Baroness Wootton of Abinger who chaired the 1968 committee which recommended the A-B-C classification of drugs; Richard Crossman, Health and Social Security minister in Jim Callaghan's Labour administration of 1970 – and wait for it, Bing Spear, the Chief Inspector of Drugs at the Home Office, who I knew personally and who publicly stated that his political views were 'to the right of Genghis Khan'. Bing was a compassionate man when it came to the treatment of heroin addicts (enough to condemn him in Hitchens' eyes), but was relentless in his pursuit of doctors he believed were irresponsible prescribers. To portray him as some

kind of behind the scenes lobbyist in cahoots with hippy legalisers is laughable.

The nub of Hitchens' argument, is that while politicians have banged the 'tough on drugs' gavel, the realities of how the law is actually enforced is very different. But in default of anything that approaches a sensible political debate on drugs in this country, it is usually political suicide for an MP, let alone a serving government minister to do anything else (although Nick Clegg might have broken the mould on that one). Hitchens is right when he says that the law reformers have hugely overstated the degree to which UK drug laws are repressive. This might be true on paper compared to some other European countries, but in general, what Hitchens decries as the result of a left-liberal establishment conspiracy to allow unfettered cannabis use for the benefit of its middle class intellectual cronies, is simply pragmatic and proportionate policing.

Hitchens is of the view that if we had banged up cannabis users en masse from the get-go then others would have got the message. We can see how well that policy has worked in America where since the sixties, millions of (mostly black) citizens have been imprisoned on charges of cannabis possession with no appreciable decline in use. Does he really want to see our already over-crowded prisons taken to the brink of collapse by stuffing them full of cannabis smokers? And think of the cost to the state of the Hitchens solution, which by the way, would also include all heroin and crack users, because in case you didn't realise this, according to Hitchens, drug addiction is nothing more than a self-inflicted criminal pleasure.

The drugs debate interweaves complex strands of public health, law, history, politics, philosophy, economics, human rights, science and socio-cultural dynamics. Only those who simply wave the shroud of morality will welcome this book.

## In Brief

### MENTAL STATE DEFENCES IN CRIMINAL LAW

**by Steven Yannoulidis**
Ashgate: 2012

One objective of this title is to "provide principled means by which to establish the criminal responsibility of an accused for conduct performed in a state of drug-induced psychosis." Written from a criminal law perspective, "the book presents a consistent and principled approach to the reform of mental state defences."

### CULTURAL ECSTASIES

**by Ilana Mountian**
Routledge: 2012

Looks at addiction from a cross-disciplinary angle, drawing on research from critical theory, gender studies, post-colonial studies, psychoanalysis and philosophy. It considers addiction, prohibition, treatment and prevention, "and highlights new ways of understanding the role that gender plays in the ethics of drug use across cultures."

*Druglink will carry a review of this title in a forthcoming issue.*

### ALCOHOL-RELATED VIOLENCE: PREVENTION AND TREATMENT

**Mary McMurran, editor**
Wiley: 2012

Part of the publisher's series in Forensic Clinical Psychology, this title "presents an authoritative collection of the most recent assessment and treatment strategies for alcohol-related aggression and violence" by "leading international academics and practitioners." It includes chapters on the extent and understandings of the problem; and accounts of the evidence-base for interventions, with individuals, couples, families and premises.

*Druglink will carry a review of this title in a forthcoming issue.*

## What lies beneath

Reviews

**NARCOMANIA**
Max Daly & Steve Sampson

The media are always up for a 'good' drug story; the latest killer drug, celebrity indiscretions, boy or girl next-door drug deaths or yet another call for law reform. What is missing from the narrative is a clear oversight as to the extent that the drug economy has become part of the warp and weft of Britain's financial fabric. *Narcomania* attempts to tease out the threads of our embedded drug culture and the contradictions and confusions that swirl around drug policy – giving rise to the title – resulting in a work which is compelling, pacey, measured and considering some of the people they spoke to, pretty brave.

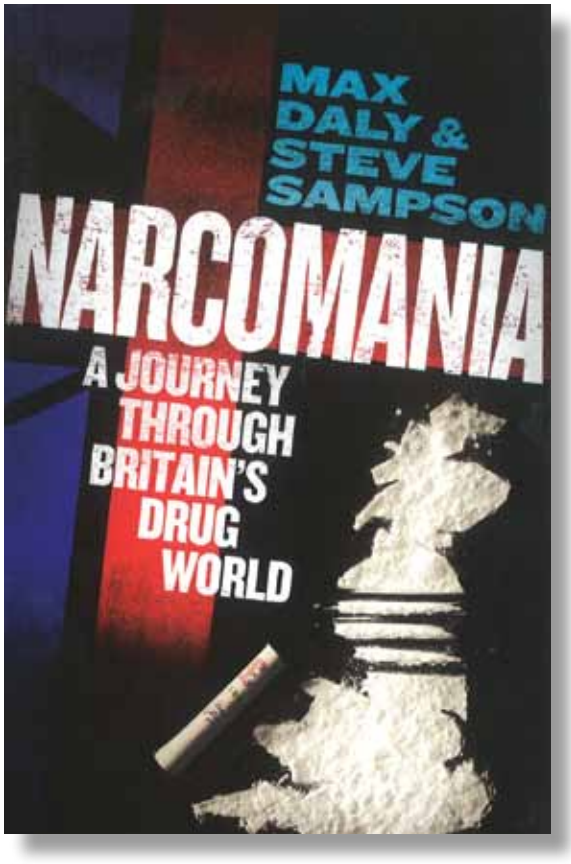
The authors are experienced journalists and seasoned writers on the subject, well used to stalking the mean streets in search of the telling story. Max Daly was for several years the *Druglink* editor at DrugScope and his co-author Steve Sampson has contributed several articles to the magazine over that period. In the course of researching the book, the authors have spoken to the widest range of sources, from psychonauts, city slickers, and active drug dealers through to policy experts, politician and media commentators.

Using a documentary personal account style, Daly and Simpson take us on a journey through the world of drugs, starting at the street level and working through the maze of middle market and upper level connections and out into the world wide web, examining the strategies and techniques adopted by street-smart gangsters to avoid detection. The early chapters play out like scenes from *The Wire*. Then they cross the frontline to view the problem from the police perspective, exposing the myriad frustrations of trying to enforce the drug laws, not least the fact that however much the enforcement agencies devote in time and money, the financial muscle of the bad guys make police resources look like chump change. Then we move into the murky world of high finance, where as recent high profile cases have revealed, some of the world's most outwardly respectable financial institutions are not averse to getting their beaks wet (to use an old Mafia expression) by laundering the profits of drug trafficking.

So in the face of what appears to be a significant financial investment in the drugs trade, not simply by multiple levels of dealers and traffickers, but a whole range of enterprises from global banks to small high street businesses cleaning dirty money, what do you do about it? The authors then turn their attention to the UK policy response which they describe as a combination of inertia and fear. They correctly identify the main obstacle to having a 'mature' debate about drugs: it is not a health, criminal justice or social issue, but at heart a moral issue and as such appears immune to external entreaties about ensuring political outcomes take due notice of the evidence base.

There is no evidence of any political will among successive UK governments for reform of the laws, especially when politicians know they will face an onslaught from our uniquely voracious tabloid press. Consider the barrage of criticism the Labour government faced from the tabloids, political opponents and the police over the very modest reclassification of cannabis. It was a decision that Gordon Brown vowed to reverse months before asking the ACMD to conduct a review. To their credit, having only recently done a thorough review, the ACMD concluded that the Class C rating remained valid. Recently Jacqui Smith, Home Secretary at the time, says she now regretted her decision about cannabis. But if the boss has already made it clear what he wants in advance of any report, was it really her decision anyway?

Daly and Sampson briefly set out the extreme solutions of legalisation and a tougher approach and then wisely set them to one side. They suggest that the UK could do down the decriminalisation route of several other countries, although in most of those countries (including Portugal), before the law change, users faced jail time for simple possession, something that has not happened in the UK for decades.




However, any book examining drugs and drug policy has to come to some conclusions, even one based firmly in reportage such as this. What is left to the authors is ironically, a strategy which has actually been in place in the UK since the late nineties even if the delivery and outcomes vary hugely; namely a pragmatic approach to possession, drug education in schools, and proper investment in treatment.

# Minimum alcohol unit pricing (MUP)

Campaigns and health lobbyists are setting much store by minimum alcohol pricing as a way of curbing problem drinking. But what does the evidence tell us? By **Mike Ashton**

For England and Wales the 2012 national alcohol strategy represented what may prove to be a turning point – acceptance that drink-related harm is spread across the population, so counter-measures too must affect the population as a whole, even if it inconveniences them or makes bigger alcohol-related holes in their pockets – and even if it may lose votes. The nettle that has been grasped here is MUP.

Scientific support for such moves includes guidance from the World Health Organisation, whose possible impact was modelled for Australia. That exercise confirmed that in countries such as the UK where hazardous drinking is common, raising alcohol taxes has the greatest yet least resource-intensive impact on public health. Britain has contributed with modelling exercises for England (1) and Scotland (2) which on public health grounds supported setting a relatively high minimum price. Britain's National Institute for Health and Clinical Excellence (NICE) argued that price rises were among the key public health levers.

Plans for the UK may yet be derailed by arguments that they contravene European Union agreements. The European Commission suggests they may constitute a disproportionate restriction on free trade and competition, and could counter-productively increase the incentive for the alcohol industry to market affected products due to higher profit margins gifted by a high minimum price. That margins and industry revenue will increase is acknowledged by official UK impact assessments, which also acknowledge that the poorest regular drinkers will be affected most, though they too stand to gain most in health terms if they respond by cutting their drinking.

One fly in the ointment rarely highlighted in public health studies is that health has little to do with why most Britons drink. The 'benefits' drinkers themselves feel they get are rarely valued in. This was one of the criticisms (3) made by a prominent alcohol expert of attempts to establish a total cost (or cost reduction due to policy changes) to society of alcohol-related harms. These harms were dominated by productivity gains due to less drink-related unemployment, calculations which ignored the probability that vacancies left by drinkers will end in someone currently unemployed gaining a job.

When the Home Office itself valued the costs and benefits of MUP, it accepted that "The costs of lost productivity due to alcohol misuse are substantial", but excluded these while consulting to see if more secure estimates can be made. Partly for this reason their estimate of the net benefit to society of a £0.45 price was just £35 million a year, much less than in modelling exercises. The Home Office also accepted that drinkers gain benefits from their drinking and that these will be countered or eroded as they are forced to pay more and/or forgo them. There will be some countervailing gains for the alcohol industry, but the result would, it was said, be a "decrease in net social welfare".

Whether consumption will really fall when MUP is imposed has been assessed in real-world studies, of which two from Canada have been influential. The most relevant (4) estimated that a 10% increase in minimum price across all beverages had been significantly associated with an 8.4% reduction in total consumption. However, in Canada the provincial governments had a direct influence on the market via government alcohol distribution monopolies. Similarly, whether health really will improve as alcohol rises in price is best assessed directly, but the data is very limited. A review widely relied on found just one study capable of addressing net health harm/benefit, because it related tax to overall mortality, whatever the cause. In this study, US state alcohol taxes were weakly related to fewer deaths overall, but not with sufficient strength or consistency to eliminate the possibility that the relationship was due to chance.

**Based on entries from the 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=DL7.php**

SOURCE STUDIES

1 **Independent review of the effects of alcohol pricing and promotion**. Meier P. *et al*. University of Sheffield, 2008.

2 **Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland**. Meier P. et al. University of Sheffield, 2009.

3 **Cost-of-alcohol studies as a research programme**. Mäkelä K. Nordic Studies on Alcohol and Drugs: 2012, 29, p. 321–343.

4 **The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health**. Stockwell T., Zhao J., Giesbrecht N. *et al*. American Journal of Public Health: 2012, 102(12), p. e103–e110.

# 45 factsheet

DrugWatch

# Mephedrone

## (4-methylmethcathinone/4-MMC)

**Street/common names: Meph, Drone, MCAT, Meow meow, Magic, Bubble, Top Cat**

Mephedrone is the most widely used of a range of synthetic cathinones that have similar stimulant and entactogenic ('loved up') effects to ecstasy. Its effects, particularly when injected, have been compared to cocaine. It is pharmacologically related to cathinone – an alkaloid found in the 'khat' plant (Catha Edulis) that has a long history of human use. Although mephedrone was first synthesised in 1929, its recreational use came to prominence in 2009 after being 'rediscovered' a few years earlier. Cheap, high purity mephedrone became readily available through internet sales and an unanticipated surge in its use coincided with a sustained decline in ecstasy purity. From 2010 it has been controlled under the Misuse of Drugs Act, since when it has become available through similar channels to other prohibited drugs such as MDMA, cocaine and the amphetamines. Within the British Crime Survey (2011/12), 'last year' use of mephedrone among 16 to 24 year olds was 3.3%, the same level as ecstasy. Far higher rates have been documented among samples of clubbers, who typically report much greater use of most legal and illicit drugs.

### Appearance

Usually a white/off-white powder with a distinctive smell that sometimes clings to people who use large quantities. It is mostly sold like other powders in 1 gram bags/wraps or less commonly in capsules or tablets. Analysis of seized and purchased mephedrone has shown that it is generally of high purity (>95%) although there are indications that purity has been reducing in some seizures.

### Cost

£10-20 per gram (street price). Much less if bought in quantity through on-line retailers/importation.

### Route of administration

Mephedrone is commonly snorted (which is often painful and damaging to nasal membranes) or swallowed (either 'dabbing' with a moistened finger or wrapping in cigarette papers and 'bombing'). A growing number of areas in the UK report injecting.

### Dosage and onset and duration of effect

The typical amount of mephedrone consumed over an evening/night is about 0.5 to one gram, usually taken in doses every hour or two; however tolerance builds quickly (some users report using 4-10 g per night). When injecting, people sometimes use 0.5g or more at a time and often inject more frequently than is typical with heroin – often in excess of ten times daily.

### Oral

- Dose, 50-100mg (light) to 150-300mg (strong)
- Onset of effects, 15- 45 minutes
- Duration of effect, 3-4 hours

### Nasal:

- Dose, 15-25mg (light) to 75-125mg (strong)
- Onset of effects, 5-10 minutes
- Duration of effect, 1-2 hours

### Injection:

- Dose, 10-20mg (light) to 60-70mg (strong)
- Onset of effects, 2-3 seconds (rush) 5-10 minutes
- Duration of effect, 5 minutes (rush), 15-30 minutes

### Patterns of use

Like ecstasy, most mephedrone use is recreational and self-regulated without evidence of serious harms. However, users commonly find it more compulsive than ecstasy and a proportion progress to daily use with increased physical and mental health problems, tolerance and dependency. Harms and risk behaviours appear to escalate sharply for many people who begin injecting mephedrone. In parts of the country there are suggestions that injecting is being adopted by a new population of young injectors.

Mephedrone is often used with other stimulants, alcohol and cannabis, which can compound its risks.

### Drug effects (dose dependent)

Sought-after effects include:

- Stimulation, alertness, rushing
- Euphoria and hypersensitivity
- Empathy and warmth
- Well-being and confidence
- Increased libido and sexual disinhibition
- Talkativeness
- Time distortions
- Visual hallucinations
- Reduced appetite

Adverse effects include:

- Toxicity (sometimes fatal)
- Elevated heart rate (tachycardia) and palpitations
- Sweating, overheating, hot flushes, dry mouth
- Headaches
- Chest pain
- Nystagymus (eye jitters)
- Teeth grinding (bruxism) and jaw clenching
- Coldness or numbness in fingers or toes
- Blurred vision, dilated pupils
- Significant nasal irritation and tissue damage
- Agitation, aggression and paranoia
- Soft tissue and vascular damage (when injected)
- Strong, unpleasant odour

Residual effects include:

- Acute depression (sometimes associated with suicide)
- Insomnia and sleeping problems
- Fatigue and low mood
- Anxiety, agitation and paranoia
- Sore mouth or throat, sore nose and nose bleeds
- Soft tissue and vascular damage
- Nausea, vomiting, stomach pain
- Skin rashes and discolouration of skin
- Amnesia

Longer-term effects:

- Largely unknown as its widespread recreational use remains recent (<5 years).

### The Law

Since April 2001, mephedrone and all cathinone derivatives (except buproprion and those already controlled under the Misuse of Drugs Act, 1971, including cathinone itself) are Class B or Class A, if prepared for injection.

# NEW YORK NOTES

■ Maia Szalavitz

## Hazelden introduce Suboxone

While the political climate in the UK has been increasingly against the use of opiate substitute prescribing – the grand-daddy of American rehab, Hazelden recently announced that it would start using outpatient buprenorphine (Suboxone) maintenance.

The reaction to the news has been intense. "Hell froze over," one tweeter responded, expressing shock that the pioneer of abstinence-based treatment could make such a big change. Others remarked that it was the addiction treatment version of the Pope endorsing contraceptive use.

"It's about time," said Dr. Charles O'Brien, director of the University of Pennsylvania's prestigious Center for Studies on Addiction, and one of the field's most eminent researchers. The head of America's National Institute on Drug Abuse, Dr. Nora Volkow, also praised the decision.

But while people familiar with the incontrovertible data showing that maintenance saves lives are singing Hosannas and hoping that Hazelden's shift foretells a sea change, those who believe that abstinence is the only acceptable treatment outcome aren't surrendering without a fight. And public misperceptions about intoxication from maintenance medications could support this backlash if not appropriately addressed.

A report published in the trade publication *Addiction Professional* says that representatives from several major private residential treatment programs – including bizarrely, Hazelden itself – met last October in Nashville to develop a "white paper" aimed at shoring up support for abstinence-only treatment and demonstrating that residential care is more effective than outpatient treatment for opioid addiction. While those involved said that they don't necessarily oppose buprenorphine maintenance, one of the paper's eight points of agreement will be that abstinence is the "desired" outcome.

Addiction Professional claims that former Obama deputy 'drug czar' and longtime University of Pennsylvania addiction researcher A. Thomas McLellan will issue the white paper. But he says that he is not involved in the project. On buprenorphine and Hazelden, he adds, "Tell me another area of medicine where willingness to use an FDA-approved medication is a bad idea. Tell me another area where it makes news."

Further signs of backlash can be seen in the responses to the articles published about the change, in which commenters cite negative anecdotes about maintenance and claim that the push for change is just another example of pharmaceutical industry pressures unduly influencing psychiatry. Yet the World Health Organization, the US Institute on Medicine and even the office of the 'drug czar' all see maintenance treatment as a crucial option and as the one most likely to save the lives of long-term opioid addicts.

The UK itself discovered in the 1980s that putting time limits on methadone increases death from overdose and disease, after it followed American treatment trends in this direction. Those visible bad outcomes were why British methadone treatment was rapidly re-expanded when the possibility of an AIDS epidemic threatened the country. The UK, which much more quickly expanded treatment and clean needle programs, was spared the large epidemic in injecting drug users, their partners and children that hit the States.

Of course, no one – let alone Hazelden – actually argues that Suboxone should be used for everyone or that abstinence-based treatment shouldn't be available to people addicted to heroin or prescription pain relievers. Hazelden's decision to offer maintenance was made because of the enormously high relapse rate it saw among opioid-addicted people leaving residential care, a group for whom abstinence-only treatment clearly wasn't working.

In recent years, at least half a dozen former Hazelden patients have died from overdose – a rate that shocked both the renowned rehab's leadership and its counselors. Prior to the recent rise in prescription drug addiction, only 15% of their young adult patients were addicted to opioid drugs; now, among this same group, the rate is 41%.

It was those frequent relapses and deaths that made Hazelden reconsider the treatment it provides. According to its chief medical officer, Dr. Marvin Seppala, the knowledge of those bad outcomes resulted in far less resistance to the decision to allow maintenance than he had expected from those steeped in 12-step treatment. During the 10-month period in which Hazelden worked on the change, it held numerous meetings and trainings to help staff get on board and address their concerns.

Addiction treatment strategies tend to wax and wane in conjunction with political fashion, not data. For once, a leading American treatment organization is responding appropriately to the research.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