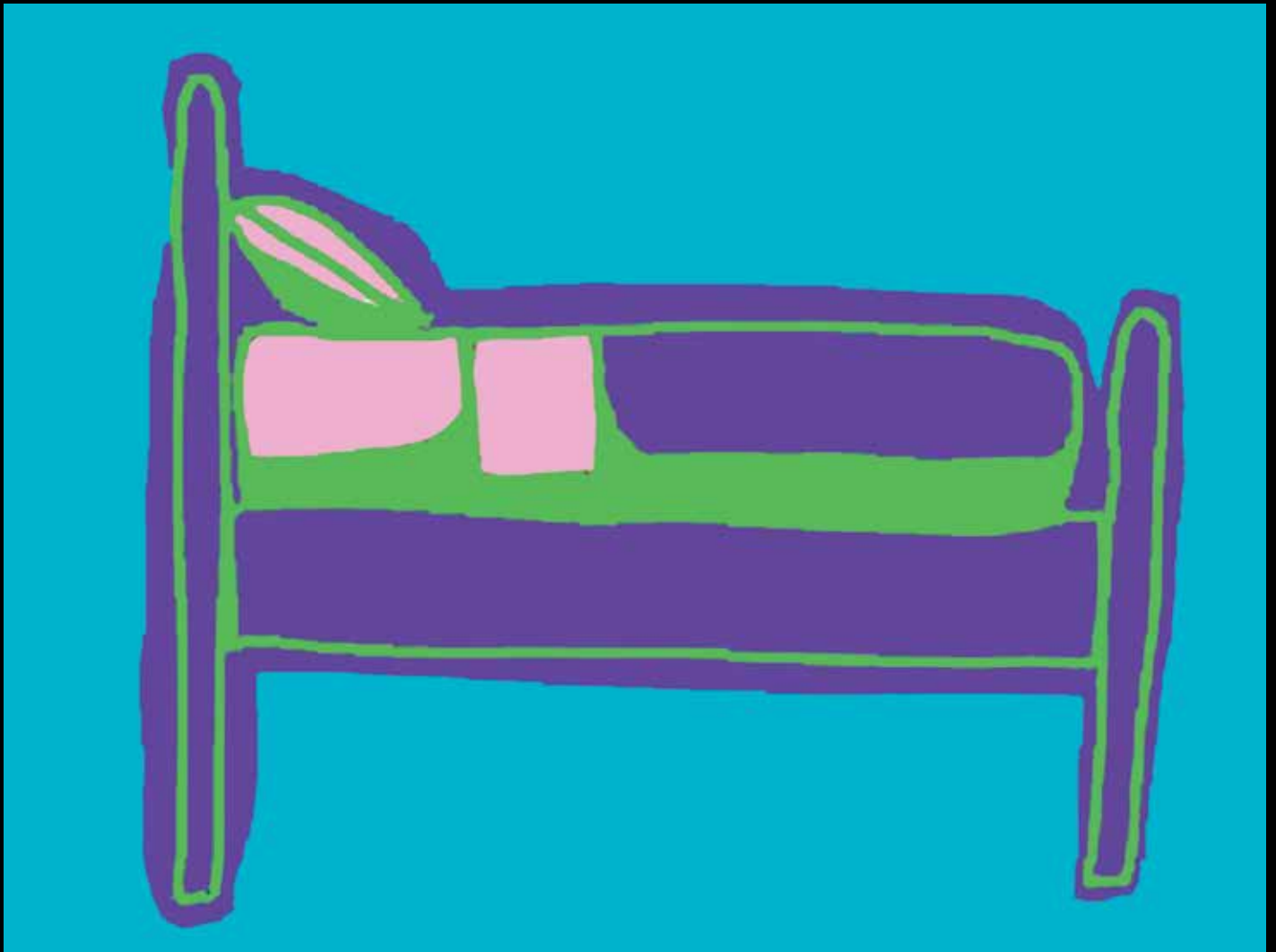


Druglink

REPORTING ON DRUGS SINCE 1975

- Heroin drought
- Iceni
- Trafficking
- Kabul

Empty bed syndrome *Can rehab find a cure?*



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Druglink

The heroin fix

In this issue, we broaden the scope of our coverage both historically and geographically while not losing sight of the changes we are all presently grappling with.

Our cover story on residential drug rehab straddles both – looking at the history of drug rehab in the UK and considering the pressure on smaller single service agencies – a threat which has been growing for several years.

While many of those in rehab will be recovering from opiate addiction, we start a journey along the heroin trail, beginning in our own back yard examining the reported shortage of heroin and then off to the premier source country to look at the problems facing Afghanistan's own population of heroin users.

Yet while the West agonises over what to do about the country's deeply embedded narco-economy, an experienced commentator on the Asian drug trade warns of the hidden danger of the region's expanding trade in crystal meth.

This year is the 50th anniversary of the key plank of international drug control which underpins all drug enforcement– the Single Convention on Narcotic Drugs. An academic, formerly employed at the UN drug control unit, recounts the history and shows how difficult it will be to affect change whatever the unintended consequences of the policy might be.

Back home, cuts to the Supporting People grant, rural rumblings about local commissioning and the risk of local disinvestment give few reasons to be cheerful. But the drug sector is nothing if not resilient and resourceful and no doubt opportunities will emerge from the sea of troubles.

Harry Shapiro,
DrugScope's Director
of Communications
and Information



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Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

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

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A Paris-based human aid organisation is aiming to expand its drop-in centres by building a carpet factory, while Kabul's injecting underclass are left to squat in the city's underbelly.

■ Powder praise

The body in control of monitoring the global illicit drug trade has for the first time dropped Colombia from its list of countries requiring special observation. The International Narcotics Control Board said the country remained the world's biggest producer of cocaine, but had made progress in its battle with drugs. According to the UN, coca cultivation in Colombia was halved between 2000 and 2009, mainly due to large-scale eradication.

■ High court

Nearly 70 per cent of crimes dealt with at a south coast crown court are drug-related, a judge has revealed. After sentencing heroin dealer Philip Dinner to seven years in jail, Judge Francis Gilbert QC told a jury at Plymouth Crown Court that his drug-related caseload included supply and possession, dealers fighting over territory and crimes committed to buy drugs, such as theft, robbery, burglary and prostitution.

■ Overdose hoax

Two teenage girls have admitted sparking an online tribute site mourning a boy's fatal mephedrone overdose. The tribute to 'Jaydon Rothwell' on Facebook attracted more than 2,000 people with hundreds posting condolences. But police discovered that Jaydon never existed and that two girls from Blackburn had created the Facebook page and his death as a prank.

■ Forced recovery

Thailand is forcing its estimated 30,000 problem drug users into 'rehabilitation centres' in a drive to eradicate addiction in the country. "There will be those who are encouraged to receive treatment on their freewill and those who will be forced against their will. A rehabilitation camp will be open for addicts elsewhere in Thailand where a rehab centre is scarce," said a government statement.

Treating young drug users 'could save £159 million'



SIMON WHEATLEY/PYMCA

- Up to £8 saved for every £1 spent
- Cost-benefit of help doubles in two years

A cost-benefit analysis has found that the immediate and long term benefits of providing specialist help for young people with drug and alcohol problems significantly outweigh the cost of providing the treatment.

The Department for Education study, which comes as many drug treatment services for under-18s face cuts as part of the government's drive to limit spending, estimated that for every £1 spent between £4 and £8 is saved.

It said the costs would be saved in relation to future spending on crime, adult drug dependency, problem alcohol use and long term exclusion from education or employment.

Carried out by consultancy firm Frontier Economics, the study, which claims that its estimates are "conservative", concluded that within two years of treatment, the cost-benefit would already have doubled.

It said that specialist services would pay for themselves if they prevented between just three and five per cent of young people from becoming dependent on drugs or alcohol as adults. Preventing 10 per cent of those likely to become problem adult drug or alcohol users would bring total lifetime benefits of between £48 million to £159 million.

Last year there were around 24,000 young people – chiefly 16 and 17 year olds – who received specialist treatment in the UK. Just over half received help for cannabis, 37 per cent for alcohol and 10 per cent for class A drugs such as heroin and crack. Most had experienced a range of other problems including involvement in crime, truancy, unemployment and bad housing.

Paul Hayes, chief executive of the National Treatment Agency, said: "Heavy use of cannabis or alcohol can lead to exclusion from school, family breakdown and crime.

"For those teenagers who seek help, substance misuse is usually one of a range of problems causing difficulties in their life, which is why treatment services must work with partners in youth services to offer a range of support.

"This research shows their efforts pay dividends for society as well as benefiting individuals, and underlines the importance of maintaining investment at local as well as national level."

■ A project to cut drug-related crime in Glasgow has saved the taxpayer more than £10m, according to research carried out by the Scottish government. The Persistent Offender Project, which has received £760,000 since opening in 2006, helped record an estimated 39 per cent fall in crime. The government's Justice Analytical Services claimed that for every £1 spent on the project, it delivered a £14 saving to society.

New prisons inspector 'shocked' at drug trade behind bars

- One in five prisoners developed a drug problem inside
- Governor admits people deliberately get themselves sent to jail to sell drugs

The healthy state of the drug trade behind many prison walls has again been highlighted after the new prisons inspector said he was shocked at the level of drug use at a Teesside jail.

Chief inspector of prisons Nick Hardwick, whose visit to Holme House last year was his first since taking up the role, said: "This is a prison with high walls and barbed wire on top, but drug use is a really significant problem at Holme House. I was quite shocked by it."

A key target of all British jails is to ensure that "prisoners are safe from exposure to and the effects of substance use while in prison". Despite this, during an unannounced inspection of Stockton's Holme House it was found that almost one in five inmates had developed a drug problem since arriving – nearly double the national average.

The report into the 1,000 capacity category B prison revealed that 44 per cent of inmates said that it was 'easy' or 'very easy' to get illegal drugs inside Holme House, compared to a national prison average of 31 per cent, and that there was drug-related violence.

The inspection also found that the prison's drug treatment system was not adequately staffed or organised, and that the clinical team manager and the CARAT manager worked in separate parts of the jail. The report said of the 282 inmates receiving methadone treatment, 70 per cent were on maintenance doses, which inspectors said needed to be reduced.

Mr Hardwick said drugs were a major issue despite a "robust" supply reduction policy including a body orifice security scanner (BOSS) chair, four on-site sniffer dogs, regular perimeter checks and the monitoring of mail and prison visits.

Holme House governor Matt Spencer admitted people find "new and ingenious ways" of bringing drugs into prison, including substances thrown over the wall inside tennis balls, oranges, and even dead pigeons for prisoners to pick up or hook into their cells from windows.

Mr Spencer added that 'drug mules' were being used to smuggle in illegal substances, worth several times their street value inside jails. He had evidence of at least 30 offenders a year who "deliberately get themselves sent to jail in order to deal drugs inside".

Last month Richard Kilbourne from Hartlepool handed himself into police after intentionally missing a court appearance, saying: "I think there's a warrant out for me."

He was remanded into custody at Holme House where the next day a stash of cannabis and 90 pills of the heroin substitute drug Subutex were found after he had hidden them internally. Police deduced after quizzing Kilbourne, a 26-year-old drug-addicted offender with 155 convictions on his record, that he had been instructed to carry out the mission on behalf of others.

■ Dedicated drug courts are a success in dealing with people who persistently commit low level crimes to fund their drug addiction, a study has found.

An evaluation of the six pilot areas in England that have drug courts – Barnsley, Bristol, Cardiff, Leeds, Salford and London – said the fact offenders see the same judge and multi-agency staff at drug courts was key in making them work.

"Continuity helped the relationship between offenders and the judiciary develop. The relationship provided a key role in providing concrete goals, raising self-esteem, engagement and a degree of accountability for offenders about their actions," said the study.

The dedicated courts, an alternative to magistrates' courts, were cost effective and viewed positively by both staff and offenders. However, the report added that staff and offenders stressed that the ability of the courts to reduce re-offending by cutting drug use was limited "because of the significant role played by the quality of treatment received" and other issues in offenders' lives.

DRUGS QUOTE

"Their ages are 17. They give them pills at night, they put hallucinatory pills in their drinks, their milk, their coffee, their Nescafe"

Libyan leader Muammar Gaddafi claims that those protesting against his rule are acting under the influence of hallucinogenic drugs.

"I am on a drug. It's called Charlie Sheen"

Actor Charlie Sheen responds to allegations that he is addicted to drugs after his TV show *Two and Half Men* was scrapped because he insulted producers on air.

"They would smoke drugs so they couldn't walk straight and these are people with our weapons"

A culture of opium and cannabis smoking exists among Afghan nationals working with British troops in Afghanistan, a preliminary inquest hearing into the deaths of five British soldiers heard.

"Maynard's worst fears were realised; each bundle was stamped Property of West Midlands Police"

With undercover police work in the spotlight, a look back at the *Observer* in 2001 reporting on a bungled crack deal.

Drug treatment in prison

We have responded to the Ministry of Justice's Green Paper, Breaking the Cycle: effective punishment, rehabilitation and sentencing of offenders. Specific government ambitions around offender drug treatment include measures to:

- reduce the availability of illicit drugs in prison and increase the number of drug free environments;
- introduce pilots for drug recovery wings in prisons;
- support the design and running of pilots to pay providers by the results they deliver in getting offenders to recover from their drug dependency;
- test options for intensive community based treatment

There is little to argue with in these proposals, but as ever the devil will be in the detail of how policies are interpreted and implemented. So on the establishment of recovery wings (which exist in many prisons already) a key issue will be how the courts decide whether to sentence offenders

either to intensive drug treatment in the community or a short prison sentence with access to a drug recovery wing. We would recommend that drug recovery wings for offenders serving sentences of less than 12 months should focus on prisoners with sentences of a minimum of six months.

We are supportive of greater emphasis on outcomes and more opportunities for third sector provision, but we have concerns about the pace of change given the complexity of the implementation issue and would favour a cautious approach to developing PbR, with careful evaluation at each stage, and a willingness to explore alternative approaches to outcome-based funding and commissioning.

We support community sentences and recognise the potential value of high intensity orders, but a critical question is how the courts determine the appropriate level of intervention. DrugScope takes

it as a fundamental principle that decisions about treatment should be based on clinical considerations. We do not underestimate the benefits of intensive treatment, however, there is a real risk of high breach rates and disruption to therapeutic environments if decisions are not based on a careful assessment of need and suitability for a particular individual at a given point .

Our full response is on the DrugScope website
www.drugscope.org.uk/

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Emma Ward, Membership Development Officer at emmaw@drugscope.org.uk

CEO Forum

On 3rd March, we held the third of our CEO forum meetings convened to discuss matters of mutual concern to treatment providers in a time of rapid change. The well-attended meeting heard presentations from Chris Heffer, Head of Drugs and Alcohol at DH, who outlined the plans for rolling out Public Health England and the role of Directors of Public Health and Health and Welfare Boards; Colin Wilkie-Jones, Head of Drug and Alcohol Policy at DWP, spoke on the key welfare and employment issues while Simon Antrobus, Addaction's CEO gave a provider perspective on the key issues. DrugScope's Policy Director, Marcus Roberts set the scene for the Payment by Results pilots and gave an overview of our response to the government's consultation on offender rehabilitation. One of the main issues raised during the subsequent discussions was the continuing concern about the quality

of service commissioning and it was also pointed out that notions of service users holding personal budgets could conflict with the policy and operational imperatives of payment by results. It was agreed that these meeting were very useful, so we will be planning more such events together with a forthcoming summit looking specifically at the latest intelligence on service cuts. Details to follow.

Barriers to Recovery

We held two expert seminars, in London and Manchester, to consider what constituted barriers to recovery and what strategies might be employed to overcome them. Some of the broad brush themes which came under scrutiny were:

- Media reporting
- Stigma
- Historically low expectations of recovery from both staff and clients
- Cuts to both drug treatment

services, but critically to those elements of public sector provision such as housing that are vital to recovery

- Localism and NIMBY-ism

Key strategies discussed included:

- Promotion of 'success stories' in the media and the community
- Increasing and highlighting drug use and treatment in the context of health
- Engage in the debate about what processes are needed in recovery and what constitute realistic outcomes
- Government to work with employers in order to support their capacity to employ those in recovery
- Training and support to shift expectations of staff and clients
- Drug and alcohol treatment to work collectively and creatively to provide a variety of 'recovery-orientated' treatment options

HOUSING CRISIS

Leaving drug treatment to begin a new life is a make or break period for many people trying to move away from addiction. But plans by some town halls to cut funding for Supporting People looks set to make this transition even harder. By **Bill Puddicombe**

The recent announcement that the Pooled Treatment Budget for drug treatment was not going to be significantly cut for 2011-12 was an enormous relief. After 10 plus years of building in the drug treatment field it was good to know that we were not going to start having to dismantle. There are no grounds for relaxing, however, until we can be sure that disinvestment from other directions is not going to halt, and reverse, the progress made.

The Supporting People (SP) funding resource provides essential housing-related support to thousands of substance misusers in treatment and exiting treatment. SP funding goes directly to local authorities in order to fund these services and, until last year, was ring-fenced, ensuring that the money went to support the people that it was destined for. SP is there to support all client groups and, according to a paper published in February by 14 organisations (including DrugScope) is a source of assistance for one million people at any one time. This paper also underlines that SP is excellent value for money, as it generates savings in acute services.

The introduction of SP in 2003 was a fraught exercise. I found an article in a housing paper about a conference in 1999 where a speaker (actually it was me) said that the changes in the system's implementation made people "want to curl up in the foetal position and start evening classes". In the intervening years, however, some excellent services have been grown across the country.

Substance misusers are beneficiaries of SP services in two ways. There are many schemes that provide specifically for them while in treatment or when they are in the process of reintegration following treatment. In other places, generic schemes for people at risk of eviction are active in supporting tenants

whose alcohol or drug use is a major contribution to a chaotic life.

The current threat to SP should be considerably lessened, as the national fund will only be cut by three per cent in cash terms over three years. While this, equivalent to 12 per cent in real terms, is difficult, it is a sustainable reduction. However the removal of the ring fence has meant that some local authorities have simply decided to spend the money on something else. A quick internet search suggests that one of the biggest migrations of funding is Nottingham City Council where a cut of 45 per cent of SP services is being considered. The effect of this kind of cut on substance misusers is almost certain to be less chances for reintegration, more evictions, more need for acute interventions.

The human cost of this will be shocking. The economics of investing in drug and alcohol treatment, while failing to provide services to assist those exiting treatment to maintain stable accommodation is questionable – even perverse.

In Newark, Nottinghamshire, Phoenix Futures and Framework Housing Association currently run the Portland House service for women. This is a unique service that offers self contained accommodation with a treatment programme for women. This service is about to close as a result of the withdrawal of SP funding. Karen Biggs, the Chief Executive of Phoenix Futures,



expresses dismay about the speed and consequences of this cut in funding by Nottinghamshire County Council. Her approach is pragmatic and forward looking: "It's difficult not to get angry about it but as a sector we need to focus on working effectively with all partners at a local level to find our way through this difficult period," she said.

Across the country in Bristol, however, the City Council has decided that the SP funding to substance misuse services will be protected. ARA is a well established treatment provider in Bristol with 21 years of experience in the field. SP is one of the essential funding streams supporting their programme of treatment and recovery. Peter Walker, ARA's Chief Executive, expresses his relief that Bristol has taken this approach. "It's a good news story for the city," he says.

Let's hope that, when the dust settles, there is more than one good news story.

■ **Bill Puddicombe** is Chief Executive of the drug treatment charity, eATA

THE GREAT HEROIN CRASH

- **Five month drought the longest on record**
- **Purity drops to record low from 32 per cent to 13 per cent**
- **Rogue high purity batches may already have triggered several overdose deaths, as treatment services around the country brace themselves for more fatalities.**

EXCLUSIVE

By Peter Simonson
and Max Daly

A snapshot *Druglink* survey carried out among frontline drug services, senior DAT staff, police and service users in 18 towns and cities across the UK has found the heroin drought is widespread, ongoing and the most severe of its kind on record.

All areas covered in the survey – Penzance, Torbay, Bristol, Cardiff, London, Canterbury, Birmingham, Manchester, Liverpool, Stoke, Sefton, Manchester Redcar, Leeds, Middlesbrough, Newcastle, Blackpool, Glasgow and Edinburgh – reported that street heroin was of an unusually low quality.

According to unpublished figures gathered by the Forensic Science Service, the average purity of street heroin is the lowest since 1984. From an average purity of between 30 and 40 per cent over the last 26 years, heroin seized by police on Britain's streets plummeted to 13.6 per cent in December and 13.1 per cent in January. By February it rose slightly to 14.5 per cent.

In most places the drought began in October last year, accelerated in December and is still present. In some

areas, batches of good quality heroin have appeared and may have been responsible – because of users' reduced tolerance levels – for drug-related deaths.

Police believe that three heroin users who died in the space of one hour in east Lancashire may have overdosed on the same batch of high purity heroin. There have also been six reported heroin-related deaths in the last two weeks of February in Ireland, where a drought has also hit.

Across the board, those working with heroin users have expressed concern over the vulnerability of drug users when, and if, the current drought lifts. Many services have put up posters warning of the risks of overdose.

Most users have continued to use heavily cut heroin while compensating for this by 'topping up' with illicit tranquillisers, pharmaceutical opiates, alcohol and stimulant drugs such as speed and crack cocaine. In London crack has been offered by dealers at bargain rates alongside poor heroin to attract customers.

Figures released in February by drug testing firm Concateno, revealing that positive tests for heroin had dropped among users in treatment by more than 50 per cent in the last year, were matched by test on arrest figures in Lancashire and Cleveland, which showed similar dramatic falls.

Druglink's research has revealed that it is likely a significant number of those negatives did not mean that people are no longer using heroin – they may have used some of such low purity that it did not register within the test's parameters.

The use of illicit diazepam has, increasingly since the start of the heroin drought, become a major problem in some areas. In Stoke on Trent there have been two reports of heroin users injecting nail varnish remover.

A detailed intelligence report into the drought's impact, compiled by Cleveland Police over three months, found that

during the drought, which began with an almost total disappearance of heroin in October last year, positive test on arrest figures for heroin nearly halved, while the numbers doubled for cocaine and crack cocaine.

Drug-related deaths averaged between zero and three a month in Cleveland up to November last year, when the figures jumped to eight deaths and six deaths in December. The report, seen exclusively by *Druglink*, said the average heroin purity was 21 per cent and there has been no increase in people going onto methadone programmes.

Although Cleveland police, believed to be the only force to carry out such an investigation, were expecting a rise in crime in the area as users needed to find more money to get the drug and dealers battled over good batches of heroin, burglary, violence and theft have fallen. There have been none of the expected raids on pharmacies. The report said some users travelled outside Cleveland, to other areas such as Northumbria, to seek out better quality heroin.

Cleveland Police said that high end dealers in the area were cutting their product as a result of having to pay higher than usual wholesale prices. Dealers have chosen to ride the drought out rather than offer their customers alternative drugs because, the report says, they did not have time to source new product lines.

But Det. Insp. Paul Tait, who compiled the report, said he believed there were signs the drought was becoming less severe in Cleveland. But he added that dealers were likely to keep purity as low as possible because they now realise most users will continue buying it at the same price as higher purity heroin.

The *Druglink* survey found that many areas described the heavily cut heroin as reddish in colour, and when it is smoked, smells of TCP. It doesn't 'run' as normal street heroin does. When prepared for injection, the heroin crystallises and

coagulates when it cools, blocking the needle.

Kath Tallboys from Blackpool's Drugline charity, who had reports of poor quality heroin from November, stated that this was corroborated by test on arrest statistics from the local DIP which showed a lower level than normal of heroin positive samples.

A number of areas in our survey reported clients who were turning up for services after having used heroin and testing negative. Michael Linnell at Lifeline in Manchester had heard of users presenting to services wanting to get onto some form of prescribed treatment and being refused as they'd tested negative for heroin use despite claiming to have used the day before. In Tower Hamlets, a current service user claimed to have used £60 worth of heroin the previous day and still tested negative.

The investigation found little evidence of the expected increase in users accessing treatment services, whether they are offering methadone and Subutex or rehab and detox.

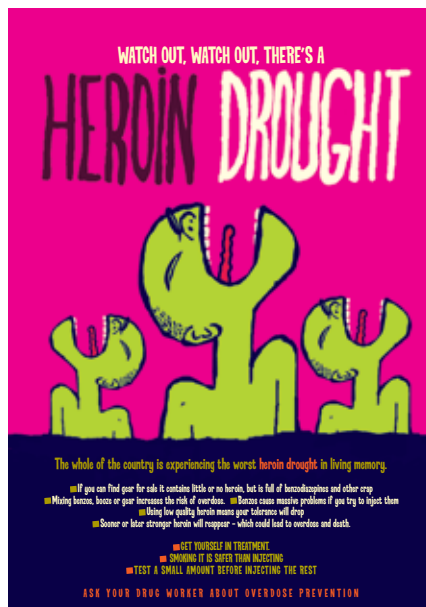
A senior drugs worker from an agency covering the south coast of England stated: "Contrary to expectations, we haven't seen a deluge of people seeking treatment because they can't get gear." David Prescott, the senior practitioner at Lifeline in Manchester, said that "despite the ongoing promotion of detox and treatment, there has been no noticeable increase in referrals".

This was a situation also seen in Merseyside and Staffordshire. Peter Sheath, of CRI, who manages two large prescribing services in Sefton and Stoke on Trent, said there had been no increase in users coming onto scripts. The absence of an increase was also noted in Southwark and Camden in London, Torbay, Blackpool, Edinburgh and Cardiff.

In Leeds and Bristol drug services experienced falls of around 50 per cent in the number of syringe packs and foil handed to drug users.

There were exceptions. Cliff Askey, service manager at Lifeline in Tower Hamlets said the service saw an increase in people attending prescribing services of 40 per cent from October and stated that the neighbouring borough of Hackney had seen big increase in new clients wanting to access prescribing services.

But the usual networks of information among users about 'good' heroin dealers has in some areas broken down, as some buyers are keeping this information close to their chest. This makes it harder



Warning: drug charity Lifeline is distributing posters warning drug users about the dangers of overdose when the drought lifts

for drug services to access important knowledge about the arrival of higher purity batches of heroin. Services are bracing themselves for a spike in heroin overdoses and deaths when, or if, purer heroin makes its way back to UK streets after users have become less tolerant to the drug.

Jill Cole of Cardiff Community Drug Team told of the increased use of black market diazepam pills, branded as 'MSJs' and thought to be from south east Asia. "We think these pills may have been responsible for a number of recent local deaths in Cardiff, initially thought to be heroin overdoses, but the use of naloxone by emergency staff had no effect. These pills vary in strength and appear to make people aggressive and black out more often than diazepam. And due to their low price and easy availability, users are taking them by the handful. The service user group in Cardiff is so concerned about the use of MSJs they are producing a warning poster," said Coles.

There has also been increased use of street tranquillisers in the North East, where one brand has been given the street name of 'charge sheets' for the propensity of the drug to cause black outs during which users wake up to find they've been arrested for some unknown crime. He states that the drought meant

that users were swallowing 20-30 10mg tablets after using heroin.

Several services said that the drought had been a positive thing for some drug users, who have become so fed up with the poor quality goods on sale that they have ditched street heroin and stabilised on methadone and Subutex.

WHAT SPARKED THE DROUGHT?

There are several theories – pin-pointing causes from the production end of the heroin trail in Afghanistan to the distribution side managed by high level dealers in the UK – as to why Britain is experiencing this dearth in heroin.

Poppy Blight

The UNODC reported in May 2010 that opium production would be severely affected by a poppy blight affecting most of the major poppy growing areas. The fungus, *macrosporium papaverus*, causes capsule rot, resulting in little to no opium latex being available for extraction by farmers. However, a shortage of heroin has not been noted in other countries across Europe.

Enforcement

SOCA have said that recent law enforcement operations against heroin wholesalers in Turkey and the dismantling of UK distribution networks had had a considerable impact on the amount of heroin entering the UK reported. SOCA accepted that other factors, such as the blight, may also be involved.

Stockpiling

This theory argues that there is not a production problem, but that wholesalers are stockpiling heroin to increase the price within the UK. Price of heroin has dropped lower than any other drugs over the last ten years.

Russian market

There is a market of upwards of three million heroin users in Russia who pay more per gram than in Britain. Also, the logistics of getting the drugs to Russia are easier. Why face the trouble of getting heroin to the UK for so little return when you can export direct to Russia over a porous border?



REHAB UK: FULL HOUSE OR BLEAK HOUSE?

Back in the day, residential rehabs were pioneers in UK treatment provision and practice. However despite the recovery agenda, commissioning practice and the apparent failure of some rehabs to evolve mean further tough times ahead. By Harry Shapiro

Stop almost anybody in the street and ask them what they think addiction treatment is all about, chances are most will name check 'rehab'. But the image won't be an especially positive one. Rather than a place to get off drugs, the public perception of a rehab is of a celebrity bolt hole to escape from the paparazzi. Rehabs are seen as almost as exclusive, expensive luxury hotels for the rich and famous which fail to work: often within weeks of leaving rehabs celebrities are back in the headlines for falling off the wagon.

Yet despite the muddled public image of what rehabs are, they have an integral place in the history of drug treatment – long before we had anything that could be regarded as a genuine system for helping people addicted to drugs.

By 1968, concern over the growing heroin scene in London, fuelled by a

small group of GPs who prescribed heroin (and cocaine) in eye-watering amounts, led to a ban on doctors handing out drugs to treat addiction. The new rules meant they could only do so if they obtained a licence from the Home Office. In practice, most doctors did not apply for the licence, they were only too glad to be able to tell users they were no longer allowed to prescribe to them. Instead, the licences went primarily to consultant psychiatrists, who were in charge of the newly opened 'drug clinics'. The clinics continued to prescribe heroin and cocaine (although in much lower quantities) in the hope of turning users away from the illicit market in imported heroin which had just begun to emerge.

But it didn't take too long for the psychiatrists and the workers to realise two things. First, although the regime moved quite quickly from heroin and

cocaine to injectable methadone and then oral methadone, there was growing unease that the clinics were little more than dispensaries. Second, while they were helping clients to detox and stabilise, it wasn't rehabilitation. They had no processes or methodologies for moving people towards a drug-free life. Looking for answers, drug clinic psychiatrists lighted upon the growing number of residential rehabs established in the USA. They were a particular type of rehab known as the 'therapeutic community' (TC).

Christian groups had been providing residential care for alcoholics in the UK since the 19th century. But the notion of the TC came from the mental health field in the 1940s and was developed by a small group of psychiatrists including Tom Main who first coined the expression in 1946. The TC aimed to

be a more democratic, user-led form of therapeutic environment, avoiding the authoritarian and demeaning practices of many psychiatric establishments of the time. The central philosophy was that clients were active participants in their own and each other's mental health treatment and that responsibility for the daily running of the community would be shared among the clients and the staff.

The American model was essentially the same, but with a crucial difference. The first TC, called Synanon, opened in California in 1958. It was founded by Chuck Diedrich, an ex-alcoholic who took his cue from the peer support approach espoused by Alcoholics Anonymous. The AA model was very supportive and unchallenging: you listened to somebody's war story and then applauded them for their courage to be up there and for their sobriety (however short a time that was). Diedrich thought, however, that all alcoholics and 'addicts' should be confronted, not comforted, and that they should take responsibility for their lives.

Synanon was run entirely by the residents on virtually military lines – a very strict hierarchy along which the resident could move up to positions of authority over the others, rigid timetables and duties which accounted for every second of the day, public humiliation for the smallest infraction of myriad rules and no-holds barred 'encounter' groups, again run by the residents where all anger, frustration and criticisms were aired. Looking to replicate the model, Daytop Village opened in New York in 1963 and in 1966 another New York-based TC, Phoenix House, was founded by a psychiatrist Efrén Ramirez.

The pilgrimage to the States made by UK psychiatrists ended up with the opening in quick succession of a series of British-based rehabs in 1960s such as Alpha House (1968), Suffolk House (1969) and Phoenix House, initially called Featherstone Lodge (1969). The Coke Hole Trust (1968) was the first of the so-called 'Christian houses', while Cranstoun (1971) offered a less draconian, more 'democratic' environment.

But the TC model, which relied on non-professional resident therapists acting with none of the ethical standards demanded of professional mental health and addiction workers, was not without risk. At its most extreme, the charismatic Diedrich became the cult leader of 'The

Church of Synanon' which engaged in all kinds of criminal activity to silence critics and ex-residents.

DECADES BEFORE THE CURRENT LEXICON OF 'RECOVERY' AND BEING 'AMBITIOUS FOR CLIENTS' WAS FASHIONABLE, THE EARLY DRUG CLINICS ACCEPTED THE CHALLENGE OF GETTING PEOPLE DRUG-FREE, TAKING THEIR CUE FROM THE WORKING PRACTICES OF REHABS WHICH THEMSELVES WERE 'RECOVERING' COMMUNITIES

In a much milder form, some of these problems were imported into the UK when two ex-residents of Phoenix US were brought over to run Featherstone Lodge. From the get-go there were conflicts between them and the professionals, who were unwilling to relinquish control of how the TC was run. However the Americans were edged out when a female resident, caught stealing food, was made to stand naked in front of everybody while she was verbally abused. Over time, Phoenix settled down, and in line with the general trend in TC programmes, the regime became less harsh. Under the leadership of ex-resident David Tomlinson, the first former user to sit on the Advisory Council on the Misuse of Drugs (ACMD), Phoenix adopted many of the business models that have stood the organisation in good stead ever since: becoming a housing association in the 1980s, for example, enabled Phoenix to draw on local authority housing budgets.

But the presence of rehabs also had an impact on clinical practice. As alluded to earlier, clinic staff wanted to do more than just hand out prescriptions. Eventually, as Dr Martin Mitcheson, the psychiatrist in charge of the clinic

at University College Hospital later wrote, "the clinics collectively swung... away from maintenance and towards confrontation of continued misuse of drugs, with active intervention and emphasis on facilitating change". Decades before the current lexicon of 'recovery' and being 'ambitious for clients' was fashionable, the early drug clinics accepted the challenge of getting people drug-free, taking their cue from the working practices of rehabs which themselves were 'recovering' communities.

Custom and practice has it that in order for a stay in rehab to stand any chance of success, it is best if the individual is not only a good distance from old haunts, but also cut off from any nearby towns and all the temptations that this can bring. And so the tradition was established for the remote setting of premises – otherwise known in the drugs field as 'The House on the Hill'. But with the geographical isolation and the intense nature of the over-arching philosophies and daily routines of the rehabs, came a psychological insularity that stayed wedded to the founding principles of rehabs. As a result, they tended not to readily embrace change.

But by the early 1980s some profound changes were sweeping through the British drug scene. The number of heroin users in the UK was rising steadily through the 1970s, but not enough to raise any real concerns. Drug use was way down the political agenda. The arrival of smokable heroin changed everything. It broke down the taboo of injecting and opened up the world of heroin use to a mass of young people whose prospects (especially outside the south-east) had been battered by the collapse of Britain's heavy and manufacturing industries and the scourge of unemployment. Numbers of heroin users rose sharply, compounded by the advent of HIV/AIDS.

These climactic changes impacted significantly on the fortunes of rehab. First, most were not equipped to respond to the challenge of HIV: the very last thing an HIV positive user needed was to be pitched into a highly stressful therapeutic environment. Second, the establishment of harm reduction services and the drive to contain the virus meant that harm reduction including maintenance prescribing, became the primary treatment imperative. Third, in the wake of the

fresh demand for treatment, shorter (and therefore cheaper) 12 step programmes run by private companies and based on the 'Minnesota Model' sprung up.

This new landscape prompted the government to set up the Central Funding Initiative (CFI) in order to encourage projects to bid for new and innovative services. Of the pot of money available under CFI, rehabs won less than 10 per cent. TC champions like Rowdy Yates from Stirling University says they lost out "because they were unwilling to embrace harm reduction". Yet Professor Susanne MacGregor, who conducted an evaluation of the CFI, points out that if rehab did not benefit much from the CFI, it was not because of the ascendancy of harm reduction, but because "the aim of CFI was to develop new services based in the community and in places where services were previously few in number".

But not all rehabs lost out. Phoenix, for example, took the opportunity to expand its services to Sheffield. And this became the pattern of the future: organisations which began as single service establishments like Turning Point and Addaction (originally a parent support group called APA), grew and diversified, taking advantage of changes in policy and funding streams to become (with more recent providers like CRI) major players in what is nowadays a market-driven medium sized industry.

Through the 1980s, while funding was always an issue, the House on the Hill was in reasonably good shape, with a steady stream of clients referred from the growing network of community-based drug services and clinics from all over the country. And then came the NHS and Community Care Act 1990 (enacted 1993), a development which those from smaller rehab services still cite as the moment the rot set in.

Up until then, it was relatively straightforward to get into rehab – not much more complicated than a phone call from a service to a facility asking if there was any space. The money to pay for it came directly from the Department for Health and Social Security (DHSS), in the form of the resident's income support, plus any grant support that the rehab might have received from the local authority in which it was based. But as far back as 1968, the Advisory Council on Drug Dependence (the forerunner of the ACMD) had made clear in their report *The Rehabilitation of Drug Addicts* that rehabs should be funded by local authorities, not central government.

And so in 1990, the Conservative

government introduced the Bill that created a 'marketplace' in the NHS. In a move currently echoed by the concept of 'localism', it transferred community care budgets down to social services. So, no longer would rehab fees be paid for through income support. Instead, community services would have to go cap in hand to social services for funding for money that wasn't ring-fenced and which would have to compete with all the other demands on social service expenditure. Except that wasn't how it was supposed to be.

BUT WITH THE GEOGRAPHICAL ISOLATION AND THE INTENSE NATURE OF THE OVER-ARCHING PHILOSOPHIES AND DAILY ROUTINES OF THE REHABS, CAME A PSYCHOLOGICAL INSULARITY THAT STAYED WEDDED TO THE FOUNDING PRINCIPLES OR REHABS. AS A RESULT, THEY TENDED NOT TO READILY EMBRACE CHANGE

The drug sector swung into action to challenge the government on the issue of ring-fencing. SCODA (the Standing Conference on Drug Abuse) was the umbrella organisation representing voluntary sector drug agencies. Initially there was to be no ring-fencing, but as the then SCODA Director David Turner recounts: "SCODA, Turning Point and Alcohol Concern had a very secret meeting with civil servants and got an agreement that ring-fencing would be in the Bill. And then with no explanation, they suddenly back-tracked and it was out. We had another meeting, this time with Health Minister Virginia Bottomley and Social Services Minister Michael Portillo, but never got a clear explanation." Turner speculates that the reason for the government's decision was that the money to be

transferred to social services was less than the total income support money previously paid to rehabs. But if they ring-fenced a budget, the government concluded that it would take the blame if local authorities couldn't make up the difference.

The upshot was that SCODA made a very public stink, going so far as to picket the first European Drug Prevention Week, held in London in 1993. But although funds were not ultimately ring-fenced, the much-touted meltdown of rehabs didn't happen. Some services closed, including Featherstone Lodge. Looking back, David Turner believes that ultimately the furore created by SCODA saved many rehabs. "We had made such a fuss that it was almost impossible for the government to take the risk that too many services would close," he says. Yet there were bigger changes to come in the way drug services were funded, with developments in local commissioning – and the creation of Drug Action Teams.

Since the 1990s, rehabs have knitted together finance through spot and block purchasing, housing benefit, and in some cases, the substantial fees paid by private patients – which helps subsidise the residencies of others. Supporting People, the housing-related funding stream started in 2003, provided a potential new pot of cash for rehabs, but only to the extent that they could demonstrate that they were 'supporting' people and not simply 'caring' for them. In this respect, Phoenix Futures CEO Karen Biggs feels that drug services missed opportunities for growth. "Money could have stayed within the sector if people had been a bit more savvy about how to produce the evidence of what they were doing," – meaning how you can present 'care' as 'support'.

Effectiveness is critical to the whole question of how marginalised some services say they feel. Those who campaign on behalf of the smaller rehab organisations are passionate in support of their belief in the virtues of rehab. A recent issue of *Addiction Today* declared 'A myth is doing the rounds that there is no evidence that rehabs work', but then cites plenty of evidence to the contrary, although not from the NTA who campaigners claim are 'anti-rehab' even though the NTA's *Models of residential rehabilitation for drug and alcohol misusers* (2006) states explicitly that rehab is "a highly effective form of treatment for drug and alcohol misusers who wish to achieve a drug-free lifestyle".

Rehab might be effective, but which



clients are likely to do best? Previous attempts to try and compare treatment effectiveness founder on the simple premise that you are not comparing like with like. There is a consensus that those clients who do best are likely to be the ones with the worst problems, those who have hit rock bottom. But is that because they are the ones most likely to receive funding – leading to another *cri de couer*: that rehab is always seen as a treatment of last resort. Would the drop-out rate from rehab be higher than it is if many more people with less severe problems – but who maybe were not ready for the tough rehab regime – were allowed in?

For rehab to demonstrate effectiveness beyond the front door is very difficult once the client leaves. The self-selecting group that stay in touch, start their own services or join the staff are in the minority. So commissioners inevitably fall back on simplified cost comparisons between community services (at around £85 per week per client) and rehab (around £500 a week), although some community service costs may be more diffused and opaque.

Why some commissioners are reluctant to refer clients to rehab probably goes deeper than cost, for as Karen Biggs says, “there are some DATs that don’t spend all their Tier 4 budgets”. It is possible that some commissioners are reluctant to send clients to whose regimes they feel are over-confrontational and harsh in an era when the professional ethos is supposed to be geared to showing more respect towards users and putting them at the heart of treatment. Because of personal relationships built up over years, some commissioners might only send clients to one or two rehabs, although

BUT IT IS BY NO MEANS ALL BAD NEWS FOR REHAB. THE LARGER PROVIDERS HAVE LONG DEMONSTRATED NOT ONLY THE VALUE OF DIVERSIFICATION, BUT OF BEING MORE RESPONSIVE TO THE NEEDS AND EXPECTATIONS OF CLIENTS IN THIS DAY AND AGE

if feedback from clients is positive, there is inherently nothing wrong with this, except it can sidestep more logical calculations on the relationship between quality, price and value across the range of rehabs available.

But it is by no means all bad news for rehab. Some providers have long demonstrated not only the value of diversification, but of being more responsive to the needs and expectations of clients in this day and age. For example, NVQs are being offered to residents engaged in house maintenance and catering. Some services offer a short induction stay for people thinking of coming into rehab, while residents at Phoenix can have virtual meetings with family through Skype. Others are working with new models of rehab, such as BAC O’Connor and Trust The Process, where the House on the Hill has given way to a much

more systematic engagement with the community through professional link-ups and the physical siting of premises in town centres. Even that classic House can still do well.

Littledale Hall in Lancashire was opened in 2006 and may well be the future for rehab. According to Director Keith Robertson, the place is “full – with a waiting list”. The programme fuses the models proposed by Tom Main and others, with contemporary addiction and psychological theories. Littledale Hall has manuals for all aspects of treatment, delivered by a multi-disciplinary team consisting of social workers, drug workers, clinical therapists and counsellors. The aim, says Robertson – who is asked to go into other Tier 4 services to advise on their programmes – is to “deliver a service grounded in a strong evidence base that is fit for practice and meets the demands of commissioners and service users looking for effective and quality treatment in the 21st Century”.

Residential rehabilitation has come down a long winding road since the late Sixties. Some would say that the virtues of rehab have been oversold and no doubt the morally-uplifting abstinence focus has great political appeal. In the run up to the 2005 general election, then Conservative Party leader Michael Howard was promising 25,000 extra rehab places without any clear strategy for paying for them. Yet there is no denying the many stories of those who declare that rehab was the last chance saloon that literally saved their lives. However, in an era of swingeing local cuts and an increasingly market-driven health economy, the foundations of some rehabs are under serious pressure.



House on the hill: Victorian style

Where were Victorians with drink or drug addictions sent to get help? Were they treated or punished? Virginia Berridge takes a look at rehab in the 19th century

On September 19, 1885, a special train ran from Euston station in London to Rickmansworth, then a country town. It carried a mixed party of doctors, clergymen, temperance abstainers, and prohibitionists, many of whom were members of the British Society for the Study of Inebriety. They were attending a reception at the Dalrymple Home, a licensed inebriates retreat run by the Homes for Inebriates Association. The guest of honour was Dr Joseph Parrish, president of the American Association for the Study and Cure of Inebriety, founded in 1870. A resolution was passed that day congratulating Parrish and his group “on the steadily increasing recognition of the diseased condition of the confirmed drunkard, and on the generous provision for the treatment of the poorest of this class in America at the public expense”.

The purpose of the day’s enthusiastic

outing resulted in part from a Victorian concern about alcohol. The best known form of that concern was the temperance movement, which had become by the late 19th century a substantial working class movement in many countries, English speaking and Nordic ones above all. But public concern took other forms, notably, in the movement to provide medical state-funded treatment for inebriates. Its intention was to divert “habitual drunkards” out of the “revolving door” of prison and into treatment; its rationale was that drinkers were diseased. Modern scientific research had revealed “that intemperance has a physical and pathological as well as a legal, moral and spiritual aspect, that there is a gospel of the body as there is a gospel of the soul...”, stated Norman Kerr, president of the British society, in an 1893 lecture on inebriety and jurisprudence.

In Britain, the classic punishment for drunkenness at the time was a fine, or imprisonment for several weeks or months. The number of those imprisoned had risen rapidly, from 4000 in the early 1860s to 23 000 in 1876. There were moves to reform this process and to insert medicine into it. In 1870, Donald Dalrymple, Liberal MP for Bath, formerly a surgeon in Norwich and proprietor of the Heigham Lunatic Asylum, unsuccessfully introduced a private member’s bill. Two years later, a parliamentary select committee on the control and management of habitual drunkards, of which Dalrymple was chairman, urged legislation to bring about the compulsory treatment of voluntary patients and of convicted drunkards. The results were initially disappointing. In 1879, the Habitual Drunkards Act made compulsory treatment of non-criminal inebriates

High Shot House, ST. MARGARETS, TWICKENHAM, Middlesex.

Frequent Trains from London, via Waterloo (L. & S. W. Railway), to St. Margarets Station.

Licensed under the Inebriates Acts, 1879-99.

Address for Telegrams:
"Pike, Highshot, Twickenham."

TELEPHONE
623 P.O. RICHMOND

Resident Medical Superintendent:
THELWELL PIKE, M.D. W. F. CHEVERS,
L.R.C.P.&S: 57

ESTABLISHED (in 1886) for the treatment of gentlemen suffering from Inebriety, the Morphia Habit and the Abuse of Drugs.

High Shot House is admirably adapted for the purpose, being roomy and comfortable, and contains a spacious dining and recreation room, reading room, visitors' room, and a billiard room with full-sized table and usual appointments. For further amusement and recreation there is lawn tennis, bowls, quoits, a workshop, and facilities for photography. The river is six minutes' distant, where excellent boating can be had.

Special attention has been paid to all sanitary arrangements, and there is good bath-room accommodation. In the immediate neighbourhood are many objects of historical and archaeological interest, and some of the most beautiful spots on the lower reaches of the Thames. Kew Gardens and Richmond Park afford additional attraction to the neighbourhood, and are within easy walking distance. There are frequent trams to Hampton Court.

The Library is furnished with works by the best novelists, as well as books of reference and scientific and miscellaneous literature. The leading daily papers, comic journals and illustrated magazines are supplied, together with professional and other periodicals.

Acute cases can be received at any time on intimation by wire or letter. Every patient is afforded the comforts of a first-class home, together with the medical treatment, supervision, and control necessary in cases of inebriety and allied conditions.

TERMS:

Entrance fee £1 1s. A minimum term of thirteen weeks' board and residence, in advance, from £2 12s. 6d. to £5 5s. per week, according to bedroom accommodation, there being no difference in any other respect. The following are extras: Laundry, private sitting rooms, meals in bedrooms, fire in bedroom, billiards, medicine. For laundry and other personal expenses a sum to be lodged with the Superintendent.

No allowance can be claimed for an unexpired period in case of determination of contract. Special arrangements and terms for permanent residence, also for short periods less than three months.

'For the treatment of gentlemen suffering from Inebriety, the Morphia Habit and the Abuse of Drugs,' begins the leaflet for High Shot House, a rehab for the cream of Victorian society – the Priory of its time.

The leaflet, displayed as part of the recent High Society exhibition at the Wellcome Collection, was published in 1900 and gives an insight into the higher end of the market in Victorian rehabs.

Opened in 1885, High Shot House was situated near the banks of the river Thames in the leafy London suburb of Twickenham, Middlesex and charged residents up to £5 (the equivalent of around £2,000 today) per week. Its earlier claim to fame was as a place of refuge for Louis Philippe, Duke of Orleans between 1800 and 1807 after he fled the French Revolution.

The house catered for a higher social order of clients, often referred to as 'gentleman of leisure', than Dalrymple House (see 'Rehab: Victorian style' feature) in Hertfordshire. The venue offered a full-sized billiard table, lawn tennis, bowls and a fully stocked library for its clients, who usually stayed for between three to nine months.

High Shot House clients were a mixture of gentleman inebriates, admitted under the 1879 Habitual Drunkards Act, and private patients, who were treated on a voluntary basis and for who the only sanction was being kicked out and losing the fees that had been paid in advance. But it was the private

patients that were most profitable for High Shot's owner Dr Harrison Branthwaite, a staunch supporter of the temperance movement. In 1900 there were 34 private patients compared to just 10 who had been admitted under the Act.

In 1889, Charles Park, a dentist from Morayshire was admitted to High Shot House after requesting treatment for injecting morphia and cocaine. 'When he assaulted an attendant and broke out of the home, the

Superintendent found it legally impossible to force his return,' says out Virginia Berridge in *Opium and the People*. It was only in 1908 that the Habitual Drunkards Act and the 1888 Inebriates Act were able to control those who injected drugs.

The rehab was finally closed in 1909 after the death of a private patient in 1900 sparked a dramatic downturn in business.

■ Max Daly

available only to those who could pay. A further act followed in 1888. The Inebriates Act of 1898 allowed the committal of criminal inebriates to state-funded reformatories if they were tried and convicted of drunkenness four times in one year. Compulsory power to detain non-criminal inebriates, long advocated by medical reformers, was never granted. Financial battles between the Home Office and the local authorities, charged with funding the reformatories, blighted the implementation of the act.

Provisions of the act covered drug taking as well as alcohol, as long as the substance was ingested by drinking it. Inebriety was classified according to the intoxicating agent: “We thus have alcohol, opium, chloral, ether, chlorodyne, and other forms of the disease.” Laudanum tipping was covered, but not drugs that were injected. A later (1908) departmental committee on the Inebriates Acts accepted that all drug taking should be included. It also proposed that an inebriate, thus defined, could apply to have an appointed guardian, a strategy derived from lunacy legislation, whereby the guardian would decide where the inebriate would live, deprive him of intoxicants, and warn sellers of drink and drugs against supplying him. After a warning had been given, any supply to a drinker or drug taker would be an offence. Provision for compulsion was in place if voluntary control proved insufficient. Plans to extend the law in this way were a faint hope. Even before the First World War, inebriates legislation fell into disuse. Only 14 reformatories, dealing with 4590 inmates, were then still in operation. Drinkers and drug takers were covered by legislation dealing with lunacy and mental deficiency.

The power to commit offenders to inebriate reformatories was heavily implemented in cases of neglect and child cruelty. The 1902 Licensing Act enabled a magistrate to send an inebriate wife to a reformatory in place of a separation order. The Provision of Meals Act of 1903 and Prevention of Cruelty Act of 1904 provided for detention when neglect and cruelty were due to drink and were also used to commit drunken prostitutes and the poorest and most troublesome section of the male labouring classes. Such sections of society, according to Mr Branthwaite, the inspector of reformatories, “...bring into the world ill-fed, uncared-for and mentally useless children, who provide the mass from which the future criminal, drunken, and lunatic army is recruited”. At the turn of the 19th century, reformers

were concerned with “the future of the race”, the transmission of the disease of alcoholism from one generation to another, and the hereditary taint, the “alcohol gene” of its day, of alcoholism. Women were disproportionately represented among those who were confined.

THE INEBRIATES ACT OF 1898 ALLOWED THE COMMITTAL OF CRIMINAL INEBRIATES TO STATE-FUNDED REFORMATORIES IF THEY WERE TRIED AND CONVICTED OF DRUNKENNESS FOUR TIMES IN ONE YEAR

The mandate of the institutions encompassed reform, rehabilitation, and punishment. Offenders were kept away from the temptations of the city (hence Rickmansworth for the Dalrymple Retreat) and confined for a lengthy period—between 1 and 3 years—as compared with 1 to 3 months in prison. Cure involved physical, mental, and moral rehabilitation. Dr F J Gray of Old Park Hall Retreat in Staffordshire described his methods in 1888: “In the cricket season we have a half-day’s match every week...often some medical men and clergymen come up for tennis, so that there are plenty of means both for exercise and amusement on the premises...we begin the day with prayers...and finish the day with prayers. Breakfast at nine o’clock, which consists of porridge (to which I attach a great importance), bacon and dried fish, varied with eggs, sausages, bread, butter, jam and marmalade.”

Enthusiasm for such treatment was international. In America, the temperance-based Washingtonian movement of the first half of the 19th century had founded small, private institutions dedicated to the moral treatment of voluntary patients. Promoters of the asylum model, some organised through the American Association for the Cure of Inebriety, wanted institutions that were large, public, rural, and capable of holding and disciplining the inmates. The concept of the “industrial hospital” argued for in the 1890s failed because jails were seen to have the same function for less cost. Public institutions specifically for

drinkers did not gain ground in the USA. The Massachusetts State Hospital for Dipsomaniacs and Inebriates was plagued by patient escapes, rebellions, and the accumulation of chronic cases. The advent of prohibition in the 1920s seemed to substitute prevention for cure.

In English-speaking countries and in Germany, the popularity of inebriate institutions peaked in the years before 1914. In the Nordic countries, the peak of interest was later, from 1910 to 1935. There were inebriate asylums in Australia and South Africa. After the first World War, with restrictions on opening hours and reduction of the strength of alcohol, prosecutions fell in England. The alcohol problem was no longer the central question, and inebriate reformatories seemed less relevant. Different trends had emerged in psychiatry. The prestige of mental-asylum doctors was eroded, and a middle-class clientele was sought outside the asylum.

The legacy in English-speaking countries was apparently minimal. Systems for handling alcoholism continued in Sweden and Switzerland, although these were less medically oriented. Both countries arrived in the period between the wars at a three-tiered system of community agencies, hospitals, and work camps. Physicians relinquished compulsory handling of cases, seeing these cases as “social” rather than “medical”.

The issue of whether alcohol and drug abuse should be handled through medical or criminal justice systems is still relevant today. Drug abuse now seems to be a greater social concern than alcohol. Coerced treatment is applied in the UK through arrest, referral, and Drug Rehabilitation Requirements. Keeping the drug-taking offender out of prison is a key objective for British drug policy, although for alcohol the objective is less clear; a community order may stipulate alcohol treatment.

Women who abuse alcohol attract disproportionate attention, as they did a century ago. Compulsory treatment is still on the agenda for offending drug takers, but porridge and healthy exercise in an institution have been replaced by less visible regimes of control.

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SKIRMISH IN SUFFOLK

In November last year it was announced that Icení, a long-running frontline drug service which gained nationwide recognition in the wake of the murder of five Ipswich sex workers, would have its funding cut.

Suffolk Drug and Alcohol Action Team (DAAT) opted to end Icení's contract following a tendering process which saw one of the country's major drug service providers, Crime Reduction Initiative (CRI), win out as the key successful bidder, alongside the Essex-based Open Road charity, to run the county's network of drug services in the east of England.

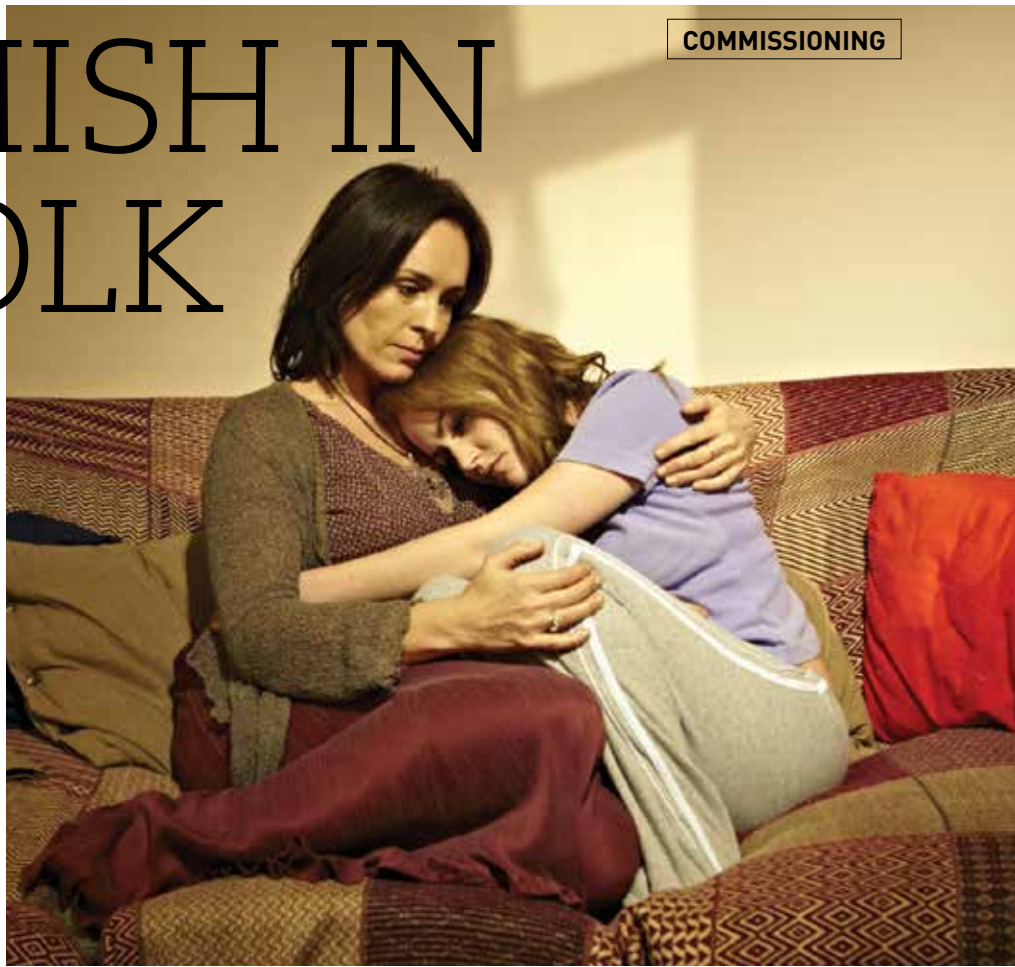
But the decision led to accusations, chiefly from Icení's director Brian Tobin, that the two year long tendering process carried out by Suffolk was biased towards big providers such as CRI – and that the local knowledge and expertise of Icení would be lost and replaced by a new, 'chain-store' style drug service. Tobin, described the decision as "farcical and a huge injustice".

Many in the drugs field say that the battle for contracts to provide drug services is increasingly a David and Goliath affair.

Yet Suffolk DAAT's tendering process, described by some as a possible framework for the future commissioning of drug services throughout the UK, was according to its authors a fair method that has the interests of the community at its heart.

In the run up to Christmas 2010, Icení gained significant backing in its bid to survive. Local newspaper the Ipswich Evening Star ran a campaign, 'Save Icení, Save Lives', which was supported by Tory MP for Ipswich, Ben Gummer. The newspaper featured interviews with current and former sex workers declaring they would most likely have been dead by now had it not been for the help given to them by Icení.

But beyond the passionate debate around the way drug services are being commissioned, the full story of Suffolk's tendering process, is yet to be explained. Below, the key players – Suffolk DAAT, Icení and CRI – explain their side of the story.



SIMON AALDERS AND MICHELLE PATERSON

Suffolk DAAT

The first step was to sign the partnership up to a formal strategic goal – in Suffolk's case, abstinence as the desired end point for as many people as possible. The aim was to develop a treatment system where all the parts worked together with the client at the centre. Consultation sessions sought service user views on what 'an ideal treatment system might look like' and which of the factors identified were most important to service users. These were then presented to service providers and other stakeholders who provided further ideas in relation to what was needed.

To meet the aspirations of those using the services we adopted the UK Drug Policy Commission's Consensus Group statement definition of recovery, with the ultimate aspiration to achieve abstinence 'voluntary sustained-control over substance use which maximises health and well-being, and participation in the rights, roles and responsibilities of society'.

We divided the treatment system into three elements – prescribing services, open access and case management and psychosocial interventions. There was nothing to stop any organisation bidding for and winning one of the three elements. However, if an organisation did not want to take any financial risk and stay with their current financial envelope, they could bid in partnership with other providers (in fact this was actively encouraged). Each element was considered separately in the bids so that bidders did not have to try and do everything, but instead focus upon their own areas of expertise.

With direction agreed, the DAAT Partnership then developed a set of 'commissioning intentions' on which to base the design of the new treatment model. Some of the key areas identified were: a need for greater clarity and less duplication in the treatment system, in other words, commissioning a clear system rather than a number of services; provision of defined and separate open access services alongside targeted time-limited structured treatment; reducing inequity of provision by filling gaps

to ensure that each type of service is readily available and accessible across Suffolk; integrating harm reduction interventions fully within the treatment system and ensuring that these are offered and provided to all clients during their treatment journey; ensuring the provision of interventions that focus on recovery, reintegration and pathways out of specialist treatment; improving each service user's experience of treatment; and ensuring that treatment services are linked in to other services, such as housing and employment.

OUR MODEL IS A RADICAL OVERHAUL OF THE TREATMENT PROVISION IN THE COUNTY. IT WILL TRANSFORM THE QUALITY AND EFFECTIVENESS OF SUBSTANCE MISUSE TREATMENT

The other added consideration was the cost. We recognised that cheapest doesn't mean best and therefore structured the evaluation to focus 70 per cent weighting upon quality and 30 per cent upon finance. Therefore financially, it was highly unlikely that larger organisations could benefit by offering a significantly cheaper bid. In fact the reverse may be true in that smaller organisations would not have the level of overheads that larger organisation have. This theory proved accurate as the financial range in the bids was small.

The main advantage that larger organisations may have is in their experience of writing tenders (having successfully won tenders to get to become a larger organisation in the first place!) and possibly the resources involved in writing a tender. However, good quality training in tendering was offered to all local providers, most of which took up the offer and plenty of preparation time was given (local providers had also been aware of the intention to tender for some years). The difference in the winning and losing bids was the quality of provision, not the size of organisation in financial terms.

The main focus was achieving the best quality provision at the best cost, regardless of how this may be packaged. The funding was structured to support the development of treatment in all areas of the county, providing organisations with the opportunity to

develop and expand regardless of their size

The bids received reflected the breadth and quality we expected, and in arriving at the final outcome we are confident that we are now well-placed to transform the old model into a system that enables the client to move through treatment, and access the right type of interventions that will enable them to meet their own aspirations.

It was the quality of the bid and the business plan that was key when evaluating individual agencies. For example, if you are confident that your service delivers excellent provision in one town for £200K then your bid could have said "we'll repeat this service in three towns for £600k" – if this was seen by the panel as the best option then the funding would have been awarded, all services had six months to then obtain new buildings and staff before starting. The process was a fair, competitive and open tender based primarily upon the quality of the services offered and the clear demonstration that the organisation can work in partnership, meet the needs of the county and deliver the recovery model required by the partnership.

Competitive tendering is always difficult and organisations will lose out, but progress in drug treatment is vital to ensure the expectations of clients can be effectively met. The Suffolk approach was designed to encourage a plurality of bids and avoid a 'one size fits all' model, but this requires providers to be ambitious, innovative and be able to demonstrate that what they offer meets the expectations of service users and commissioners.

Our model, the 'Partnerships Recovery Model', is a radical overhaul of the treatment provision in the county. It will transform the quality and effectiveness of substance misuse treatment and ensure that the significant amounts of public money being spent in this area are fully performance managed, utilised with the greatest efficiency and accountability to service users and commissioners.

National changes to commissioning, such as Payment by Results, the end of the ring-fenced pooled treatment budget and PCTs, and the advent of Health and Welfare Boards, will affect all areas. However, if DAATs are properly constituted, demonstrate clear and robust performance management, financial accountability and transparent partnership decision making, then the partnership commissioning and strategic decision making will ensure they have

a vital role to play in substance misuse treatment, prevention of harm, crime reduction and improved community and social outcomes. An effective way of tackling the complex social and health issues of substance misuse is through a partnership and the DAATs across the country are ideally placed to bring partners together and effectively tackle these issues. Challenges for smaller charities are apparent and these charities must meet the challenge of good financial planning, business planning and develop cooperative relationships with their funding partners.

BRIAN TOBIN *Director, Icen*

It is a sensitive topic and one that will resonate with many who have experienced similar processes and results. Attempting to describe the nebulous tendering process we were subject to is extremely difficult and could appear to be a case of sour grapes on our behalf, however, it is as much about the ability of commissioners to set parameters that enable small charities to compete with larger size charities and not stick with the belief that big is always beautiful.

Icen is fighting to survive and has produced a new service aimed at working with the whole family. Primarily it is aimed at keeping children with their birth parents where an addiction is present. Icen, like many other small charities, has lost out in a recent tender bidding process to the growing emergence of large charities, who are cutting swathes across the country, effectively running small local charities like Icen out of 'business'. Icen has, year-on-year, met and exceeded key performance indicators set by the DAAT. A cruel injustice has been served on Icen and the people of Ipswich and Suffolk have been dealt a huge disservice by nothing more than an elitist group of individuals who agreed to proceed with an archaic tendering process that prevented Icen from standing any realistic chance of winning a competitive tender. Based on the flimsiest of evidence, such people are responsible for potentially destroying one of the most well regarded and successful treatment providers in the county.

What makes the decision and situation for Icen even more galling and difficult to comprehend is that the government has committed to return power to communities and charities like Icen, which is an important part of

David Cameron's 'Big Society'. Suffolk County Council declared, prior to the commencement of the tendering process that local charities are highly valued and that they provide vital services to the local communities and that every effort would be made to ensure local services survive post tender. Yet the tendering process and outcome went in the opposite direction, favouring big charities from London and Essex.

It is frequently the case that the organisations that are successful in winning the tenders are those that choose to spend part of their income from such contracts on their business development. Until last year, all service providers have been based in Suffolk. This meant that the money that was used to support their infrastructures was recycled in local communities. We now have a situation where Suffolk County Council is contributing to the running costs and central salaries of organisations based further afield; money that will stay outside the local economy.

AN ELITIST GROUP OF INDIVIDUALS WHO AGREED TO PROCEED WITH AN ARCHAIC TENDERING PROCESS PREVENTED ICENI FROM STANDING ANY REALISTIC CHANCE OF WINNING A COMPETITIVE TENDER

Contracts to deliver services have largely replaced grants because competition is deemed to deliver value for money and contracts are getting larger in the misguided belief that scaling up reduces costs. Such contracting via a tendering process is suddenly beyond the reach of small charities like IcenI. Whilst not criticising the large organisations who have won these contracts, as I'm sure they did not set out with the intention of undermining IcenI, it is perhaps the contract process itself that is at fault. There is now more focus on the contract and the tendering process than on the service itself and it was this focus that prevented IcenI from bidding as a main contractor, thus greatly reducing the chances of being successful.

National organisations cannot have the same local commitment to Ipswich as IcenI, which has forged enduring ties to its community because it was set up and is run by local people. Partnerships and networks have been formed based on mutual trust and the coming together of like minded individuals and organisations who truly want to make a difference in the communities of Ipswich. IcenI does more than just deliver services, it has worked to make neighbourhoods better places to live. IcenI has the ability to react to local problems and was at the very heart of working to assist women off the streets of Ipswich during and in the aftermath of the murders in 2006.

The government is right to see local charities and community groups as vital in strengthening local communities. The super-sized charities of this world continue to thrive whilst IcenI and others, who operate at the heart of the communities and understand the ethos, culture and individual needs of the places where they work, will simply disappear and the connection with our most hard to reach and vulnerable lost.

Whilst IcenI will always look at improving its performance, I believe we can become even more effective and creative without the shackles of Suffolk DAAT forcing us into providing nothing more than tick box exercises. The time will come when DAAT's are devolved, and not before time in my opinion. In the current climate such entities should be the ones facing closure and not those that seek to genuinely improve the health and well-being of the communities we serve.

IcenI has always delivered a high class service and provided good returns on those that invest in us, however, we have to acknowledge that when it comes to selling ourselves to businesses and new investors we have often fallen short. Doing good without anybody noticing is interesting, but not necessarily economically profitable. This is another example of where super-sized charities gain an advantage on small local organisations.

If we secure the requisite funding for the next 12 months then we will have a little breathing space to work on thriving and not just surviving! We have an application in with the Transition Fund (Home Office) and the outcome of this will give us a clear indication of what shape we will be in.

KEVIN CROWLEY

CRI director of operations

CRI believe that the new commissioning landscape offers greater than ever opportunities for local providers and smaller charities to contribute to the development of services for communities and service users.

THE NEW COMMISSIONING LANDSCAPE OFFERS GREATER THAN EVER OPPORTUNITIES FOR LOCAL PROVIDERS AND SMALLER CHARITIES TO CONTRIBUTE TO THE DEVELOPMENT OF SERVICES

Not long ago CRI was born of the amalgamation of five small charities which came together to create financial stability and share expertise and resources. We understand the challenges of operating from a small revenue base and recognise the many benefits that collaboration and collective working can bring to service delivery – for service users, providers and commissioners.

CRI is committed to delivering locally managed services. Across the UK we have formal and informal partnerships with other providers, working across prescribing, housing, education and employment services. These partnerships enable us to meet the range of service users' needs in a local context. We also consult closely with service users and incorporate their feedback into our working practices to ensure that services are accessible and responsive to their individual needs.

Where larger contracts are tendered, partnerships between smaller charities can bring together the necessary range of local knowledge and expertise that is required to deliver comprehensive, integrated, local services on a larger scale. CRI welcome the opportunity to work creatively with local providers at all stages of service development.

We look forward to working with our new partners Open Road in Suffolk. We also look forward to becoming part of the Suffolk provider network and will use all our experience of partnership working to ensure that services meet the needs of local users and the communities we serve.

BORN IN THE USA

Fifty years ago an international treaty consolidated global anti-drug laws and set the framework for the future of drug prohibition. **Cindy Fazey** charts the development and impact of the 1961 Single Convention on Narcotic Drugs.

“International treaties signed 30 years ago are not appropriate to the modern age. The treaty does not recognise the present or point to the future. It enshrines the past”.

George W. Bush, 1st May 2001

Many believe this sentiment should apply to the Single Convention on Narcotic Drugs, which was signed 50 years ago in 1961. But unlike the Strategic Arms Limitation Treaty George W. Bush was referring to, the Convention is not regarded by the US and many other nations as out of date. It is so set in stone as to be immovable, although an amending Protocol was added in 1972. It cannot be denounced (that is, revoked), changed or even tinkered with. Together with two other subsequent Conventions (1972 and 1988), it remains the world's basic control mechanism not only for illicit or illegal drugs, but also the control of these drugs in their legal form, such as morphine.

The Single Convention consolidated all earlier attempts at control, from the 1912 International Opium Convention, known as the Hague Convention, through the Geneva Conventions of 1925 and 1931 and a series of additions, agreements and protocols that beefed up regulations and amended conventions. It established four schedules of drugs. Schedules I to III largely reflect the A,B,C of the UK classification system.

The schedules were based on distinctions made by the 1931 Geneva Convention. Schedule 1 drugs were those capable of causing addiction, being converted into addictive drugs but which were rarely used in medicine and Schedule II drugs were those that did not cause addiction, were capable of being converted into addictive drugs, and widely used in medicine. The Schedule III drugs were largely those which had been exempted from the more onerous burdens of regulation. Schedule IV was the tightest of all. It existed for those Schedule I drugs for which nations may want to introduce stricter controls or more severe punishments.

Therefore the classification system we have today is based on the thinking from 1931. The Commission on Narcotic Drugs can add to or change the drugs under control. The main drugs under control were the opium poppy, the coca bush and cannabis (but only the ‘flowering and fruiting tops of the cannabis plant’).

A Geneva Convention in 1924, also known as the Second Opium Conference, was called to set maximum limits on production of legal morphine, heroin and cocaine and to restrict for export the raw materials from which the drugs were made. The Americans walked out when their proposal to restrict the use of opium and coca drugs to “medical or scientific” purposes was rejected. Other countries argued this would make the League of Nations authority superior to their national sovereignty – they wanted control over their own domestic drug policy.

The issue of cannabis was not even on the agenda, but in the furore that followed the walk-out, Egypt's delegate Dr Mohamed El Guindy proposed a ban on cannabis, supported by the Turkish delegate and also by any remaining Americans. El Guindy may have been motivated by a desire to punish the British for their occupation of his country, which had ended only two years previously. Moreover, the ban would hit a very large cannabis trade between the UK and India; cannabis, or Indian Hemp, was the main source for rope-making and sailing ships traditionally used a prodigious amount of rope. So the compromise was to define cannabis as the flowering and fruiting tops of the plant, which definition was incorporated into the 1961 Convention which says “this Convention shall not apply to the cultivation of the cannabis plant exclusively for industrial purposes...or horticultural purposes”.

In the run-up to Single Convention, there was a strong US-led push to create a worldwide total ban on morphine and heroin, one that would even withdraw it from medicinal use. But other countries resisted. The UK, guided by the Rolleston Committee of 1926, had taken the treatment route and permitted physicians to prescribe these drugs if “after every effort has been made for the cure of addiction, the drug cannot be completely withdrawn”.

The prohibitionists had started their campaign in 1923, continuing at the Geneva conferences of 1925 and 1931,

and through the WHO in 1955. But at the 1961 Single Convention discussions, other countries insisted on a clause in the preamble “recognising that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes.” The drugs being controlled should be limited to “medical and scientific purposes”, but these terms were never defined, thus allowing the prescription of heroin to heroin addicts in England and later in the 1990s in Switzerland and the Netherlands.

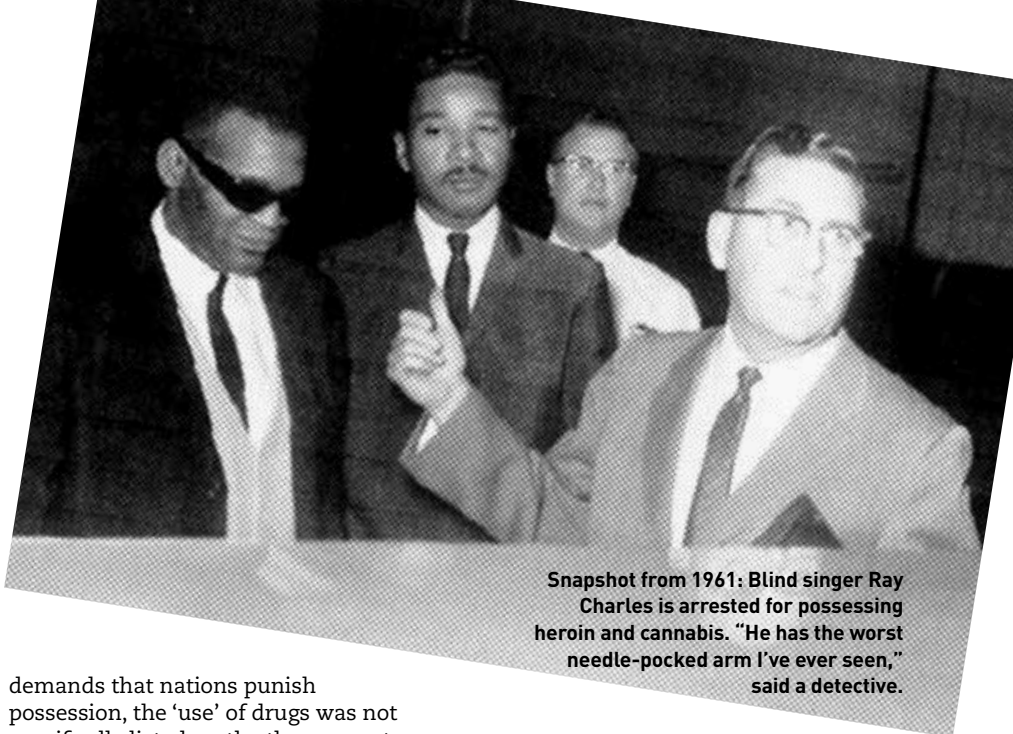
The Single Convention set out a list of substances under control and established the bodies to supervise that control, namely the Commission on Narcotic Drugs and the International Narcotic Control Board (INCB). It is, however, important to note that they have no mechanism to enforce or execute the Convention, other than pillorying parties that do not follow their interpretation of the Convention.

The 1961 Convention’s two ‘guardians’ have since shaped much international policy and practice. The Commission on Narcotic Drugs now comprises 53 member states, but virtually every country sends an observer if they are not a member, and since no votes are taken the distinction is marginal. The INCB comprises only 13 ‘experts’.

The essential role of the INCB is to “ensure adequate availability of narcotic drugs, including opiates, for medical and scientific purposes, while at the same time preventing illicit production of, trafficking in and use of such drugs”. To this end, governments estimate their needs on an annual basis and the Board attempts to match these with estimates from officially recognised manufacturers and growers in countries authorised by the Board. Governments can then import or manufacture any of these drugs within the estimated ranges.

The Board’s functions, therefore, were supposed to be limited to monitoring and controlling the legal production, import and export of opium, cannabis and cocaine, and ensuring stringent controls to prevent supplies being diverted to the illicit market. However, both as a result the influence of some early secretaries to the Board and also because of the self-importance with which some Board members view their brief and role, its pronouncements often greatly exceed its original brief and often go beyond board members’ spheres of technical competence.

Although the Convention specifically



Snapshot from 1961: Blind singer Ray Charles is arrested for possessing heroin and cannabis. “He has the worst needle-pocked arm I’ve ever seen,” said a detective.

demands that nations punish possession, the ‘use’ of drugs was not specifically listed, so they are not required to punish the offender. This led over the years to many vehement exchanges at the Commission on Narcotic Drugs where the US insisted that possession and use were the same, and the Netherlands, among others, that they were not, and that the UN had no right to interfere in a sovereign nation’s domestic legislation. The US was eventually to get its way in 1988 when the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances obliged signatories to make the possession of controlled drugs for personal consumption a criminal offence under domestic law.

IN THE RUN-UP TO SINGLE CONVENTION, THERE WAS A STRONG US-LED PUSH TO CREATE A WORLDWIDE TOTAL BAN ON MORPHINE AND HEROIN, ONE THAT WOULD EVEN WITHDRAW IT FROM MEDICINAL USE

Out of 51 Articles in the Convention, only one (Article 38) deals – in three very brief sentences – with ‘measures against the abuse of drugs’, in other words drug education and treatment. “The Parties shall give special attention to and take all practicable measures for

the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the person involved and shall co-ordinate their efforts to these ends”.

One of the most misunderstood parts of this and subsequent Conventions, and often misunderstood by international lawyers, is that the conventions are immovable. Article 46 of the 1961 Convention states it can be denounced, while Article 47 says that “any Party may propose an amendment to this Convention.”

Yet no member state is going to risk being a pariah state and threatening the whole international treaty edifice by denouncing the Convention. Although the Convention says that it can be amended, de facto it cannot because the mechanism to do so makes it highly unlikely. A proposed change has to go from the Commission on Narcotic Drugs to its next superior body in the UN – The Economic and Social Council (ECOSOC). Unanimity is required: just one country opposing the amendment will kill it.

And then there is the 1969 Vienna Convention on the Law of Treaties which states that “every treaty in force is binding upon the parties to it and must be performed by them in good faith.” In effect, once you have signed a treaty you cannot get out of it – unless, as in the case of strategic arms, the super-powers agree. In the matter of illicit drugs, they never will.

■ **Cindy Fazey** is Honorary Visiting Professor of International Drug Policy at the University of Liverpool



Local zeroes

The government is ambitious for solving the problems they see inherent in delivering public services. But could local disinvestment leave drug services struggling to cope? In the first of two articles assessing impact of these changes on the sector, **Sara McGrail** looks at the risk factors

With the announcement of the Pooled Treatment Budget (PTB), many were relieved, in a time of cuts, that no area was left completely devastated. Yet there are significant financial threats on the horizon for the sector and we mustn't assume that simply because the axe hasn't fallen yet, it won't.

A major threat is disinvestment of mainstream monies – local funding that supports and supplements the PTB. In 2008, in some areas, 50 per cent of treatment spend came from local mainstream funds. Local investment has been critical to many partnerships, not simply by increasing budgets, but also because it provides the flexibility to develop interventions that cannot be funded by the PTB. Local funding can support employment and housing projects and services for families – as well as delivering equitable access to treatment for alcohol users. This means that in those areas with high levels of mainstream funding, the value of central investment increases significantly.

When the current formula for the PTB was first set in 2008, it included an

incidental incentive for local investment. Areas that had higher levels of local investment looked more efficient and so received higher levels of central investment. If next year's formula includes the same bias, then areas from which local partners are disinvesting – maybe because of increased pressure on other services – will face additional disinvestment from the centre. This will act as a double whammy, further eroding services and creating a spiral of decreasing funding. Local Drugs Partnerships will need to work hard to retain mainstream investment over the next few years. For many located within Crime and Disorder Reduction Partnerships (CDRPs), this could prove impossible.

In a letter to local authorities and police in February the Home Office delivered some bad news for CDRPs. Core Community Safety funding (the Home Office component of the Safer Stronger Communities Fund, the Young Persons Substance Misuse Funding and the Community Call for Action) will be cut by 20 per cent in 2011/12 – from an

allocation of just under £75 million to £58.8 million. In 2012/13, funding will fall to just £28.8 million – a reduction of 60 per cent on this year's baseline.

These budgets will not be ring-fenced and from April 2012 will no longer be allocated on a borough basis, but transferred to the Police and Crime Commissioners (PCCs) – the newly created elected posts that will take on the functions of Police Authorities. In London this shift of funding from boroughs will take place in April, when for the first time community safety funding for Greater London will be allocated to the Mayor and the GLA. This is devastating for CDRPs. Without doubt it will lead to redundancies in community safety units affecting core services (data analysis, crime mapping etc) and will have a similar impact on community services supported by CDRPs including young people's services, victim support and initiatives tackling hate crime and anti-social behaviour.

It appears that Home Office DIP funding will be shifted from local authorities to the PCCs and from

April 2012 will again be included in an unringfenced single pot to enable PCCs to meet local priorities

There will be significant pressure on PCCs to increase investment in the kind of frontline services that quickly improve public confidence and reduce the fear of crime. PCCs will be directly accountable to their electorate, and they will need to be convinced that investment in drug treatment can bring about the kind of increased confidence that will lead to re election. Gaining investment from PCCs will depend to a large part on the results that can be demonstrated to the community.

And what of the ubiquitous yet ill defined Payment by Results (PbR) – the single most important factor in reshaping the public sector over the next few years? In a report he co-authored for accounting firm KPMG in 2010 entitled Payment for Success, KPMG, 2010, newly appointed Downing Street policy supremo, Paul Kirby said: “Where payment by results exists it should be made enhanced and where it does not exist it should be hurried into existence, even if it is crude to start with.”

Drug treatment PbR pilots begin in October. A central commitment to developing our understanding of shared outcomes is very positive – as long as it is intelligently evaluated. The field has been waiting for a system that lets us demonstrate real impact. The challenge then is to deploy this new system on a short timescale, but hurrying it into existence – against a background of reducing funding and likely (given the impact of the recession on many people) increased demand, will be tricky.

The difficulties of developing a universal measure for recovery sophisticated enough to reflect individual experience is notoriously difficult. Defining recovery by the relationship of an individual to a chemical substance or a drug treatment service is simple and seductive for people making policy up on the trot, but it's also reductive of that individual experience and thus likely to misrepresent the real Value for Money (VfM) of public investment. If the only measures we can muster are those available at the point of discharge – like successful treatment completions, or almost arbitrary success markers like the magical 13 weeks – then we are not really much further advanced from the process indicators we've been using for the past decade.

Sustainable VfM gains from PbR will

also be dependent on the extent to which we can resolve the difficulties of engaging effectively with smaller local third sector groups. PbR demands that providers cover the costs of the intervention until such time as the state can be sure the outcomes it wants to pay for are achieved. For many smaller organisations the financial risks of this are unsustainable. Many voluntary sector agencies are extremely worried that they will not be able to compete in the new market place unless the risk is managed by a bigger private sector organisation like SERCO or Reed or a statutory provider. And the problems faced by providers in the voluntary sector add to the pressure to be hurried and simplistic about outcomes. If PbR is to be a success for drug treatment then we need the time and space to develop an outcomes framework and financial systems that genuinely reflect individuals and communities experience, not just an approximated measure of VfM and some crude targets.

THESE CHANGES COULD IN THE END AFFECT OUR COMMUNITIES, CLIENTS AND SERVICES IN WAYS WE DO NOT WANT – AND RATHER THAN MEET THE GOVERNMENTS BROAD OUTCOMES OF MORE RECOVERY AND LESS DRUG USE, BRING US THE OPPOSITE

These pressures to rapidly demonstrate VfM are evident in the letter sent to Local Partnerships announcing the new PTB allocations. The PbR pilots have only just been announced, but a new formula for relating funding allocations to performance against a key indicator has already been announced as well. This in effect will bypass some of the critical findings of the pilots and instead impose on local areas a financial incentive to meet a central process target. Exactly what the government said they didn't want to do.

Next year's PtB allocation will be set on the basis of a formula which for the first time will include a financial

incentive for treatment completions and as the money will be based on this years' performance in getting people out of treatment, we can expect this work-in-progress to begin to have an immediate impact on our commissioners and treatment systems. A commissioner faced with a budget allocation predicated on increasing the numbers of people leaving treatment will apply levers and pressures on their service providers to do just that. The potential for the reinstallation of the revolving door into our treatment systems is suddenly very real.

This is an ambitious government, and there can be no doubt that many of the reforms they propose have the potential to solve very real problems in the delivery of public services – and not least in the area of drug strategy. What is not clear is whether the impact of such fundamental change deployed across such a range of services at a time of massive public sector funding cuts has been adequately anticipated. The impact assessment of the new drug strategy is largely incomplete suggesting an absence of real planning. In the drugs field like many others, the multitude of reforms to structures, local and national responsibilities and commissioning are falling at a time of redundancies and funding cuts. These changes could in the end affect our communities, clients and services in ways we do not want – and rather than meet the governments broad outcomes of more recovery and less drug use, bring us the opposite.

But we have been through difficult times before in the drugs field and most likely we will come through these. The resourcefulness of local services and commissioners – though diminished by a decade of central hand holding – will be key as they develop effective public health led partnerships and protect services that we have spent too long building to allow to simply fall by the wayside now. Our strong tradition of peer support and volunteering makes the drugs field a positive arena in which to look at new ways of delivering public services. In part two of this article, I'll be looking at how local areas might manage the cuts – and what opportunities changing commissioning structures, the Big Society and the move to public health could bring to the field in the long term.

■ **Sara McGrail** is an independent drug policy commentator

Crystal crescent

Matthew C. DuPée on the spread of the methamphetamine trade in south west Asia

As the 21st century unfolds, Afghanistan finds itself in a profound socio-economic crisis. It is one in which the illegal drug trade and insurgency plays a very complex and important role.

According to the United Nations Office on Drugs and Crime (UNODC), the global dynamics of the illicit opiates market “are not well understood” – and the same can be said of south west Asia’s transforming narcotics industry. All the attention given to Afghanistan’s poppy problem obscures the rapidly growing distribution, trade and production of other narcotics in the region.

The first UNODC *Afghan Cannabis Survey*, published in 2010, confirmed suspicions that Afghanistan is the now the world’s largest producer of cannabis resin, better known as hashish, accounting for approximately 1,500 to 3,500 metric tons of resin in 2009 alone.

Alarming, little to no attention has been paid to another creeping problem: the proliferation of cheaply produced south west Asian amphetamine-type-stimulants (ATS) such as amphetamine, methamphetamine, methcathinone, and ‘ecstasy’-like substances (MDMA and its analogues). The UNODC has issued two comprehensive reports on the proliferation of ATS production and abuse in south east and east Asia since 2008. Unfortunately, these reports do not elaborate on the growing storm of cheaply produced ATS in the historical drug producing region known as the Golden Crescent (comprised of Pakistan, Afghanistan and Iran).

Synthetic drugs, such as crystal methamphetamine (called *shisheh*, which means “glass” in Farsi), LSD, and various forms of refined heroin including a smokeable condensed rock form (referred to locally as ‘crack’), are flooding south Asia and feeding the region’s underground drug culture.

Despite the strict Sharia laws which govern the country’s Islamic system, according to the UN World Drug Report for 2005, Iran has the highest proportion

of opiate addicts in the world – 2.8 percent of the population over the age of 15. Each year, across east and south-east Asia, hundreds of Iranians are charged with drug trafficking and manufacture offences. In January an Iranian drug ‘mule’ died at Kuala Lumpur airport in Malaysia after some of the 137 methamphetamine capsules he had swallowed ruptured in his stomach.

ALL THE ATTENTION GIVEN TO AFGHANISTAN’S POPPY PROBLEM OBSCURES THE RAPIDLY GROWING DISTRIBUTION, TRADE AND PRODUCTION OF OTHER NARCOTICS IN THE REGION

Iranian authorities, who last April seized 220 lbs of crystal methamphetamine in the south eastern town of Hirmand, blame the proliferation of synthetic drugs in the region on an attempt by drug-traffickers to switch drug use from conventional drugs like opium and hashish to those most prevalent in the West. However, implications from the emerging trends reported from the Iranian front are not just restricted to regional concerns; rather, the production of synthetic drugs, especially cheaply made ATS which include the street variants of ecstasy, has major global implications concerning addiction habits, social and health costs, as well as security concerns.

Currently, the center of gravity for south west Asia’s production of ATS remains Iran. According to Iranian counternarcotics reports, *shisheh* ‘kitchens’ are springing up across the region and counter-drug operations are increasingly seizing multi-kilogram quantities of *shisheh* on the Iranian

railway system destined for Turkey and Syria. Earlier this summer, the UNODC reported that Iranian produced *shisheh* was being trafficked to “lucrative markets” as far away as south east Asia because its manufacture outpaced domestic consumption.

Anecdotal evidence shows that during the past few years, a growing number of Iranian nationals have been arrested in several Asian countries, including Japan, Indonesia, Malaysia, the Philippines and Thailand, for attempting to traffic crystal methamphetamine and its liquid form. Among items disclosed in the controversial release of thousands of classified US embassy cables by the whistle blowing website *Wikileaks* in November, American diplomats have voiced concern over the growing threat of Iran’s emergence as the next larger exporter of narcotics to Saudi Arabia, Kuwait, Russia and other countries in the region. In one cable from Baku, US officials citing Azerbaijani reports documented the dramatic increase in Iranian trafficked heroin through its territory; reporting that the seizure of 20 kilograms of heroin in 2006 soared to 59,000 kilograms seized in 2009. Furthermore, evidence exists that Iranian mafia figures in Azerbaijan, some of whom maintain close contacts with the Iranian government, act as liaisons between Iranian and Azeri/Russian drug trafficking syndicates.

Iranian organised crime syndicates are major participants in trafficking Afghan origin narcotics both internally and internationally. Despite serious efforts to counter the region’s drug menace, the entrenched smuggling infrastructure of Afghanistan’s narco-industry is robust. Traffickers are believed to smuggle over 60 per cent of all illicit opiates over the ‘western route’, which includes the wild Iran-Afghan frontier, a desolate section of Turkmenistan and a desert area of Pakistan’s Baluchistan province. From here, tons of opium and refined heroin

Iranian DIY: shisheh (crystal meth) kitchens are springing up across the region according to counternarcotics reports



are smuggled to Caspian Sea ports and to Turkey where drug shipments continue their route to Europe via the 'Balkan Route'. In October 2010, Serbia's Interior Minister Ivica Dacic said close to 80 per cent of the heroin smuggled from Afghanistan to Europe goes through the Balkans, with a lack of efficient control in Kosovo making this route an attractive one to traffickers.

State efforts to identify and adapt to the emergence of ATS production in the region remains slow going, however an increase in ATS production has resulted in a surge of synthetic drug seizures. In Pakistan, the increase in ATS seizures between 2005 and 2006 increased 64 per cent; in Iran, the seizures of ATS increased 60 per cent between 2008 and 2009. Two years ago, abuse of synthetic drugs like ATS in South Asia was restricted to affluent young people because of high prices and limited availability, but with increased manufacturing of these harmful stimulants, market prices are quickly dropping. Iran's Drug Control Headquarters indicates that the price of a kilogram of high quality *shisheh* decreased significantly between 2008 and 2009; going from \$100,000-125,000 per kilogram to \$10,000-15,000 per kilogram.

If methamphetamine production and consumption becomes deeply rooted in Iran, the production of ATS could easily spread, through cultural, social

and economic ties, to neighbouring Afghanistan. Unlike organically produced drugs like cannabis, coca and opium poppies, there are no hectares of crops to measure, no timeframe or seasons to analyse growth patterns, and no ability for anti-narcotics authorities to remotely sensor the clandestine nature of chemically 'cooked' synthetic drugs that take place indoors.

The prospect of ATS production in Afghanistan is very real – the criterion for its production are already in place. Porous and uncontrolled borders, deeply corrupt security and government officials, large swathes of territory that are outside the jurisdiction of law enforcement, entrenched and functioning smuggling networks, the presence of networks apt to smuggling pharmaceutical and industrial chemicals and exporting drugs, a surge in domestic and regional narcotics consumption, and the presence of clandestine narco-processing workshops (labs) are reasons to believe that ATS production could eventually supplement the traditional organic narcotics market of Afghanistan.

When Burma transferred from the world's number one producer of illicit opium to the world's largest supplier of ATS (over 700 million tabs of ATS annually by 2007), Burmese chemists found it quite easy to convert heroin-processing workshops into ATS production houses. The first

large seizures of ATS by Thai officials found trace amounts of opiates within the tablets, indicating an overnight conversion of the workshops had taken place. In 2007, it is also believed a Burmese chemist traveled to Afghanistan to advise on better ways to refine heroin and how to use fewer chemicals during the process, possibly also introducing methods to 'cook' cheaply made versions of amphetamine.

There is a strong need to enhance existing monitoring systems and actively track any possible emergence of new synthetic drugs being manufactured and trafficked from South Asia. Iran is currently emerging as the new conglomerate of cheaply produced ATS, a trend that has serious implications for the flow of illicit narcotics into Eurasia and Western Europe. If left unchallenged, Iran's ATS production will likely spill-over into neighboring states, causing Afghanistan to emerge as a galvanized global narco-hegemony, dictating the global market price for a wide-range of illicit narcotics.

■ **Matthew C. DuPée** is a research associate for the Program for Culture & Conflict Studies at the Naval Postgraduate School in Monterey, CA. His studies focus on the narcotics industry, organised crime, and conflict in Southwest Asia. The opinions expressed here are his own.

Kabul's heroin injectors

A Paris-based human aid organisation is aiming to expand its drop-in centres by building a carpet factory, while Kabul's injecting underclass are left to squat in the city's underbelly

Words: Max Daly and Sandra Calligaro

Pictures: Sandra Calligaro

Opium amounts to half of Afghanistan's GDP, employs 12 per cent of its citizens and partly contributes to funding for the Taliban. Beyond its status as a producer, the country is also a big consumer. It is estimated there are one million opiate users in a country of 28 million people, with spiralling levels of HIV, hepatitis C and mental health problems among drug users.

The international human aid organisation, Medecins du Monde, has set up a harm reduction drop-in centre in Kabul to attempt to address this problem. The centre has operated a successful methadone clinic since 2009 and has 70 patients on its books. It also provides resources and training for scores of harm reduction workers in readiness for the expansion of drop-in centres around Kabul and the rest of Afghanistan.

Olivier Maguet, the outgoing head of Medecins du Monde's six year harm reduction mission in Kabul, was handed the Bonnie Devlin Memorial Scholarship Award for his work in Kabul at a ceremony hosted by Liverpool-based drug project HIT in November. Maguet said that Medecins du Monde was planning to set up a carpet factory in Kabul that would sell carpets on the international market to raise money for 14 new drop-in centres.

While in the provinces opium continues to be smoked in the traditional manner, in Kabul, intravenous injection of heroin is growing. Until it was broken up at the end of last year, hundreds of injectors had created a huge squat within the bullet-ridden remains of the former Soviet Cultural Centre in the west of Kabul.

The complex was chiefly a refuge for Afghan nationals who had been deported from neighbouring Iran after developing addictions to heroin there. Some were children, many had to leave their families behind them and the death rate from overdoses in the squat was high. Since the government built a wall around the complex in November, the squatters have moved to a new compound in the area, underneath a bridge, living amidst mud and insanitary water.

Drug users standing in the ruins of the former Russian Cultural Centre. Above them, Lenin's portrait, destroyed by Islamic insurgents.



Said (left side) and Mussa (right side) smoking heroin. Mussa died a few weeks after. He was only 19.



Drug users standing outside the former Russian Cultural Centre. In the middle of the picture, Said and Jawed are two brothers, both users. Jawed died a few months after.



Hassan, sleeping in the room he was living. Hassan died a few months after. He was HIV positive.



A global brew

Reviews

The first edition of this book, published eight years ago, had a major worldwide impact on alcohol policymakers. It provided a lucid and well-documented case for evidence-based policy concerning alcohol misuse. In this new second edition, all chapters have been updated and a new chapter, on the influence of the international drinks industry, has been added. There has also been some expansion of the evidence from research beyond the industrialised world.

The 15 contributors, a very experienced, highly regarded group of social research scientists and alcohol policy experts from around the world, are not restricted to particular chapters in the book, with none of the unevenness sometimes associated with multi-author volumes. Their aim is to expand and collate the growing research basis for policy at local, national and, importantly, international level. The international perspective is particularly important now that the beer and spirits industry

is concentrated in a small number of enormously influential multinational companies.

It is often forgotten that alcohol is our favourite drug and one that has widespread social, psychosocial and physical consequences. In that important sense it cannot be thought of as an 'ordinary commodity' - and yet this is often overlooked in the interests of trade and profit. The early chapters deal with the epidemiology of alcohol and alcohol misuse and its impact on public health and social welfare. It is impossible to examine alcohol policy without an understanding of the role and ambitions of the alcohol industry and two chapters usefully describe the way in which the industry has

become so important in the marketing of alcohol as a global commodity. It is particularly noteworthy that many parts of the developing world are now seeing a rapid expansion in alcohol misuse and its damaging consequences, whereas some parts of western Europe, although not the UK and Ireland, are experiencing a decline.

The authors jointly review the evidence supporting the major approaches to alcohol policy: controlling affordability by pricing and taxation; regulating physical availability; modifying the drinking context in the licensed drinking environment and other contexts; drink-driving

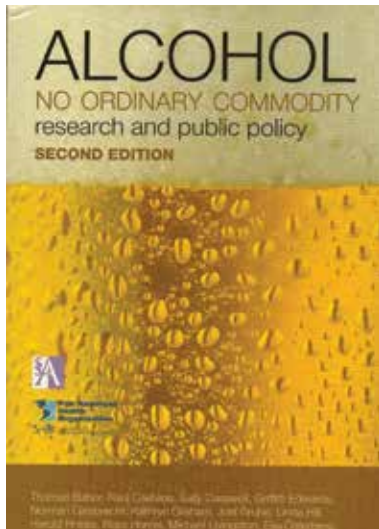
prevention and counter measures; restrictions on marketing; education and persuasion strategies; and treatment and early intervention services. Each chapter provides the evidence for the merits of each approach and the quality and applicability of the research that underpins their conclusions. When considering measures that look promising, but remain inadequately tested, the reader is reminded of the precautionary principle in public health, which broadly encourages preventive action even in the face of uncertainty, to shift the burden of proof to the proponents of any harmful activity.

THE BOOK IS METICULOUSLY REFERENCED AND IT IS PEPPERED WITH CASE STUDIES WHICH HIGHLIGHT EXAMPLES OF PREVENTIVE PROJECTS THAT HAVE SUCCEEDED AND MIGHT BE ADOPTED ELSEWHERE.

Many will be drawn to the chapter entitled 'Alcohol Policies: a consumer's guide'. A lengthy table summarises each element of policy in terms of effectiveness, both of research support and cross-national testing. It will come as no surprise that a range of control policies and restrictions of availability come out most favourably from this review. Education, "the triumph of hope over experience", fares less well. The conclusion would seem to be to divert resources from education to proven strategies, such as early recognition and brief intervention for individuals who are already showing signs of drinking in a hazardous way - and, of course, promoting and supporting community action and government policy that will limit availability.

Like its predecessor, this excellent work is destined to prove an important influence on policy makers throughout the world. As one would expect with this pedigree, the book is meticulously referenced and it is peppered with case studies which highlight examples of preventive projects that have succeeded and might be adopted elsewhere. Whosoever is responsible for commissioning or advocating alcohol policy and services should read this book.

■ **Bruce Ritson MD**, Chairman, Scottish Health Action on Alcohol Problems



ALCOHOL: NO ORDINARY COMMODITY - RESEARCH AND PUBLIC POLICY

Thomas Babor, Raul Caetano, Sally Casswell.
Oxford University Press
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Into the breach

The subject of Philip Bean's recent book, *Legalising drugs*, is constantly topical, as shown by the heated public response to former minister Bob Ainsworth's call in December to make drugs legally available. This response demonstrated yet again the level of confusion over terms such as legalisation, prescription, decriminalisation, and harm reduction. It also showed the urgent need for terminological clarity to allow serious discussion without instant disapproval or sarcasm.

Reviews

Bean pursues several aims in this book: firstly, to explore options for legalising drugs and the changes they would mean in practice; secondly, to "impose some order on what is often a chaotic use of language"; and thirdly, to outline the UK debate and stimulate further discussion.

Bean defines prohibition as "the imposition of legal restrictions on the possession and use of selected substances", as opposed to legalisation, which is "a generic term, covering a wide range of activities, but referring to any proposal which seeks to amend or repeal existing legislation." Bean emphasises that, contrary to popular belief, most legalisers do not promote a 'drugs free-for-all', but suggest a different system of regulation and licensing. Therefore, it remains unclear to the reader how such proposals differ from prohibition as defined above, indicating that Bean's definitions do not provide a clear distinction between prohibition and legalisation.

Bean tries to avoid simplistically opposing prohibition and legalisation by discussing six different policy options. Presented as 'ideal types', they range from no availability to unrestricted availability of currently illegal drugs. They are: prohibition; harm reduction (reducing the adverse consequences of drug use); medicalisation (providing drugs through medical services); decriminalisation (reducing the severity of legal sanctions); legal moralism (challenging the right of the state to sanction drug use); and economic liberalism (supplying drugs through the free market). It is striking that legalisation does not feature as a separate policy option – 'economic liberalism' comes closest to the common understanding of legalisation.

Bean shows how these options featured in UK policy and practice over the last century. This approach highlights the diversity of ideas, but using legalisation as a catch-all term for different proposals may inadvertently cause further confusion. Interestingly, Bean describes the inconsistency of current UK policy as a merit which allows the partial implementation of all approaches: "Under prohibition we can prescribe, we can decriminalise, we can legalise and we can

promote harm reduction. The trick is to get the correct balance between the various options. There will always be a debate about that."

Although Bean stresses that these 'ideal types' represent working definitions only, their place at the core of the book requires that they be carefully examined. In fairness, Bean's account must be understood as an attempt to distinguish terms hitherto used synonymously in a heated policy debate. His 'ideal types' represent a valuable contribution to the debate, though with shortcomings.

The book's major weakness is its discussion of harm reduction. The term has been included as a policy option for reasons too obvious for Bean to explain: the drugs strategy employed by the previous government put a greater emphasis on methadone prescription in the treatment of heroin users, and has therefore been described as a 'harm reduction strategy' by its critics. Including 'harm reduction' in the legalisation debate makes sense only where it refers to the legal supply or possession of drugs. By using the wider term 'harm reduction', Bean obscures that many harm reduction programmes do not promote legalisation, they only acknowledge the existence of continued drug use. Bean fails to point out that 'harm reduction' does not itself constitute a comprehensive drugs policy, thus missing the opportunity to place harm reduction where it belongs: alongside prevention, treatment, and social reintegration. This would correspond to the classification of health and social responses to drug use used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and others. Harm reduction programmes can be implemented under prohibition as well as legalisation, as can prevention or treatment activities. In this respect, Bean's criticism – that harm reduction should commit itself to prohibition or legalisation – is irrelevant. Removing harm reduction from the legalisation debate could enable a more rational discussion of options.

As the title suggests, the book outlines debates and dilemmas – indeed its strength lies in highlighting the unresolved issues that separate different stances in the debate. They include such

LEGALISERS FACE TWO PARTICULAR CHALLENGES: WHICH DRUGS TO LEGALISE; AND WHETHER TO EXCLUDE ANY GROUPS FROM GAINING LEGAL ACCESS TO DRUGS

questions as: what is the justification for regulating drug use? Is it the potential harm of use? If so, do we mean harm to others and/or harm to oneself? How can we define 'harm'? Should drugs be prohibited simply because drug taking is morally 'wrong'? The ongoing debate on the classification of drugs has shown that harmfulness is only one defining factor. For Bean too, debate often reflects ideological views on society rather than realistic assessment of consequences. Thus, he asks another crucial question: what would the outcome be of increased availability? Would drug use increase or decrease? How would this impact on society's functioning? There are no straightforward answers, but Bean argues that any proposal for change must face such questions if it is to be taken seriously.

Bean also seeks to understand the impact that different proposals could have on crime, young people, society and the individual. His focus on ideal types may obscure possibilities of making less extreme changes to current practice, but his orientation towards the practicalities of change is useful. Legalisers face two particular challenges: which drugs to legalise; and whether to exclude any groups from gaining legal access to drugs (for example, young people). Bean suggests that current legalisation proposals offer no satisfactory solutions for vulnerable groups such as young people or adults with poor health literacy. Legalisation assumes people's ability to make informed decisions, but, says Bean, this is not always present amongst vulnerable members of society. He argues that these groups would suffer most from legal availability of drugs through "the selective impact on those least able to resist".

While prohibition can be seen as a punishment for the majority of drug users whose use is non-problematic, Bean seems to suggest that it may be an appropriate sacrifice to protect a vulnerable minority. The discussion shows that people have different needs and are affected by policies differently. It seems to me that the fruitlessness of the legalisation debate calls for a greater focus on demand reduction and health promotion. As long as people are not (en)able(d) to make healthy and informed choices, the debate will not be resolved and changes to current practice will be opposed.

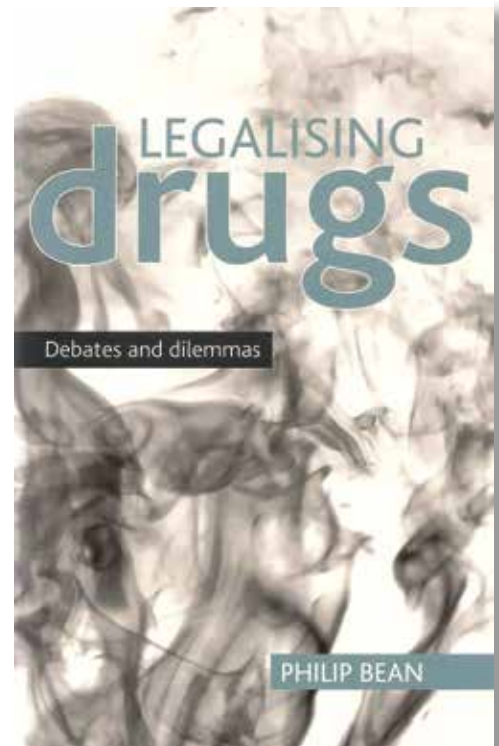
The book is short, easy to read and will be of interest to a wide range of public health professionals. It represents a commentary on the UK drugs policy debate, and readers should not expect a neat overview table on the pros and cons of legalisation and prohibition.

Unfortunately, Bean focuses too often on being polemical and personal, which can push content and quality into second place. A useful conclusion would have been to outline a new proposal based on his discussion of policy options. The book's style and structure do not make it suitable as an introductory text for students. Additionally, its emphasis on the UK situation may confine the book's relevance to a national audience only.

■ **Angelina Brotherhood**, Public Health Researcher at the Centre for Public Health, Liverpool John Moores University

LEGALISING DRUGS: DEBATES AND DILEMMAS

Philip Bean
The Policy Press, 2010
Paperback, 157 pages
ISBN 9781847423757



drugworld DIARIES



TIM SAMPEY

Service User Coordinator

**London Borough of Kensington
and Chelsea**

It's a busy week for me in February. Kensington and Chelsea's service user group has been commissioned to design and run a borough-wide peer mentoring service, and today we began our in-house training. We have interviewed and selected nine peer mentors from the volunteers who work in our peer-run weekend service. I spend a busy day running through role play scenarios looking at different ways of supporting service users. The mentors were enthusiastic and wonderfully inventive.

I move on to the town hall for a 'service redesign' meeting between the DAAT and services. One project, Blenheim/CDP, is preparing to move to new premises and there are some interesting discussions taking place on satellite services. The new building is intended to be the main service for drug users in the borough, with care managers, BBV nurses and so on popping in to run surgeries, giving a focal point for pathways across a variety of services in Kensington and Chelsea.

After another challenging day of training, it's back off to the town hall for the user group's monthly management committee meeting with the commissioner. It's always good to sit down with the user group's team leaders and look at the challenges of running a weekend service that has 85 volunteers and between 5,000-6,000 contacts a year. We are about to publish an impact and evaluation report on the user group's weekend peer run service, and to be honest, I think we are all a

little stunned by the results. To be able to demonstrate that we have a non-therapeutic model of engagement that is significantly impacting on individual's drug use is great. We have always had faith in what we do, but to see it evidenced like this is a proud and powerful moment. For a service that started with a small badminton club five years ago, we have come a very long way.

It's the NTA's London Service User Coordinator's Forum and time for a discussion on the new drug strategy and the recovery agenda. Everyone is worried about funding cuts and reductions in local services, and although the new agenda really opens up doors for service user involvement, the challenges involved are huge. Service user involvement is moving faster by the month in London, especially with regard to peer-run services, but we can all feel the uncertainty of walking these new and sometimes unexpected paths into the future. There is a lot of fear around cuts to housing benefits, changes to incapacity benefit and Employment and Support Allowance (ESA), and the potential for reduction in services across the treatment system. The NTA may be reasonably up-beat, but some of us are not so sure. Right now there are far too many questions that cannot be effectively answered, and as service user coordinators, we are going to be at the sharp end of things.

The relationship between the

user group and Blenheim/CDP has always been an excellent example of partnership working and this morning is our bi-monthly team meeting, when both organisations look at logistics, practical issues and any difficulties we may encounter with service users. This can require careful handling, if a service user (as is currently the case) is barred from accessing one service but not the other. We are both running drop-ins; but our ground rules and manner of operation are entirely different, as are the services we offer. I have always found it immensely encouraging that a service user group is able to negotiate and work with a service provider without falling into the trap of Us versus Them. Such relationships can only improve the treatment system.

I popped into the Social Club to facilitate a discussion among the volunteer team about 'boundaries' before the drop-in opened for the day. As service user volunteers working in a service designed to operate as much like a family as possible, the line between personal and professional relationships is one that needs to be revisited every so often, and we have found the best way to do this is with honesty, humour and openness. We have always accepted the reality of relationships occurring between volunteers, after all there are more than 80 of us. Nevertheless, it is something that needs to be carefully managed, and like any family there are times when we need to clear the air.

Headspace

...drugs from the left field

■ by Keith Humphreys

Career research scientist, US Veterans Health Administration and Professor of Psychiatry at Stanford University.

Peace pipes

When Dr. Alan Leshner was Director of the US National Institute of Drug Abuse, he used to say that “when those of us in the treatment field feel threatened, we circle the wagons and then fire our guns inward”. Whether or not the UK recovery movement thrives will depend on whether it can avoid this mistake.

For many years, when I gave a lecture or did a media event in the US about one of the recovery-promoting resources I have studied or worked with – Alcoholics Anonymous, Women for Sobriety, SMART Recovery, buprenorphine clinics, faith-based organisations, you name it – I would get angry emails afterwards saying how stupid I was for talking about path to recovery A when the email author had recovered via path to recovery B, the true and only pathway. I felt like I was in the midst of a religious debate rather than in a dialogue about how to promote public health in a pragmatic fashion.

This internecine behavior began to abate in the US in the mid-1990s, spurred on I believe by two events. The first was a National Summit on Recovery in Washington, DC. National leaders in the recovery movement took the risk to stand up in front of their own at the summit, side by side on the podium with others who had recovered ‘the wrong way’. Each said that they embraced their brothers and sisters in recovery regardless of the path they had walked. I still remember that moment and the electricity in the room, as if Middle East peace had at last broken out. It was one of many times of in my life that, as a non-recovering person, I stood in awe of what recovering people can accomplish.

A few years later, Faces and Voices of Recovery was formed as an umbrella organisation for people in recovery and those that support them. From the first, the organisation made a conscious effort to include people who recovered via



When those of us in the treatment field feel threatened, we circle the wagons and then fire our guns inward

psychotherapy, 12-step programmes, faith-based organisations, medication-assisted treatment or no intervention at all. The result has been that a bunch of squabbling sects have become an important force for sociopolitical change. I doubt that President Obama’s National Drug Control Strategy would have adopted recovery as a central theme if the movement hadn’t gone through its remarkable transformation beforehand and laid the necessary groundwork.

The situation in England now, and to a lesser extent in Scotland, sometimes brings back for me the sadness I experienced when I read all those angry emails. Lines have been drawn and harsh words said, dividing good people who

share a noble mission: helping suffering people turn their lives around. My hope is that this conflictual period is part of a developmental process of movement formation and that in the coming years, national umbrella organisations and individual bridge builders will rise to prominence and unite the warring clans. There are two reasons why this is essential.

First, to state the very obvious, the UK has serious drug and alcohol problems that will be challenging to address even if everyone works together. Second, the drug and alcohol field don’t have many external supporters. If we want to rip each other apart, few people outside of our field will try to stop us or even care; they are more likely to take the opportunity to capture some of our resources. In the current brutal budget environment, those who don’t hang together may end up hanging separately.

This article is a statement of personal opinion.

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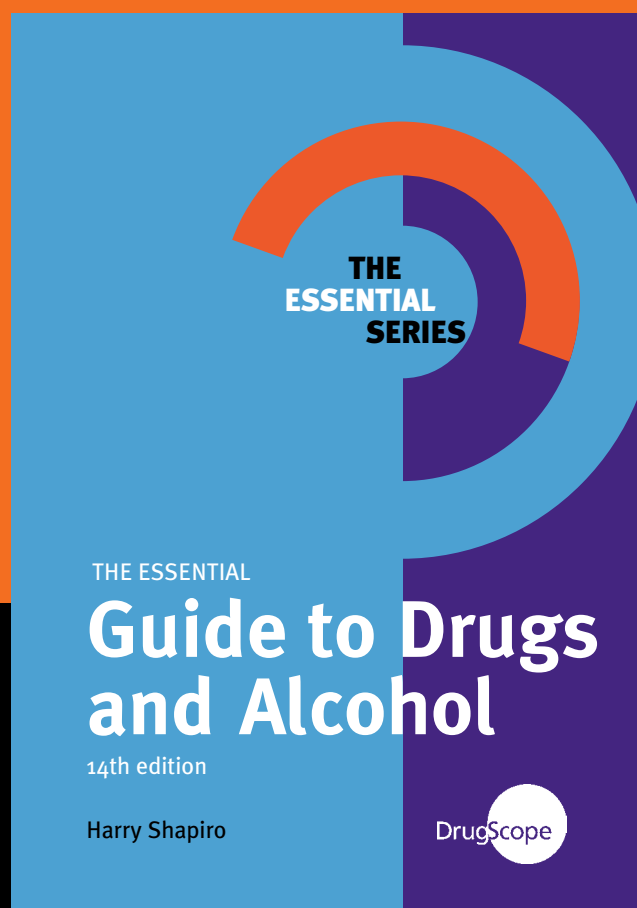
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