

Druglink

REPORTING ON DRUGS SINCE 1975

- Payment by results
- Drinking culture
- Solvents
- Money laundering

Hubble, bubble, toil and trouble *Problems brewing with mephedrone*



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Druglink

A scene in transition

Whether it's cannabis or cocaine, all the official figures for the traditional drugs on the UK drug scene show a continuing downward trend. And this coupled with the rise of those successfully leaving treatment and the non-appearance of young heroin and crack users at services is clearly an encouraging sign.

But history tells us that drug use goes in cycles driven by a constellation of factors including upstream issues like the economy and general fashion in popular youth culture through to changing technologies in the drug scene itself. But it isn't a seamless segue from one environment to another; there is normally some kind of transition period where the picture is fuzzy. This is where we could be now.

The evidence is growing that newer drugs are beginning to cause problems, ketamine, GHB and the array of synthetic cannabis compounds are some examples. But maybe the more worrying development surrounds mephedrone. Originally thought of as a 'party' drug (and so almost by definition not likely to trouble drug agencies), the latest *Druglink* street drug survey paints a very different picture. Workers report a significant increase in the number of referrals they are seeing of young people suffering from the psychological impact of taking a stimulant drug whose strength appears to outstrip other street stimulants like amphetamine. Worse still, are reports of an injecting culture developing among chaotic homeless heroin users. The nature of the drug engenders compulsive use, with potentially awful consequences for the individual as we reported from Ireland earlier this year.

The questions such a development may ask of a treatment system still primarily opiate-focused and operating at a time of severe financial constraint are no less critical for being obvious.

Harry Shapiro

Editor and Director of Communications and Information

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



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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.

SUBSCRIPTIONS
Subscription for the year (six issues): £55
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Design
Helen Joubert Design
helenjoubertdesign.com

Print Holbrooks Printers Ltd, Portsmouth PO3 5HX

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ISSN 0305-4349

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Charity growers jailed

A couple who ran a cannabis factory have been jailed for three years despite using most of the proceeds to help a Kenyan village they often visited. They paid for schooling, life saving surgery and bought computers for an eye hospital.

Police raided the Lincolnshire farm of Susan Cooper and Michael Foster after a policeman, in pursuit of a burglar happened to catch the whiff of a distinctive smell. Police investigations revealed that the couple were running a substantial business with around £400,000 banked since 2004.

Numbers crunched

The Driver and Vehicle Licensing Agency (DVLA) have determined that certain personalised number plates will not be allowed. So anything ending in 2HAG (shag) or 2LUT (slut) is a definite off-roader – as is FU12KER. And if you had aspirations to a 'highway' oriented plate – forget it. HE12 OIN is a no go.

No laughing matter

A 17 year old schoolboy has died after inhaling nitrous oxide. Joe Benett suffered a heart attack and sustained brain damage. He fell into a coma and died a month later. The action of nitrous oxide starves oxygen to the brain. This gives the high, but can also have disastrous consequences. While there are no figures, there are increasing reports of nitrous oxide misuse, often obtained from the small refill canisters for whipped cream. **See Drug Watch Factsheet page 26**

Prison pill problem

In his latest annual report, the Chief Inspector of Prisons has expressed concern over the growing problem of prescription drug misuse in English and Welsh prisons. In his previous report, Nick Hardwick highlighted concerns about the diversion of pain-killing drugs like Tramadol, Gabapentin and Pregabalin among high security and vulnerable prison populations. Now this has spread to mainstream populations 'and it has become a major concern'. These drugs are not routinely detectable under the current drug testing procedures.

In terms of illegal drugs, cannabis and Subutex predominate over heroin. Overall, the report's survey findings revealed that 29% of prisoners reported having a drug problem when they arrived at prison and 6% said they developed a problem since arriving. Twenty-four per cent of prisoners said it was easy or very easy to get drugs in prison.

Counterfeit medicine crackdown



A worldwide enforcement operation has resulted in the seizure of over £6m in counterfeit medicines and the closure of around 18,000 online pharmacies.

Starting in 2010 and one of the largest internet-based enforcement operations of its kind, Operation Pangea was coordinated by Interpol and brought together police, customs and national medicines regulators in over 200 countries targeting four main arms of the trade; the drug suppliers, internet infrastructure, the electronic payments system and mail delivery.

Working with the Border Force,

the UK medicines regulator, the Medicines and Healthcare products Regulatory Agency (MHRA) seized more than 2 million doses of unlicensed medicines. There were no illegal drugs in the haul, but there were significant quantities of pain-killers, anabolic steroids and sedatives. As part of the operation, the MHRA launched an investigation into a number of UK-based websites including one called Stay Massive which ended with the sentencing of three men on a number of charges including the manufacture of anabolic steroids.

New Zealand to regulate legal highs

In a ground-breaking move, the New Zealand government is planning the world's first regulated market in recreational drugs. The law, currently in preparation, will mean that from 2014, substances which mimic the effects of drugs like cannabis and ecstasy will be on legal sale. Manufacturers will have to pay around \$2m to prove their product is 'low risk' through both

animal and human testing. The government estimate that they will receive ten applications in the first year for product licensing. Associate Health Minister Peter Dunne said that the 'absolute intention' of the government was to control a hitherto uncontrolled market, 'I am quite unapologetic about leading changes that will make things safer for young New Zealanders'.

Growing concerns over payment by results

Key third sector organisations and individuals have been warning government about the problems that charities will face delivering on payment by results (PBR).

In their discussion paper *Funding outcomes; using social investment to support payment by results*, the Charities Aid Foundation highlighted that many charities would not be able to take up PBR contracts because they have limited funds and need to be paid up-front for their work. The paper goes on to point out that commissioning practices are making it too difficult and risky for charities to get involved often because they are brought in at a very late stage and do not have enough time to undertake necessary due diligence work.

Giving evidence to The Panel on the Independence of the Voluntary Sector, Clive Martin, CEO of the criminal justice umbrella body Clinks, claimed that large charities speak publicly in favour of PBR, but in private say it doesn't work. "They don't want to look old fashioned or not-fit-for-purpose" he said, "but privately at least six large members (of Clinks) say they don't believe it is a good model, but they don't want to speak out about it. One even said we should stop bringing up the issue as we have been saying too much".

An announcement by the Prime Minister that the government wanted to extend the PBR model in the youth justice system to reduce reoffending provoked more alarm within that sector.

Criminologist Tim Bateman said that any drive for profits could lead to an attempt to achieve the desired rehabilitation results on a shoestring. It would be problematic just to focus on re-offending 'because there are other developmental factors it is essential the youth justice system engage with'.

As if to underline the potential problems, *Third Sector* magazine (30 October 2012) reported that two London employment-focused charities had to close over the summer partly because of PBR. Both struggled to raise the working capital needed to fund the work for a year or more until they received full payment.

And finally, in a new report, the influential health think-tank, the King's Fund Centre have said that PBR is no longer an effective way for the NHS to fund English hospitals. The Fund's chief economist John Appleby said that they were not calling for PBR to be scrapped, but simply that the original scheme devised to drive down waiting times in hospitals was now outdated and needed to be more flexible. While not directly comparable to the situation in the drug treatment field, Appleby did make this telling comment that PBR needed to be set within a national framework, 'We're not suggesting that people go off and draw up contracts and invent any old payment system'. But this is exactly what is happening in the drug treatment sector outside of the pilot studies.

(See PBR feature page 12)

Solvent law to combat legal highs?

A law dating back to the mid 1980s could be used to stem the sale of legal highs to those aged under 18.

In 1985, at the height of concerns over 'glue sniffing', the Intoxicating Substances Supply Act was passed in England and Wales. Under this law, it is illegal for a retailer to sell solvents to under-18 year olds if they had any suspicions that the product would be misused. Scottish Common Law provides for a similar offence of "recklessly" selling substances knowing they are going to be inhaled. There is no age limit in Scotland, but the wording makes it unclear whether this means that the law only applies to inhaled substances or also for example, those that are sniffed or swallowed as pills.

The possibility came to light following comments by a policeman investigating the case of a teenager in Bridlington who collapsed after taking Black Mamba. Sergeant Carl Sweeting told the BBC that "it is against the law to sell Black Mamba to under-18s because it is a noxious substance" and repeated the assertion in an interview with BBC Radio Humberside.

Very few prosecutions are brought under the Act against the sale of solvents, partly because of resource issues, but also presumably in the case of adhesives or lighter fuel, it would be difficult to prove that the retailer had good reason to suspect that the product would be misused. The law was only really used against the cynical sale of glue sniffing kits by unscrupulous retailers. However the situation with sales in head shops could potentially be very different. Despite packaging disclaimers that a product might be bath salts or plant food, the chance that a teenager would be genuinely shopping for either product in a head shop is unlikely.

Customs investigate HSBC offshore accounts

HSBC accounts of major criminals living in Jersey are being examined by HM Revenue and Customs for tax evasion after a whistle-blower provided detailed list of names, addresses and account balances reports *The Daily Telegraph*. Among those named are a drug dealer now living in Venezuela, a man convicted of possessing more than 300 weapons at his Devon home and three bankers

facing fraud allegations. Those named are among a list of over 4000 people holding a total of nearly £700m in offshore current accounts which do not include unknown fortunes in investment schemes. One analyst typified HSBC banking practices as 'a wink/nod business model' that showed 'a profound lack of controls'. **(See article on money-laundering on page 20)**

ALCOHOL UPDATE

Costs of alcohol to society exaggerated, claims researcher



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Klaus Makela, a prominent alcohol researcher and formerly Research Director of the Finnish Foundation of Alcohol Studies, says estimates that drinking imposes billions of pounds of costs on society are so value-laden and imprecise that their main value is propaganda.

Writing in the journal *Nordic Studies on Alcohol and Drugs*, Makela questions the assumptions that all hazardous drinking must be irrational and therefore an absolute detriment to society, that nobody benefits from crime, that there are no indirect business benefits to hazardous drinking and that alcohol impaired workers leave an employment gap that isn't filled by workers without a drink problem.

He cites a number of cost headings which should either be excluded completely or not fully included. So for example, he argues that the cost of theft, is not a total loss to society. The thief will sell to a 'fence' who will sell on the goods more cheaply to a new end owner, so there is a clear benefit here to others in society if not the crime victim themselves. The loss to the

economy accounted for by premature worker mortality is also misleading, he writes, because it is assumed that the loss amounts to lost work over what would have been the entire productive life of the worker. But in an era of rising unemployment, there is every chance that the deceased worker will be replaced by somebody who would otherwise be unemployed. Makela's analysis challenges some of the key assumptions on which the Sheffield Alcohol Policy Model is based, the model currently driving British alcohol pricing proposals.

Some years ago, the University of York published a comparable kind of cost analysis relating to the impact of heroin and crack use. Their report was challenged by Mike Ashton, Editor of *Drug and Alcohol Findings*, on very similar grounds to that put forward by Makela about alcohol harms. Commenting on this latest report, Ashton concludes that the current state of the science does not allow for 'whole society' policies like minimum pricing for alcohol to be reliably determined by this kind of analysis.

Canadian study back benefits of minimum pricing policy

Results published in the *American Journal of Public Health* from a study conducted in Saskatchewan show that a 10% hike in alcohol prices reduced overall consumption by 8%. The biggest drop was in high strength beers which fell by 22%. The study's lead author, Tim Stockwell said, "As cheaper alcohol is preferred by young and heavier drinkers, both of whom are more liable to experience alcohol-related harms, price increases that target the cheapest, strongest alcohol products are likely to have significant public health benefits".

Health agency warning on syringe provision

Both in its July Hepatitis C report and the November update, the Health Protection Agency (HPA) warned that there are indications that not enough injecting equipment is being distributed to help stem the tide of growing drug-related hepatitis C infection. The HPA point out that among injecting drug users in England for example, 57% of users surveyed said the number of needles received from their needle exchange was greater than the number of times they injected which means this wasn't the case for the remaining 43%.

This warning comes against a background of growing concern among some drugs workers about the future of needle syringe programmes (NSP)

in a political climate of recovery. The HPA assert that NSP provision remains 'extensive' in the UK, which is still true, but *Druglink* understands that the patterns of provision appears to be changing and the importance of NSP downplayed within the treatment mix. In some areas, service-based NSPs have been replaced by those delivered by pharmacies while in other stand-alone NSPs have been decommissioned entirely to be integrated into so-called treatment/recovery 'hubs'. Workers told *Druglink* that some voluntary sector agencies are not publicising their NSP and generally down-playing their harm reduction functions for the purposes of tendering for contracts.

CANNABIS UPDATE

More controls on synthetic cannabis

On the advice of the ACMD, the government has announced that more strains of synthetic cannabis will be controlled as Class B drugs under the Misuse of Drugs Act. This will now capture those compounds currently marketed as 'Black Mamba' and 'Annihilation', although in reporting about suspect substances, the ACMD warn against correlating brand name with compound without supporting analysis.

The first tranche of controls came into force in 2009 under a new legal framework which rather than just

naming individual substances also created five generic definitions of synthetic cannabis in order to capture the many variations that exist. However, it was always recognised that the underground chemists would continue to modify the basic chemistry and this has proved the case. Use of both 'Black Mamba' and 'Annihilation' have been anecdotally widely reported across the UK with a number of young people admitted to hospital suffering a range of symptoms including physical collapse and paranoia.

Law reform moves in The Americas

■ Voters in Colorado and Washington have backed proposals to legalise cannabis and medical cannabis also got the thumbs up in Massachusetts. Cannabis is already available for medicinal purposes in Colorado, but now it will be available to anybody over the age of 21 and will be taxed like alcohol and tobacco. However voters in Oregon said no to legalisation, those in Arkansas rejected the introduction of medical cannabis while voters in Montana voted for tougher restrictions on the provision of medical cannabis. The reform states have put themselves on a collision course with the federal government who already are challenging medical cannabis provision through the courts.

■ Despite polls which suggest that 60% of the people are against cannabis sales, the government of Uruguay is proposing to allow cannabis users to buy up to twenty state-provided joints a month (about 40g of cannabis) in a bid to undermine organised crime. Users will be given cards with a bar code to monitor their buying. President Jose Mujica said, 'We are losing the battle against drugs and crime in South America. Somebody has to be the first'. But economist Carlos Casacuberta remains unconvinced that the illegal market will disappear. 'The drug traffickers will react as any business would' he said, 'they will look to compete with the government's marijuana'.

Voluntary ban on high strength beer and cider trialled in Ipswich

In a pioneering move, alcohol retailers in Ipswich are being asked to remove from their shelves, such products as White Ace, Carbon White and White Star ciders which have a 7.5% alcohol content and sell for as little as 59p a can.

The Reducing Strength Campaign is backed by Suffolk police, the local NHS, Ipswich borough council and Suffolk county council. So far, Tesco and some leading local retailers have signed up. But as a report in *The Independent*,

revealed, while publicly supporting responsible drinking, the major drinks companies earn substantial revenue from the sale of super strength lager. Carlsberg (Special Brew and Skol Super) and InBev (Tennent's Super) produce the top three selling brands generating annual UK sales of £104m. Two years ago, Heineken halted production of 8.5% White Lightning cider.

Guinea Bissau: Africa's 'worst narco-state'

This damning indictment of the West African state comes from the US Drug Enforcement Agency in the wake of a military coup which has subsequently seen in a sizeable increase in drug trafficking. The suspicion is that the military largely control the trade and that their action amounted to what *The New York Times* called 'a cocaine coup'.

Since the coup in April, more planes

than ever are making the trip across the Atlantic to land cocaine in the country for trans-shipment north. A UN official asserted that, 'the coup was perpetrated by people totally embedded in the drugs business'.

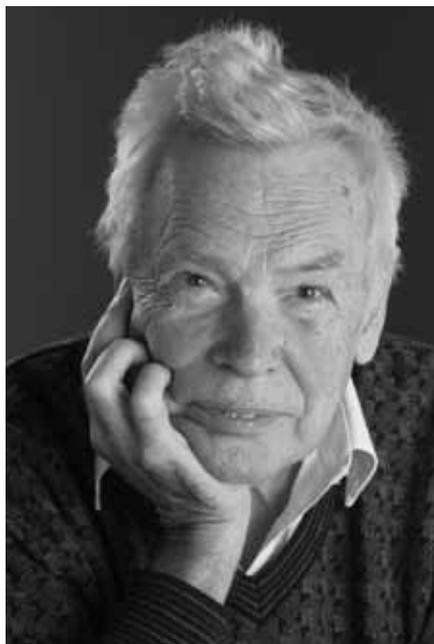
Over the past three years, there have been a number of unsolved political assassinations as well as two other coups attempts in this troubled state.

In October, the justice minister of the transitional government warned opposition politicians not to speak about their killings while journalists trying to get at the truth have received death threats directly from the army chief of staff.

(Is Ghana in danger of going the same way? See article on page 22)

Professor Griffith Edwards

1928-2012



There's a telling scene recounted in Horace Freeland Judson's book *Heroin Addiction in Britain*, which explores the British drug treatment landscape of the early 1970s. Judson was bothered by the punitive response to the drug problem adopted by his US homeland and had come to Britain to explore and document its more medical approach. Judson describes a conversation with Griffith Edwards, "over an institutional lunch – a pale, English institutional lunch of poached fresh fish fillets, broad beans, and stewed gooseberries with custard sauce". By this time Griffith was already a leading NHS psychiatrist treating addiction problems, was director of the Addiction Research Unit (ARU) at the Maudsley Hospital and Institute of Psychiatry in south London, and was also an expert scientific adviser and all-round expert guide to addiction. Judson reports Griffith saying "One wonders how far the differences between the British and American drug problems are really the consequences of social policies.... The relation between a drug and a community can be very unstable – our problem with heroin, barbiturates, and amphetamines may, possibly, be unstable right now. But take the British and alcohol, or India and cannabis – sometimes the relationship is not at all easy to change." Such insights demonstrated that, despite the medical core of his profession and the lofty position in addiction psychiatry he enjoyed, Griffith put the individual experience of alcohol and drug problems and their impact on the community at the heart of his work. For Griffith, science needed to be connected to policy and contribute to the public good.

Griffith's work flourished at a time when addiction was still a very young science and a subject surrounded by ignorance and stigma. Unhindered by the constraints of the current academic world with its research metrics and h-indexes, Griffith nurtured an imaginative range of studies at the ARU undertaken by young researchers who themselves went on to become leading lights in their own right. However, working with Griffith Edwards was not only inspiring but was also challenging. He was intensely encouraging and

supportive, such was the range of topics explored by Griffith and his group that a leading contemporary researcher has remarked that most addiction research topics today already have "Griff's fingerprints on them."

But the encouragement was also challenging and demanding. How might the good idea be made better? How might it be viewed from a different standpoint? For many of today's leading figures in the addictions field, it was their time in the crucible of Griffith's unit which made them grow taller, made them look further, and made them see in 3-D. The criticism alongside the encouragement may have hurt at the time (and for some, it may ache still) but it unquestionably raised the bar and was a key influence on the emergence of stronger science-policy-practice relationships.

Griffith made a further profound contribution to developing the quality of addiction science by his editorship from 1978 to 2005 of the *British Journal of Addiction*, over which period he transformed an interesting but quirky house journal of the British addiction field into the leading international addiction journal of today. The journal is now called *Addiction* and is not only the leading journal in our field, but is also truly international, with a networked editorial office around the world and an international contributor and readership base. Griffith harnessed the power of this invisible college of leading colleagues to drive the inter-disciplinary international initiatives that produced influential state-of-the-art books which brought quality science to the policy, public and practitioner communities – *Alcohol Policy and the Public Good*, *Alcohol: no ordinary commodity* and *Drug Policy and the Public Good* to choose some classic examples. And his book for the practicing clinician, *The Treatment of Drinking Problems*, remains a classic today and is now in its fifth edition.

New framing or insights from Griffith Edwards have often had profound influence over the longer term. Back in 1976 Griffith, with the US psychiatrist Milton Gross, published a paper in the *British Medical Journal* that established the concept of alcohol dependence, a

concept that moved the idea of alcohol dependence away from a narrow view of an inescapable condition that could only be identified by the presence of physical withdrawal symptoms to one that took in a range of behaviours that marked an individual's inability to stop alcohol and/or other drugs becoming a central part of their lives. This new concept entered the psychiatric diagnostic bibles of the World Health Organisation's *International Classification of Diseases* and the American Psychiatric Association's *Diagnostic and Statistical Manual* and enabled a move away from strictly medical approaches to dependence to more evidence-based approaches that took into account all the aspects of the alcohol dependent's life and world.

Griffith himself helped to move treatment away from the clinic to the community through his support for the founding of community projects such as Phoenix House, the Community Drug Project and the Alcohol Recovery Project in South London which went on to become important pathfinders in the voluntary field.

Griffith will be remembered for his scholarship, having produced nearly 200 research papers and 40 books and for his advocacy and policy influence. But he will also be remembered for being as happy to share his enthusiasm for Beethoven's late string quartets with a passing colleague as arguing the finer points of defining dependence. Judson described Griffith as "that old-fashioned delight, a physician with a scholar's sense of the history of his subject", a description that many of Griffith's colleagues and friends would recognise. Griffith always had his eye to the future and took great delight in his later years in chatting to PhD students and leading student seminars. Not only was this refreshing for Griffith but, through this, the fruits of his life's work would be carried on, by the many of us whose lives and careers and interests were so profoundly touched by this colleague, mentor and friend.

■ **Professor John Strang**, National Addiction Centre, London

inside

DrugScope

Work Programme consultation

DrugScope is gathering evidence for the Work & Pensions Select Committee inquiry into the DWP Work Programme.

The Work Programme was launched in mid-2011 and is one of the means by which the Department for Work and Pensions aims to support the long-term unemployed into paid work; the Work and Pensions Select Committee will shortly be holding an inquiry into the performance of the Programme for different customer groups. DrugScope is keen to hear from any agency working with people who are on the Programme – the deadline for submissions is 7th December 2012.

Please contact Paul Anders for more information.
paul.anders@drugscope.org.uk <http://tiny.cc/workprogramme>

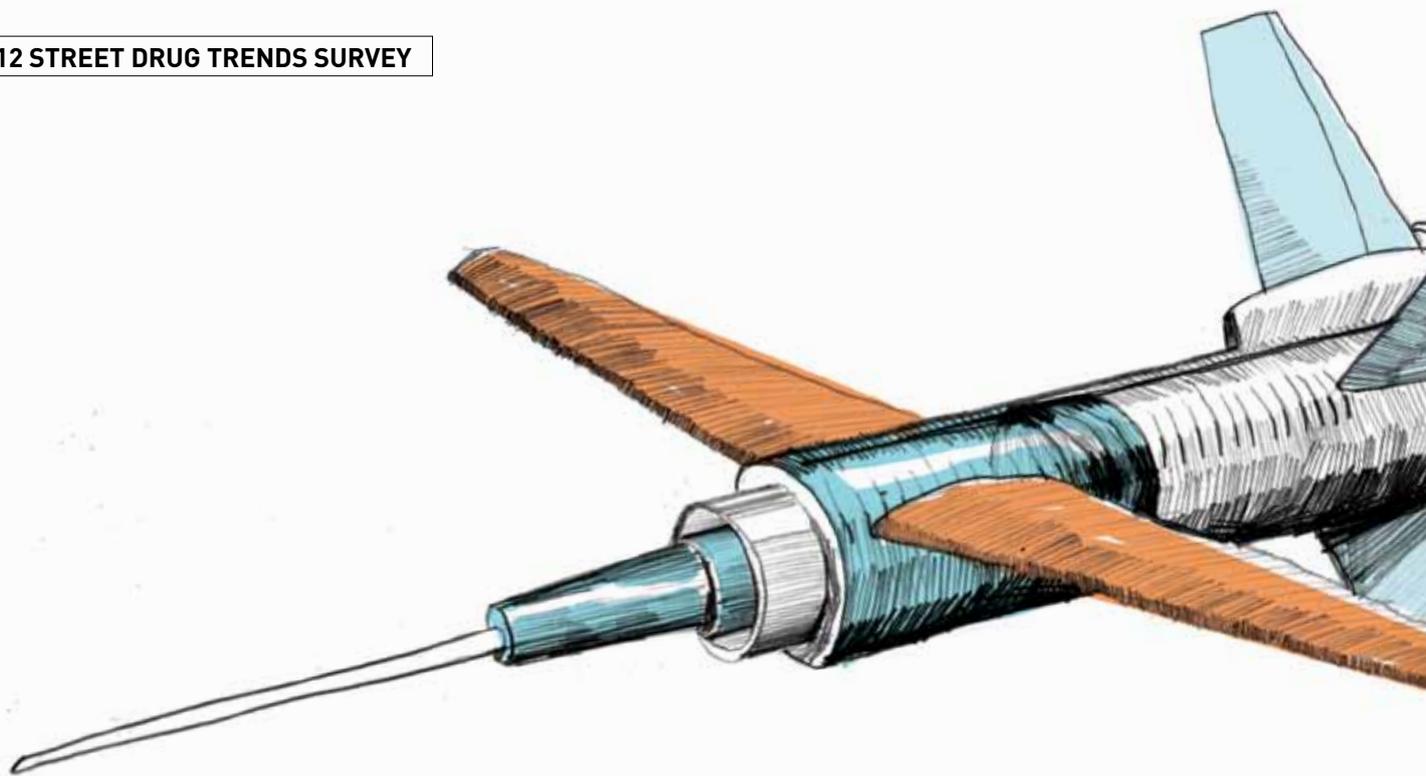
New Minister addresses DrugScope conference

Anna Soubry, the new Public Health Minister, gave the keynote speech at the recent DrugScope conference held in London on 6th November. She informed delegates of her first hand knowledge of those with drug problems gained during her time as a criminal defence barrister. She told a packed audience how moved she was to see clients shaking a judge's hand after successfully completing treatment. She acknowledged the concerns that the sector had expressed about the changing landscape while expressing optimism about Payment by Results. She was challenged to speak to frontline drugs workers and services users rather than rely on the word of those running the PBR pilots and this she said she would do.

To view the conference presentations and picture gallery go to:
<http://www.drugscope.org.uk/events/drugscopeevents>

Communication team changes

Our communications manager Ruth Goldsmith is now on maternity leave. In her place is David Ader, previously a DrugScope intern. His email is davida@drugscope.org.uk and his direct line is 0207 234 9737.



‘Drone strikes

Despite the 2010 ban on mephedrone, drug services are seeing increasing numbers of people coming forward to report serious problems with the drug. **By Max Daly**

Mephedrone, known variously as mcat, bubble and fert is a powerful stimulant whose use appeared to dip after being controlled as a Class B drug two years ago. However, it is gaining a significant presence as a problematic drug on the UK drug scene, according to the *Druglink Street Drug Trends Survey 2012*, carried out among police forces, drug agencies, frontline treatment services and drug user groups.

Drug treatment services reported more people coming forward for help with both physical and psychological problems associated with their mephedrone use. Most worryingly, however is what appears to be a growing cohort of people injecting the drug; some are existing heroin and crack users known to services, others are injecting for the first time having used mephedrone either orally or nasally

for the past few years. Establishing prevalence rates for mephedrone is difficult. The figure for those using the drug when it was legal is unknown. Mephedrone only appeared in the British Crime Survey (BCS) household report on drug use among the general population after it was made illegal, so there are only two year's figures. These indicate a decline in overall use, so there is no evidence that mephedrone use overall is increasing. But those who continue to use are now experiencing problems.

Druglink first reported on mephedrone back in March 2009 as a drug in the vanguard of internet drug sales. Then it was chiefly used by online drug buyers and young people, many of whom were attracted to trying (and selling) the drug because it was legal. There were reports of young people being hospitalised through acute incidents and many initial,

ultimately unsubstantiated, reports of mephedrone-related deaths. It also found favour with existing users, who were turning away from other stimulants such as amphetamine and cocaine because of continuing poor quality. By contrast, mephedrone did what it said on the tin. Once the drug was banned, it is reasonable to guess that use probably fell as the naïve and curious dropped out, but left mephedrone to become an integral part of the drug scene. Feedback from the survey shows that mephedrone's relatively cheap cost, easy availability and reliable potency, is transforming it into an 'everyman' drug that is marking a shift away from traditional drug use patterns. The survey found mephedrone is being taken by a more diverse population, not only as a "poor man's cocaine", as one drug worker described it, but as a stimulant

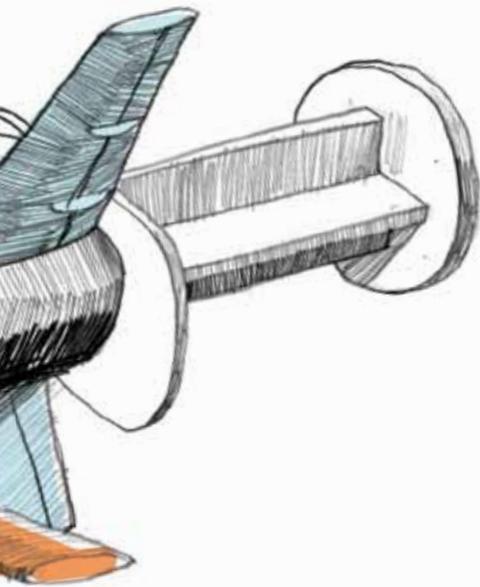


ILLUSTRATION BY LUKE WALLER

high for Britain's ageing heroin and crack using population.

Lucy Hulin, a substance misuse worker in Gloucester, says mephedrone use has mushroomed. "It has become really prolific in the last 12 months; we have young people from 13 years old taking it, and our adult treatment service says it's big with them. People we see are using the drug all day, mainly because they are bored."

THOSE INJECTING MEPHEDRONE ARE MOST COMMONLY FORMER OR CURRENT HEROIN AND CRACK INJECTORS, ALTHOUGH SOME ARE TEENAGERS AND PEOPLE WHO PREVIOUSLY HAVE NEVER INJECTED DRUGS

Many parts of the country reported a rise in the numbers of users developing severe behavioural, addiction and health problems as a result of their mephedrone use. Because of the drug's 'more-ish' nature, many users end up bingeing on the drug. Hulin says Gloucester's young people's drug service has seen more than 50 new presentations for problematic mephedrone use in the last year, with symptoms such as stomach pain, dehydration, volatile behaviour and mood swings.

Elaine Driver, a mental health nurse who works with recreational and addicted drug users in Bristol, said: "Mephedrone has been growing in popularity population wide in Bristol. Why? Because it's such an effective drug. That's why it's being used across the board. Among people in their 20s, older clubbers, but also people we are prescribing opiate substitutes to." She said some well known heroin-using clients had started to turn up at services being verbally aggressive towards staff after taking 'bubble', another name for mephedrone.

Rather than individuals buying mephedrone online, it is now most commonly being bought from street dealers, who buy it over the internet in bulk, cut it with adulterants such as benzocaine and sell it on, typically at around £20 a gram. Its purity, however, appears to average 50 per cent, far higher than cocaine, which is on average at least twice the price. Some sellers, according to one drug worker,

are distributing leaflets advertising mephedrone at coffee shops popular with the local student population. Kim Michelle, from Lifeline's young people's service in York, said that mephedrone is now in the top three primary problem drugs among their clients alongside cannabis and alcohol.

The most surprising and disturbing feedback from the 2012 survey however, is the new phenomenon of mephedrone injecting. Drug workers have reported outbreaks in towns across the UK, such as Barry in south Wales, Barnsley in south Yorkshire, Worksop in Nottinghamshire, and in clusters in Cumbria, Scotland, but also in parts of southern England such as Gloucestershire. Interestingly the survey did not identify the practice as yet being taken up in any of the major cities.

Those injecting mephedrone are most commonly former or current heroin and crack injectors, although some are teenagers and people who previously have never injected drugs. Users say mephedrone offers more 'bang for your buck', in terms of being a cheaper, more potent high than heroin, speed and crack. It is also readily available and has less stigma attached to it than heroin and crack.

Some are taking mephedrone alongside heroin in a similar way to a crack and heroin 'speedball', a stimulant high followed by an opiate comedown. Others are former and current amphetamine injectors. Not all of those injecting mephedrone have taken drugs intravenously before, with some starting to inject the drug after snorting it over several months.

The trend is a major concern for treatment services, many of which have had reason for optimism after witnessing falling levels of heroin injecting. There is the very real fear among survey respondents that drug addiction may not be reducing, but merely shifting. Lowering levels of cocaine and heroin purity, caused by a mixture of enforcement and profiteering by drug gangs, have in turn created an opening in the market for a cheap, reliable stimulant such as mephedrone.

Mephedrone's compulsive nature means that in extreme cases, users are injecting up to 20 to 40 times a day. With rapid increases in tolerance, some are getting through 20 grams in 24 hours and spending £1,000 a week.

Added to the mood swings, paranoia and anxiety associated with frequent mephedrone snorting, injectors of the drug show increased aggression and violence. Drug workers report that

How we did the survey

Our team of researchers contacted police forces, drug action teams, frontline treatment services and user groups in 20 towns and cities in the UK. The areas were chosen, when the survey began in its present form in 2006, to reflect a cross section of the UK. The areas surveyed were: Belfast, Birmingham, Blackpool, Bristol, Cardiff, Glasgow, Gloucester, Ipswich, Liverpool, London, Luton, Manchester, Middlesbrough, Newcastle, Nottingham, Penzance, Portsmouth, Sheffield, Torquay and York.

Research was not limited to the above towns and cities. Researchers spoke to drugs experts and drug services working nationally, across regions, countywide and in towns and cities in the UK. In addition, we received 180 responses from drug workers across the UK to an online questionnaire asking about the latest drug trends.

Druglink Street Drug Trends 2012 was carried out between September and November 2012. Responses were received in strict confidentiality, although some interviewees were re-contacted to request permission for the use of localised quotes and statistics.

former heroin users who have turned to mephedrone injecting are far more difficult to deal with: users come for help suffering from acute mental health problems, weight-loss, fits, horrific abscesses at injecting wounds and permanent damage to veins and body tissue.

The unpredictable nature of substances sold as mephedrone – drug services have reported it being cut with everything from benzocaine to monosodium glutamate (the flavour enhancer added to many Asian foods is also added to mephedrone by some sellers in order to make it less painful to snort), mean drug users are taking significant risks when they inject it.

Drug workers in Barry, a large seaside town 10 miles south west of Cardiff, told the survey that they have witnessed a near epidemic of mephedrone injecting among its population of 200 intravenous heroin and amphetamine users – mainly vulnerable teenagers and jobless, long term drug users aged 16 to 40.

“We noticed in February this year, it happened very quickly and we didn’t see it coming,” says Mike Brown, a case manager at south Wales drug charity Inroads, of events in Barry, formerly a major port and now more famous for being the setting for the comedy show Gavin and Stacey.

“Virtually all our heroin and speed injectors suddenly started injecting mephedrone instead, it’s a close community so habits spread quickly here. They call it fert or m-cat, but some users have referred to it as m-smack.”

Aud Fawcett, a young people’s outreach worker for Inroads, added: “We think they made the switch because of the big fall in the purity and availability of heroin in the last two years [a heroin drought affected much of the UK in

VIRTUALLY ALL OUR HEROIN AND SPEED INJECTORS SUDDENLY STARTED INJECTING MEPHEDRONE INSTEAD, IT’S A CLOSE COMMUNITY SO HABITS SPREAD QUICKLY HERE

2010 and 2011] and also because of the publicity in the media surrounding the new drug ‘mcat’, which people had never previously heard of. I spoke to a GP in the Valleys who has seen lots of horrible mephedrone injecting injuries – skin and muscle removed because of abscesses.”

Drug workers have seen groups of mephedrone injectors across south Wales, not only in the Vale of Glamorgan, but also in the Rhondda, Bridgend, Pembroke Dock, Caerphilly and through the Valleys up to Merthyr Tydfil.

Glen Jarvis, Service User Involvement Officer in Nottingham, which is reconfiguring its services in the wake shifting of drug trends, said:

“I am increasingly concerned about mephedrone use here. Since being made illegal it had lost its innocent appeal and has gone underground, become a hard-core drug. We are hearing about a lot of intravenous use and some very worrying reactions: abscesses that move up the arms, paranoia, psychosis and violence. There are increasing numbers of young people snorting it and even more worrying is that former and existing heroin and crack community now seem to be turning to it. Formerly compliant clients are very difficult to work with and, anecdotally, some are reporting use of £1500 of the drug in a binge.”

But why are people injecting mephedrone? The consensus among drug workers is that, even in the context of heroin and crack use, it is a desperate act committed by people with low self-esteem living moribund, dead-end existences, away from the country’s major urban centres.

The other major trends unearthed by our 2012 survey reflect Britain’s shifting drug scene. The fall in quality of heroin and the rise of internet drug sales and the importation of foreign-made, illicit prescription drugs have resulted in the second most noticeable trend this year: the continued increase in the use and availability of benzodiazepines, such as diazepam and other synthetic opiate painkillers including Tramadol.

The majority of survey respondents said they had seen a rise in the use of Valium-type substances in their area, particularly by former and current heroin and crack users, but increasingly among the general population including young people and those living in deprived housing projects. Even in Belfast and Glasgow, cities well known for heavy diazepam use, the police and local drug services have reported an escalation in use and seizures. Although many

Average UK prices at the time of the survey

Herbal cannabis (standard) per qtr oz:	£37
Herbal cannabis (high strength) per qtr oz:	£55
Resin cannabis per qtr oz:	£27
Heroin per bag (average gram weight):	0.21g
Heroin per bag (average price):	£11
Cocaine per gram:	£46
Crack per rock (average gram weight):	0.25g
Crack per rock (average price):	£16
Ecstasy per pill:	£6.30
MDMA powder/crystal per gram:	£39
Amphetamine per gram:	£13
Ketamine per gram:	£21
Mephedrone per gram:	£19
Diazepam per pill:	£0.67p

Freddie, 48 from Barry, ex Army, unemployed, five children. He is a long term amphetamine injector over the past 24 years. He started injecting mephedrone in March.

Mephedrone injecting is going to be huge, because it’s so lush. When I first injected mephedrone, it took me off my feet. It’s an immense overwhelming buzz. I went on a three month binge. At the end of it I was so wrecked I couldn’t stop crying for two days, all the emotions flooded out of me. I never usually cry. I couldn’t stop. I take it whenever I have the money, me and my girlfriend have 3 bags a day (cost £10 for 0.7g). Every spare penny after food and water goes on mephedrone. I get ulcers. Mephedrone injecting is huge in Barry. Most of my friends are doing it, a lot of those who usually use heroin. It’s a close knit community so word spreads quick. I steered clear of crack because I was scared of getting hooked. Don’t think I’m addicted to mephedrone, just like it. Once it’s in front of me I have to have it all.

diazepam pills come into the UK through the post from Pakistan, Sri Lanka and India, police this year uncovered evidence that criminals were making Valium type pills in Scotland.

Overwhelmingly, feedback from the survey backed up evidence from the NTA and found heroin injecting was falling, although not all services reported similar falls in crack use. Heroin purity levels had recovered from the 2010/2011 drought in some areas, but most reported very low quality levels. Kenny Simpson, of the Scottish Crime and Drug Enforcement Agency, said the trade in cutting agents for heroin was starting to

mirror that of cocaine. In the past year, police have intercepted 25 kilo barrels of toasted caffeine and paracetamol, a mixture now being imported by gangs who use it to dilute heroin.

The survey found a continued rise in most areas of ketamine, steroids and problem alcohol use. Cocaine, cannabis and ecstasy use has remained stable, with varying levels of purity and price. As reported in previous years' surveys, expensive and potent skunk still dominates the cannabis trade, and many police forces are raiding a seemingly never-ending number of growing houses while synthetic cannabis such as 'black

mamba' featured in some reports.

And finally, along with most consumer goods, the prices of drugs have increased in the past year. Although the average price of a gram of cocaine in the UK has fallen from £50 to £46, other drugs have become slightly more expensive, most noticeably all forms of cannabis, as well as ecstasy pills, MDMA powder and speed.

■ **Max Daly** is a freelance journalist and co-author with Steve Sampson of *Narcomania: a journey through Britain's drug world*

Barnsley case study report for Addaction on mephedrone injecting

We first became aware of a change in the way in which people were using mephedrone in early 2012. Both our adult and young person's services in Barnsley had seen people whose use had become problematic since 2010, these had all been people sniffing the drug, who had been recreational users whose use had got out of control. What we began to see early this year was current or former intravenous (IV) heroin users who were now using mephedrone in the same way. We also began to see people who had never previously injected accessing specialist services seeking injecting equipment to inject mephedrone.

Very quickly we saw people's use begin to rise and people who were using spoke of the compulsive nature of their use. We also saw a variety of negative impacts on physical and mental health. Worryingly we began to see people who had been fairly stable for several years begin to decline rapidly and appear to suffer serious setbacks in their recovery.

Between May and August 2012 we spoke to 24 mephedrone injectors, 17 males and 7 females. They were a broad age range, but mostly between 25 – 35, although nine were aged under 25. Seventeen people had a history of heroin use, meaning that 7 of those surveyed were new to IV drug use and had become IV users fairly recently, as a result of their use of mephedrone. Of the 17 people who had been heroin users, 11 of them were still engaged in using heroin alongside their IV use of mephedrone. None of these reported that their heroin use had escalated and most said it had decreased. Of the 17 who had a history of heroin use,

12 of them were currently receiving substitute prescribing treatment.

The length of time that they had been injecting mephedrone varied, but most had been injecting for between 2-3 months, some less and some for longer periods of time, including one female who had been using mephedrone when it was legal and whose use had gradually become more problematic over the last two years until the point where she was now an IV user.

We asked people to try to explain their reasons for IV mephedrone use. Most people stated that IV use provided them with a better hit or buzz. People who had been previous or current heroin users discussed the low quality and poor availability of street heroin and crack cocaine and this seemed to have been a significant factor in people switching their use to mephedrone. Some people who had switched from using nasally to IV stated that injecting was better as it avoided the taste of the mephedrone. One female had a plastic insert in her nose as a result of nasal use, so she had moved to IV use to prevent further damage to her nose.

People reported that they were using very large amounts of the drug on a daily basis. Between two or three grams per day was common but we have people who state that they were using in the region of 20g daily. Some users report between 20 – 40 injections per day. All those who we surveyed reported a rapid rise in their tolerance to the drug, leading to increased amounts being used, often in very short time frames.

There were many health issues, such as dramatic weight loss, fitting

and infected injecting sites. Many people also reported increased levels of violence and aggression and stated that they or others around them were resorting to violence or being drawn in to violent situations far quicker so than they had previously.

So what are the key challenges that the service faces?

We need to ensure adequate equipment provision to very chaotic injectors and balance this against the need to ensure returns back in to the needle syringe programme to meet needs of local commissioners.

We need to ensure that all staff have an awareness and knowledge of the drug so that relevant and correct information can be passed onto service users.

Increased aggression and violence is reported by many users. This is backed up by our experiences as workers where we have seen service users who we know well act in erratic or aggressive ways. Anecdotal reports from the police indicate that they have also seen an increase in violence and aggression when dealing with people they believe to be under the influence of mephedrone.

There is significant negative impact on both physical and mental health. As part of the work in Barnsley, Addaction has taken a lead on training mental health teams in the area on mephedrone. Figures are hard to come by, but it seems clear that mental health services are increasingly concerned by the amount of people they are seeing who are using mephedrone.

TWIST IN THE TALE

Payment by results (PBR) fundamentally changes the way that providers will be paid for services. But many are sceptical it can be made to work in our sector. **John Densmore** examines one especially knotty issue.

PBR will change the funding of service provision by providing payment for an agreed outcome, such as abstinence, instead of the traditional way which pays upfront for an activity, such as treatment or counselling. The idea is to 'incentivise' service providers into focusing on the results of their interventions and to let market forces sort out who does it best at the best price. How the service provider achieves the result is up to them. The hope is that enterprise and initiative will find innovative ways of achieving outcomes, cutting bureaucracy and costs. PBR could also provide interim payments for milestones along the way to the final outcome, such as drug free urine samples from service users who are on a substitute prescription but who cannot yet claim abstinence from all drugs. The appeal to the coalition government is that PBR seems to tick all the boxes – application of market forces, the transfer of risk to the provider instead of the funder, a promise of efficiency and hoped-for reduction of cost, and even the use of private rather than public money. It looks good on paper but how will it work in practice?

Playing the game

There is general agreement that 'gaming' can undermine any PBR scheme. This is the process whereby providers might play the system for financial advantage. Even those who support PBR appreciate that gaming is inevitable. To prevent or reduce gaming, the Department of Health (DH) set up the independent Gaming Commission on Drug and Alcohol Recovery PBR Pilots in August 2011. They were given a short period to report and had a limited brief "to identify gaming opportunities within the Drug and Alcohol (D&A) pilot schemes, and to recommend how these might be eradicated or minimised". They reported the possibility of "creaming" (deliberately choosing service users who they think are likely to achieve a payment for reaching a target), "parking" (providing a minimal service to those who they think will not achieve a payment) and other methods of gaming. The Commission was not asked to find definitive responses to gaming but they did suggest two principal responses. The first is an independent Local Area Single and Referral Services (LASARS) which will make the initial assessment and refer on to the most appropriate service, which they hope will prevent "creaming" and make a more objective assessment of the complexity of a case (which could

extract a higher payment) than is likely to be achieved by the service provider. The second is a robust auditing service within the local area to keep an eye on the claims of service providers in extracting payments.

WHO IS MOST LIKELY TO ACHIEVE PAYMENTS FOR ABSTINENCE QUICKLY – AN OCCASIONAL PROBLEMATIC CANNABIS USER WHO USES ONLY CANNABIS OR AN INJECTING HEROIN USER OF SEVERAL YEARS?

Both of these responses have major problems, some of which have already been identified by the Commission. Will LASARS have the expertise to make an accurate assessment? Often new clients may not tell you everything that is relevant until they think they can trust you. Many new service users come in saying "I've come for a script" and when asked how long they think they will need it, the answer is often optimistic, either from lack of experience in achieving and maintaining abstinence or possibly because they think that is what you want to hear. Without continuing contact with the client, how will LASARS workers learn from their experience?

Auditing will be almost impossible in individual cases where the claim is for abstinence, because of the difficulties and time required to find former service users, abstinent or not, 12 months after the end of treatment. The best that can be done is to audit on a statistical basis. Auditors should certainly become suspicious of claims of increases in abstinence of 15 or 20% in only a year but will have no way to check these claims. In addition, the new LASARS and auditors will be expensive, using money that could be used for service provision.

Defining outcomes

A first attempt at defining outcomes and how they will be achieved was made by the DH in their recent *Recovery Payment by Results Pilots – Final Outcome Definitions*. Trying to be fair and trying to respond to

the concerns of treatment providers, the DH devised a system which nevertheless risks being bureaucratic and possibly unworkable. The payment outcomes for the PBR pilots started last year are grouped into three domains:

- Domain 1** Free from drug(s) of dependence
- Domain 2** Offending
- Domain 3** Health and wellbeing outcomes

Domain 1 will have 4 levels. Each level is defined and also has eligibility criteria. All drugs are treated equally – opiates, cocaine, cannabis, alcohol and so forth. This already presents a significant anomaly. Who is most likely to achieve payments for abstinence quickly – an occasional problematic cannabis user who uses only cannabis or an injecting heroin user of several years? It takes no account of "recovery capital", so someone with a good education, no criminal record, a good job and family support will earn the same payment as someone who has a long criminal history, no family, never in regular employment, little education and homeless. No prizes for predicting the client who is most likely to produce the highest payment.

There are two stages within the first domain: abstinence from all presenting substances in any two TOP reviews will receive a payment as will planned exit from the treatment component of the recovery journey. The big financial prize will be for "discharge from treatment successfully (free of drugs) of dependence and does not re-present for treatment or within the criminal justice system (taken onto the DIP/ prison caseload) in the following 12 months". But is the service user really abstinent? Did he go out and score after the last appointment? Was he arrested and jailed in another town the next week and did not return for help for that reason, or maybe he just moved? Has he changed to internet drugs – legal or not? What about alcohol – is he now alcohol dependent? If he is, how do you know? What happens about relapse? Do service users get only one chance to achieve these milestones; how many relapses are they allowed? What about a benzodiazepine prescription from a GP? The questions go on indefinitely, the system becomes more and more complex and more information is required.

Even now drug workers groan under

the weight of recording information. They need to keep up to date with NDTMS (National Drug Treatment Monitoring System) which will become more onerous as more data is added in November this year, and, if they work in the criminal justice sector, CRAMS (Case Recording and Management System). Everyone has to complete TOP forms for each service user, a system which still lacks credibility among many workers.

EVERYONE WILL WANT THE NEW SYSTEM TO WORK – POLITICIANS, FAMILIES, SERVICE USERS, SERVICE PROVIDERS AND COMMISSIONERS. YET THOSE WHO HAVE POWER TO INFLUENCE THE SYSTEM WILL BE UNDER VERY CONSIDERABLE PRESSURE NOT TO ROCK THE BOAT

Cash for questions

Under PBR, treatment agencies will need to wait until their service users have achieved their outcomes before they receive a significant part of their payment. This will be difficult for the interim payments and very difficult for the final abstinence payment – at least 12 months. How will service providers pay their staff during this time? The government is hoping that the financial industry will come to the rescue in the form of Social Impact Bonds (SIBs). These are investments from a financial institution which will ‘invest’ in a particular service and only get a return if the intervention improves outcomes, leading to lower government spending for that individual over the longer term. Government will pay out only if there are identifiable savings. Most investors in SIBs will want a premium rate of return on their investment, money which might be better used directly by service providers. In these financially difficult times are hedge funds, banks and hard headed investors really willing to put their money into SIBs when even profitable businesses are being starved of funds?

In any event, the notion of PBR is having a hard time. Recently, the finance industry has been criticised by the

Financial Services Authority for massive failures and mis-selling of their products as a result of paying bonuses based on results. A4e, a private employment contract agency on payment by results contracts has been accused of fraud by whistleblowers, and “gaming” to maximise payments. Why this same system is now deemed to be the appropriate engine for change in the drug and alcohol service industry is a mystery to me.

Everyone will want the new system to work – politicians, families, service users, service providers and commissioners. Yet those who have power to influence the system will be under very considerable pressure not to rock the boat. Will commissioners, despite their good intentions, want to hear that their systems don’t work or that their choice in service providers was a mistake? Will provider agencies be willing to complain about a system which they have recently signed up to? It is hoped that those service providers who have mastered the new system will maximise their payments by providing a better service which makes for better outcomes, but can we be sure that they are not making up the data or engaging in clever gaming? It will be impossible to tell. Politicians will be happy if the new system really does improve services. Some genuinely believe it will. But with the political capital invested in PBR, will they be able to backtrack if evidence is produced that it does not work?

POLITICIANS WILL BE HAPPY IF THE NEW SYSTEM REALLY DOES IMPROVE SERVICES. SOME GENUINELY BELIEVE IT WILL. BUT WITH THE POLITICAL CAPITAL INVESTED IN PBR, WILL THEY BE ABLE TO BACKTRACK IF EVIDENCE IS PRODUCED THAT IT DOES NOT WORK?

While the government is keen for PBR to be rolled out nationally, the localism agenda will mean that local commissioners should have the final say about whether or not to implement it. I have met a few commissioners who are keen but more are sceptical and have said they will see how it works in other areas before they decide.

For those of you who have not already guessed, I’m less than enthusiastic at this development for reasons which I have already stated. However, there is another reason why I think this is a misjudged idea and the best way to explain my reasons can be found in a true story.

Several years ago I was in a supermarket and noticed a man who looked familiar but I couldn’t remember his name. He stopped and asked me my name and told me his. He was a former service user I knew from years back and his story demonstrates why payment by results is misconceived. He came to our agency having left a residential rehabilitation treatment programme against advice. He started using heroin again soon after and came to us asking for a methadone prescription. He managed to reduce and was abstinent in about 4 months. I was seeing him frequently at this point and one day he failed to meet me at our normal meeting place. I wrote to him and even went to where he was living but he had gone. By chance he was offered a job in another part of the country and had to leave immediately to take up the offer. Despite a very brief relapse and a short period of heavy drinking (which he managed himself with no treatment), he made himself a new life. He has now been drug-free for 10 years, raising a family, running a business, no longer offending and paying his taxes. So, who should be paid for his success? How about the street agency who first helped him detox and get to the rehab? What about his GP who gave him his first methadone prescription? What about the pharmaceutical company which manufactures methadone? What about the rehab that gave him the confidence that he could achieve abstinence? He acknowledged that they all played a vital part but somehow the payment will be made out to me (why not him?). I treated him last and he ticks all the boxes. So, if the commissioners are reading this please make the cheque out to me.

■ **The author** has been a commissioner and provider. He is writing under a pseudonym (name supplied).

So is PBR doomed before it starts or is that an over-pessimistic view?

Write to the Editor at harrys@drugscope.org.uk

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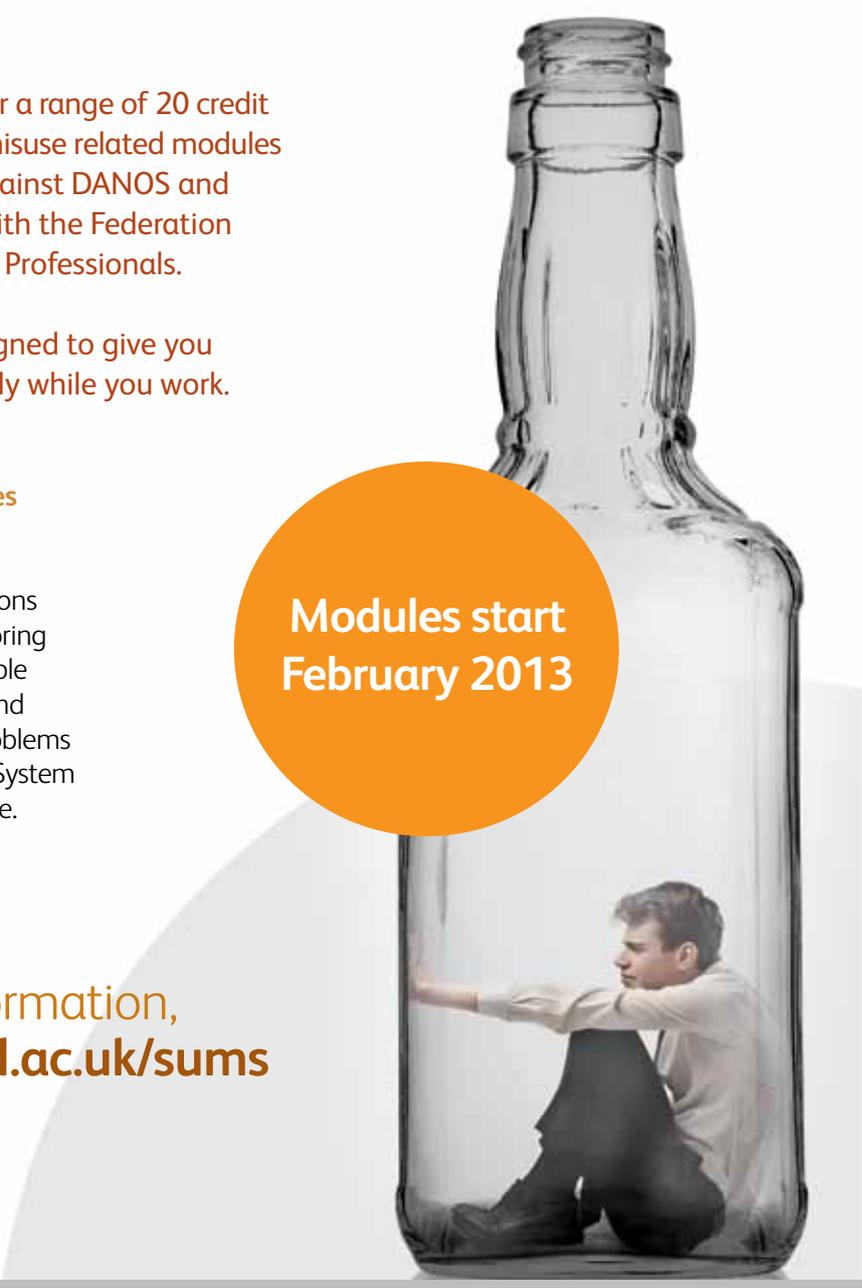
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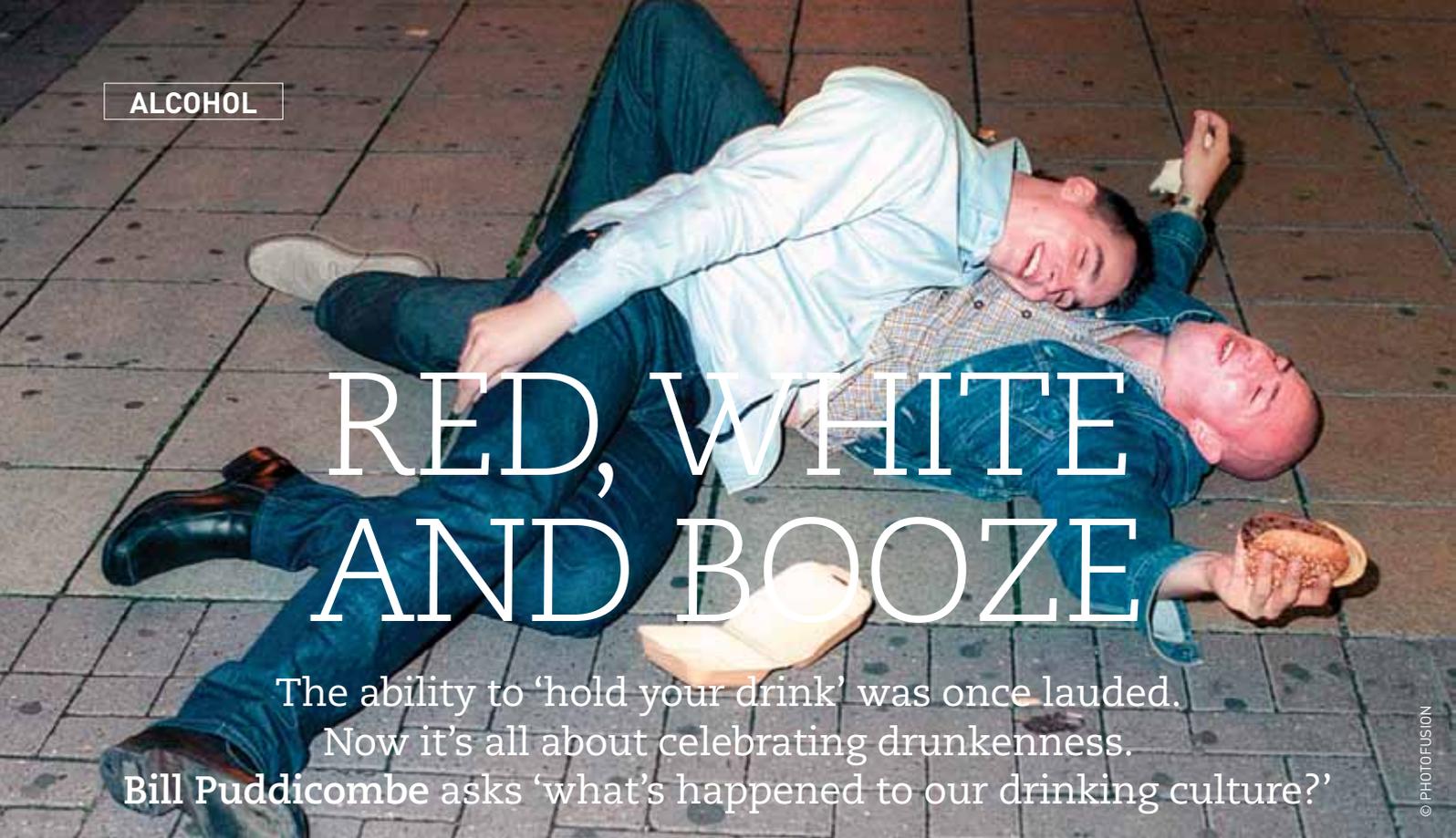
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RED, WHITE AND BOOZE

The ability to 'hold your drink' was once lauded. Now it's all about celebrating drunkenness. Bill Puddicombe asks 'what's happened to our drinking culture?'

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The latest figures for alcohol consumption in England indicate that consumption is falling including among the young, more of whom think it is not acceptable to be drunk even once a week. Yet figures for hospital admissions have soared by 40% since 2002 which suggests that people are drinking more dangerously, as a walk around most city centres at night would appear to confirm.

This is a phenomenon which warrants far more debate than currently happens. Moralistic hectoring about 'misbehaviour' which seems to be the subtext of the government's alcohol strategy or general hand-wringing about public health isn't enough.

Drinking has always been a highly visible part of our culture. The late Professor Griffith Edwards (see obituary on page 6) in his book *Alcohol – The World's Favourite Drug* wrote:

"Alcohol is a pervasive fact of life, but an extraordinary fact – pleasurable and destructive, anathematised and adulated, and deeply ambiguous."

In this book Griff had a chapter called "A short history of drunkenness" in which he describes the changes in British intoxication from the eighth century to the 1920s. This is full of fascinating quotes, particularly Walter Raleigh's statement that "A drunkard

will never shake off the delight of beastliness..." By the end of the account, mass drunkenness as an accompanying factor of severe poverty had stopped being an urgent social issue and public health concerns had taken over.

Eighty years later and mass intoxication is once again back on the social, cultural and moral agenda. Drinking and intoxication have become a tolerated part of English life in a way that it has not been for many decades.

I was set off thinking about this by Radio 1 breakfast DJs (bear with me on this). In the 1970s and 1980s the men (they were all men, of course) who provided the wake up call for families starting their day were themselves family friendly. Remember such figures of fun as Dave Lee Travis* (the Hairy Cornflake) and Mike Read? The idea that any of this lot would talk openly on air about being intoxicated was unthinkable. To be drunk was generally considered shameful: definitely not the subject of polite conversation.

Shift forward to the year 2000 and we have Sara Cox in the same chair. In contrast she became notorious for openly discussing her regular experiences with intoxication in graphic detail. Her predecessor, Chris Evans, was fairly open about excessive consumption as well. While this change was taking

place Radio 1 was deliberately shifting their listening age down; the implication is that the pleasure of intoxication had become a reasonable subject for discussion on "family" media. Something had changed in public perception.

The recent government Alcohol Strategy is aimed very much at the perceived problems arising from public behaviour linked to intoxication. It starts with a preface from the Prime Minister that talks almost exclusively about binge drinking and there is very little content about treatment of dependence or harm reduction.

At a local level things are rather different. I worked with some local authorities a couple of years ago and saw the effort that goes into managing mass town centre intoxication (generally referred to as the "night time economy"). I was involved in putting measures in place that protected young people who were intoxicated and might come to harm from other people who were intoxicated. The environment was being managed to make this phenomenon less risky.

One innovation was the introduction of SOS buses (I saw these in operation in town centres in Essex). These provide a place where people who are at risk because of intoxication or who are simply feeling ill can go for support

and basic treatment. One of the most intriguing things about these services, which survived on a mixture of charitable and statutory funding, was the number of volunteers prepared to come forward and work in them on Friday and Saturday nights. People giving up their free time to help other people who had come to harm having a good time.

All of this suggests that we have come to a point where mass intoxication has become a tolerated, expected facet of life right across the country and that the shame that used to attach to being drunk has receded.

DRINKING AND INTOXICATION HAVE BECOME A TOLERATED PART OF ENGLISH LIFE IN A WAY THAT IT HAS NOT BEEN FOR MANY DECADES

While a large part of the advice available publicly about alcohol use is of the “two-three units” a day variety, there is a considerable amount that assumes large numbers of people will not stick at the recommended safe level (or, for that matter, consider a binge to constitute six units as per the NHS guideline). For example, the Guardian Money section recently contained a guide for new students on how to live on a budget. This had practical hints on how to manage cash “when you are out drinking”, mostly consisting of advice that is unlikely to be heeded after the first couple of hours of WKD.

Back in the day when drinking sessions were generally considered the preserve of young males, one of the unwritten rules was that “holding your drink” was a mark of status. Someone who could walk and talk straight after 6 or 7 pints of Hofmeister or Courage bitter was lauded above the guy who ended up under the pub table. Alcoholic drinks were to be tasted and enjoyed – drinking with the express intention of getting drunk a frowned-upon activity.

Now there is a clear aim to enter an altered state through alcohol. There is a stated intent to access the release and catharsis of intoxication. The consistent tale of Friday and Saturday nights for a lot of young people is of consuming cheap supermarket alcohol before going out so that there is not so much need to splash out on pub and club drinks. Older people are apparently drinking in patterns that

would suggest they are regularly drunk; reference for example the recent BBC Panorama programme, Old Drunk and Disorderly (10th September 2012). While there are some clear geographical and cultural differences, in general there are larger numbers of us for whom regular intoxication has become a fact of life.

Also emerging is a whole set of language that implies an integral understanding that there is an element of self harm in drinking too much. The excellent *Online Slang Dictionary* lists over 200 contemporary words for drunk, from “annihilated” to “zosted”. More than half of these have overtones of damage, (fucked up, slaughtered and trashed are examples). This suggests the “deeply ambiguous” relation with alcohol that Griff Edwards noted.

All of this requires some serious consideration. It requires a public debate about the underlying causes of the change. It has been suggested to me that this a product of the libertarianism of the 60s and succeeding decades. The idea that everything should be tested, tried and enjoyed is at root of the change. The argument for increasing the cost of alcohol to stem drinking suggests that increased prosperity and, especially, reducing real costs of alcoholic drinks may play a part. Some of the most vociferous condemnation of alcohol used to come from organised religion. With the majority of the population no longer listening too hard to religious leaders have we simply reverted to preferred habits?

None of these explanations seem satisfactory to me. The change in attitude and behaviour is a British one and therefore needs a British explanation. The complication we need to avoid is that this is a moral issue. From a humanistic viewpoint there is nothing intrinsically immoral about intoxication.

While the debate rests on political point scoring about “binge drinking” and concerns about liver disease we are missing the opportunity to understand.

■ **Bill Puddicombe** is the Chief Executive of Equinox Care. He writes here in a personal capacity.

* this article was written before the recent arrest of David Lee Travis

So do you agree that our drinking culture has undergone a sea change in recent years? If so, why do you think it is happening?
Email the *Druglink* editor harrys@drugscope.org.uk

On drinking and drunkenness:

Noah, a man of the soil, began the planting of vineyards. He drank some of the wine, became drunk and lay naked inside his tent.

New English Bible, Genesis 9:20

MacDuff: What three things does drink especially provoke?

Porter: Marry, sir, nose-painting, sleep and urine.

MacBeth

A man who exposes himself when he is intoxicated, has not the art of getting drunk.

Samuel Johnson 1791

Like other parties of the kind, it was first silent, then talky, then argumentative, then disputatious, then unintelligible, then altogether, then inarticulate, and then drunk.

Lord Byron 1815

Heaven protects children, sailors and drunken men.

19th Century Proverb

An alcoholic is a man you don't like who drinks as much as you do.

Dylan Thomas

I have taken more out of alcohol than it has taken out of me.

Winston Churchill

It was my Uncle George who discovered that alcohol was a food well in advance of medical thought.

P.G.Wodehouse – The Bertie Wooster stories

Humanity I love you because when you're hard up you pawn your intelligence to buy a drink.

E.E.Cummings

Sobriety is a real turn-on for me. You can see what you're doing.

Peter O'Toole

Whatever happened to 'glue-sniffing?'

Although technically incorrect, the expression gained traction with the media when the practice was at its height back in the 1980s. But whatever you call it, the misuse of solvents has dropped off the radar. By **Richard Ives** and **Nicola Morgan**

It may come as a surprise to many people to reveal that volatile solvent abuse (VSA) (including adhesives and butane lighter fuel) has killed more young people under the age of 16, over the past twenty years, than all the Class A drugs put together. They were in fact, the first legal highs.

Prevalence statistics for VSA are essentially limited to surveys of young people. The NHS Information Centre's *Smoking, drinking and drug use among young people in England* report shows that VSA has declined among young people aged 11 to 15 years over the last 10 years. In 2001, 7.1% of young people reported misusing a volatile substance in the last year, compared to 3.5% in 2011. It is worth noting that volatile substances are reported as second only to cannabis for this group, and in the younger age groups (11, 12 and 13-years-olds) solvents still have the highest percentage of misuse. Statistics for adult misuse of solvents had been collected in the Home Office's Drug misuse declared (part of the British Crime Survey) but were dropped in 2011 because of the need to collect data on new psychoactive substances. The percentage of adults aged 16 to 59 years old reporting previous year use of 'glues' was consistently at 0.1% or 0.2% since 1996.

One of the reasons that we don't hear

much about this these days, (although nitrous oxide has become fashionable accompanied by the tragic death of a seventeen year old in October) has been the steep decline in the number of deaths; they have fallen from an average of just over 100 per year in the early 1990s to an average of 48 per year in the last five years on record (2004 to 2008). And indeed, the decline in deaths can be construed as a prevention success story – a range of different organisations have undertaken activities to address the problem: and, it seems, with some success.

But the statistics tell a more complex story; while deaths among young people have declined, the proportion of adults has increased significantly since 2005. In the period 1971- 2005, just over half of all deaths were attributable to those aged 18 and over, during 2006-2007, the percentage had jumped to nearly 90%.

The recorded history of volatile substance abuse (VSA) in the UK started in the 1970s, although before then there were sniffers – for example, 1950s army draftees sniffing button cleaning fluid, and even further back, in the nineteenth century the use of 'laughing gas' (nitrous oxide) to achieve intoxication by such scientific luminaries as Humphry Davy, which as I have noted, has made something of a comeback through the

use of whipped cream canisters.

But it wasn't until the 1980s that there was considerable public and political concern about the issue; then, the Department of Health funded a research project to identify the deaths related to VSA. This was necessary as VSA-related deaths were not always identified in drug-related deaths statistics. That research project, *Trends in UK deaths associated with abuse of volatile substances*, continued until 2009, producing an annual report which received wide-spread media coverage and helped ensure that the issue was kept on the agenda. It is a big loss and a disappointment that the work is no longer funded.

Also back in the 1980s, in response to the misuse of glues, the British Adhesives and Sealants Association, with a Director seconded from Staffordshire glue manufacturer, Evode, established a charity to tackle the problem. From their head office, still based in Staffordshire today, Re-Solv continues to take action across a wide spectrum, aiming to support those affected by VSA, campaign for more effective services and better information, undertake and encourage research to identify the issues more clearly, and generally to ensure that there is a response to the problem.

Re-Solv is currently running one

major research project supported by the Big Lottery through a funding stream aimed to help charities make better use of research data. Re-Solv's project is in two parts. Firstly, a 'secondary analysis' of the data on VSA-related deaths gathered by the mortality research project at St George's University for over 25 years. This unparalleled dataset has been interrogated to identify some features of the deaths and their connection with changes in the legislation and with a major prevention campaign of the 1990s. A report of this work will be given in a peer-reviewed paper to be published shortly in the journal, *Addiction*. As previous studies have shown, it is possible that the 1990s prevention campaign aimed largely at parents may have been an important factor in the reduction in under-18 year old deaths. This contrasts with the lack of evidence showing a positive correlation between legislation and reduced mortality.

The second part of the research includes a variety of research activities to better understand current and emerging trends so that Re-Solv can anticipate and respond to changing needs.

The project's findings will also inform government policies at regional, national and international levels. For example, one significant activity has involved working with the Welsh Assembly Government (WAG) to publicise their new volatile substance abuse guidelines (see <http://tinyurl.com/9nhnd6a>) and to encourage the WAG to ensure that the guidelines are implemented. Finding appropriate treatment modalities is complex, and Re-Solv contributed to a consultation by the Australian Government on VSA treatment – although in Australia major problems with VSA are associated with some Aboriginal communities, and treatment in this context is very different to the approaches in the UK.

One issue for the UK is the way that VSA is recorded in the National Treatment Agency's data set and the limited data collection about VSA – we do not have an accurate picture of how many people present for treatment with VSA-related problems, nor if treatment is effective in helping them to tackle their difficulties. This is especially important if the age of VS misusers is increasing and it is becoming more of an issue for adults. Re-Solv is working with the NTA to explore ways of improving data collection.

Much of the prevention work that Re-Solv participates in is based in schools and other youth settings. The research



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VSA HAS KILLED MORE YOUNG PEOPLE UNDER THE AGE OF 16 THAN ALL THE CLASS A DRUGS PUT TOGETHER

has explored the effectiveness of some of the school-based interventions that Re-Solv undertakes. Findings from a small survey indicate positive and lasting changes in pupil attitudes associated with this educational work.

Another strand of the work is to pull out more VSA information from existing surveys. We are building on a paper that analysed published VSA data from the European School Project on Alcohol and Drugs (ESPAD) surveys of 2007 and 2011, and hope to publish these findings in 2013. We are also working with the Schools Health Education Unit (SHEU) to explore some of the correlates of VSA in their large national samples and again intend to publish findings from this study. In some studies, VSA has been associated with other substance use and with 'risky' behaviours and is perhaps connected with being bullied, and other potentially negative childhood experiences, such as being 'looked after' by the local authority.

Re-Solv recently commenced a new project in conjunction with the other charity in this field, Solve-It.

Solve-It (www.solveitonline.co.uk) was established by a mother whose son died from inhaling aerosols, and has provided help for those misusing VSAs and for those affected, as well as supporting training and running prevention projects. The new joint three-year project, entitled 'Community for Recovery', is funded by the Department of Health's Innovation, Excellence and Strategic Development Fund, and will help drug users dependent on volatile substances access equality of treatment and support. A Web-Hub will provide direct access to information, professional advice, counselling and peer support, without stigma, for VS users and those close to them. The Hub will also connect users with local services whose staff have been specifically trained to effectively address VSA, enabling services to support users and their families, and help them along recovery pathways.

Finally, we would like to hear from you if you are working on VS-related issues – we are especially interested in identifying good professional practice with VS users. Please contact Steve Ream at Re-Solv on 01785 817885, or email director@re-solv.org

■ **Richard Ives** is CEO of *educari* ltd, and is working with Re-Solv on the Big Lottery-funded project.

■ **Nicola Morgan** is the Research Project Co-ordinator for Re-Solv.



To paraphrase *The Wire*, if you just go after the drugs, all you get is drugs; chase the money and you never know where it may lead. But with HSBC the latest bank to be embroiled in a drug money scandal, how effective are anti-money laundering strategies?

By Euan Grant

In April 2006, Mexican soldiers intercepted a plane carrying 5.7 tons of cocaine. But as reported in *The Observer* (3rd April 2011), they also found something far more significant than even nearly six tons of coke. They uncovered the paper trail behind the purchase of the plane itself by the Sinaloa drug cartel. That sparked a twenty two month investigation which revealed that nearly four hundred billion dollars in wire transfers, traveller's cheques and cash shipments – a sum nearly equivalent to a third of Mexico's GDP – went into Wachovia, one of America's biggest banks. The case never came to court; instead the bank settled with the federal authorities for a fine equivalent of less than 2% of its profit for 2009. And the only reason that all the details came to light was through the tenacity of the bank's London-based senior anti-money laundering officer who had to whistleblow in order to spark the investigation and was hounded out of the company for his troubles. The federal prosecutor remarked, "Wachovia's blatant disregard for our banking laws gave international cocaine cartels a virtual carte blanche to finance their operation".

Money laundering is the process by which the proceeds of criminal activity are cleaned (or laundered) by

a transaction or series of transactions which seek to disguise the criminal origins of the proceeds. It follows that nearly all criminal activities carried out for gain will involve money laundering. Cash is turned into other assets, and non-cash transactions are disguised through a series of financial transactions which make identification of the ultimate source or destination of the funds very difficult.

There are different types of money laundering. For example, cash smuggling involves the physical carrying of cash within countries and across borders. At its simplest this might involve the transfer of the proceeds of a drugs deal in a nightclub to a safe house, literally under the bed. It can equally apply to carrying the cash on international travel routes. That is certainly what many see money laundering as being. It is for these reasons that within the EU, cash sums of 10,000 euros equivalent and above must be declared to the border agencies, who keep records and use it for intelligence purposes. The Mexican authorities tackling their lethal drugs trafficking gangs place a lot of emphasis on how the cartels use cash businesses such as cafes and dry cleaners. Knowing this is one thing, however; trying to stop it in such a violent and corrupt environment is another.

Moving money internationally makes it harder to detect at destination but does run some risk of confiscation or detection at border controls (if there are any). Smugglers take countermeasures (more couriers, smaller sums) so cross-border identifications will often only be made if the person is already somebody who is being watched.

The key point is that cash remains cash and does not go through the banking system to any extent. Criminals have been making more use of *bureaux de change* and money transfer services such as Western Union to launder cash rather than relying solely on the banks. These more recent outlets are also the subject of law enforcement interest but the sheer number of transactions and lack of customer identification limits the chance of detection.

The HSBC case in Mexico and Florida is a classic example of where cash based money laundering schemes merge with bank transaction money laundering. In July, the US Senate on Homeland Security and Governmental Affairs published a scathing three hundred page report into the banking activities of HSBC, accusing it of exposing the US financial system to an array of financial risk including the washing of drug money from the Mexican drug cartels.

The very large sums which were

transferred from Mexico to the Miami branch of HSBC were originally deposited into the system in Mexico in cash from traditional cash businesses. The frequency, duration and scale of the transfers were later admitted to have been such that they were not considered consistent with legitimate activities. HSBC has admitted that the transactions should, like the transactions to Wachovia bank, have been positively identified earlier.

Launderers seek safety in numbers. Those involved in the HSBC case chose Miami which is a centre for transfers involving Latin America. They assumed correctly that the bank's on-site compliance staff would have been overwhelmed by the number of suspicious transactions from numerous accounts. The launderers felt there was safety in numbers, an argument which certainly applies to transactions to, from, and especially through the UK, particularly London. The bank's overseeing compliance staff were reportedly based in India and were probably using automated detection systems with limited human oversight. Both are needed. Staff numbers and staff training (or lack of it) contribute heavily to the detection failures.

Suspicious transactions are evidence of crime, but don't necessarily identify what kind of crime. The recent confiscation of assets from a drug dealer who was the son-in-law of Neil Aspinall, CEO of the Beatles Apple Corporation (London Evening Standard 15th October 2012) shows this. The bank transactions were originally investigated by the Metropolitan Police's National Terrorist Financial Investigation Unit but were found to be from drug dealing. The patterns of cash flows are typically very similar.

White collar money laundering is the same in principle as cash smuggling, but more complex. At the highest levels, these crimes see the involvement of 'deep state' national interests, which are very difficult indeed to confront. The recent reports of the involvement of Standard Chartered and RBS in dealings with Iran provide an example. The UK is especially used as a respectable transit destination for such movements as it is somewhat misleadingly considered to be clean by international law enforcement agencies and monitoring bodies. It also has a huge network of no questions asked facilitators, such as company formation agents, as a recent report in The Economist (22nd September 2012) has highlighted. The basic aim of the

creation of long corporate chains and bank accounts outside the jurisdictions of the companies – a classic giveaway is to disguise the true owner of the assets (the real or "beneficial owner"). The authors of the article asked 3700 agents in 182 countries to form 'shell' companies for them. Nearly half of the agents failed to ask for proper identification in direct contravention of the international standard for governing shell companies.

In most countries of the world money laundering is a criminal offence in itself, regardless of the nature of the criminal offence in relation to which the money laundering is carried out. Increasingly, criminals are being convicted of money laundering without proof of the original criminal being required.

WACHOVIA'S BLATANT DISREGARD FOR OUR BANKING LAWS GAVE INTERNATIONAL COCAINE CARTELS A VIRTUAL CARTE BLANCHE TO FINANCE THEIR OPERATION

However, in practice enforcement of the legislation is very difficult. Many countries with such legislation have produced very few convictions. The system in western developed countries is complex and cumbersome while in large parts of the middle income and developing world, the legal, financial and investigative infrastructures are virtually non-existent. So much needs to be done to improve the situation; the key tools of prosecution, civil confiscation and the freezing of assets need to be much more closely coordinated.

Progress is also inhibited because money laundering is 'asymmetric' as far as regulators and law enforcement agencies are concerned. Successful action in one country against an international criminal organisation might not be repeated in cooperating countries because the assisting agencies feel they are not getting sufficient credit for their role in the prosecutions: they are helping agencies in other countries without necessarily getting 'results' in their own.

Another reason why the success rate is low is because major money launderers have typically taken steps to place their assets beyond the reach of the UK's courts. Recent case successes involving Nigerian criminals have

involved positive developments with convictions and seizures of deposits and other assets and an extradition from Dubai, but the persons involved had much less political clout than the really big players such as Afghan politicians and Pakistani generals where political protection is bought for those who might be involved in drug trafficking and the financing of terrorism. Longer term, as Clare Short, former Secretary of State for International Development said, prosecution is not the only answer. There needs to be much greater civil enforcement and other regulatory cooperation between governments.

So you have a situation where major western banks have been ignoring the banking rules and governmental bureaucracy hampers intelligence gathering and sharing and that's just in countries which actually have any kind of anti-money laundering infrastructure in place. So how can the situation be improved?

The current embarrassments in the banking world do offer real opportunities. A posting to a bank's compliance department should be regarded as a positive career move and not the graveyard slot as it often is now. Banks must raise the level of training of cashier and other branch staff involved in applying the "know your customer" regulations appropriately. The banks should be enhancing their image by deploying some of their investment bankers (who know all about risk!) to support the retail banking compliance teams.

In the UK, there should be a greater emphasis on involving the tax authorities in producing improved guidance for identification of suspicious transactions, as these may well identify tax evasion too, given launderers' favoured use of cash businesses.

And then, what next? If the banking system is really tightened, how will the money launderers react? There may well be an increase in bartering of goods and services, but that has obvious practical limitations and requires unusual levels of trust, as do the hawala banking systems common in the Middle East, East Africa and South Asia and in their diaspora communities in Europe and North America. And these systems do involve cash transactions at either end, so old fashioned identification of unusually active retail outlets still comes into play.

■ **Euan Grant** is a customs, tax and border security consultant

BIRTH OF A NARCO-STATE

In Ghana, greater self-sufficiency, improvements in health care and a reduction in poverty have all contributed to its stability over the last 20 years. However, the result of the national election to be held in December 2012 has the potential to destroy these gains.

A post-election narco-state may be looming. **By Andrew Craig**

Over the last decade, drug trafficking throughout West Africa has boomed. With many of their old smuggling routes closed off, South American cartels have increasingly turned their attention to this region. Porous borders, fragile governance and widespread corruption are conditions that are open for exploitation by drug barons. So much so, that the World Bank estimates that in 2008 cocaine with a street value of \$6.8 billion was trafficked through West Africa. Seizures have risen from 100 kilos a year to 6,500 kilos a year in the decade to 2009. The United Nations Office for Drugs and Crime (UNODC) maintains that there are regional drug cartels emerging across the whole of West Africa. At the centre lies Ghana.

Although having relatively stable institutions and a functioning democracy, there is increasing evidence of the influence that the drug trade is having over Ghana's political parties.

The centre-right New Patriotic Party (NPP), in particular, has been associated with obtaining financial support from the regional trade in illicit drugs. Wikileaks have cited connections between drug cartels and the NPP. Their defeat in the 2008 elections caused some commentators within Ghana to claim that a narco-state had been averted. There was a perception locally that there had been a surge in activity by cartels during the preceding years under NPP rule.

The current administration of the National Democratic Congress (NDC) has acknowledged on several occasions that the drug trade poses a threat to the country's institutions, while simultaneously appearing unable to combat it. It is reported that in February 2010, President Mills told a U.S. Secretary of State official that Ghana was struggling with drug trafficking and increased drug use and that he feared "a bleak future for Ghanaian people". According to Wikileaks, the U.S. Embassy in Accra concluded in 2009 that the Ghanaian authorities directed 'little or no effort at pursuing middle and high-level traffickers'. It is said that Janet Douglas, a senior British Foreign Office official in Accra, warned that the drugs trade was 'becoming institutionalised' in the area. Wikileaks also revealed that a 2009 American Embassy cable claimed President Mills was aware that 'elements of his government' were 'already compromised' and that officials at Kotoka Airport in Accra tipped-off drug traffickers about 'Operation Westbridge' (a British funded and managed security programme targeting drug mules boarding planes to the U.K.).

The Director of Ghana's Narcotics Control Board (NACOB), Mr. Akrasi Sarpong, has counselled Ghana's politicians against using drug money for political gain. He claims that there is a long-standing relationship between drug money and the funding of Ghanaian

political parties. He has also stated that NACOB have information that some current politicians are heavily funded by drug barons. With the 2012 national elections pending, he warned last year in a radio interview that "NACOB will deal with any politician caught to be using proceeds from the illicit trade notwithstanding the party that the person belongs to". However, some in the political ranks have taken issue with NACOB's stance. Jake Obetsebi Lampety, Chairman of the NPP ordered Mr Sarpong to "provide evidence of his claims and avoid speaking loosely". Mr Sarpong countered that NACOB cannot be forced to disclose the identities of the individuals under surveillance, but they need to be aware that they are being observed in order to deter them from further dealings with cartels. It is debatable how capable NACOB is of influencing a politician's choice of financial backer, but its publicly aggressive stance has ensured that the issue of drug-related corruption will feature prominently throughout the election campaign. Clearly, there have been attempts to politicise this matter. However, Ghanaian political history shows that individuals involved in drugs have come from all backgrounds and are not aligned to any particular party.

Others with an interest in West Africa have expressed their unease over the deteriorating situation in Ghana.

In June 2011, the Washington-based

Center for Strategic and International Studies published a paper on Ghana entitled *Assessing Risks to Stability*. In it, the Centre makes reference to Ghana's system of patronage and weak institutions that encourages corruption and 'increases the risk of violence surrounding elections'. It rightly suggests that drug trafficking, 'particularly its increasing role in financing patronage politics' could have a destabilising impact on the country over the next decade. It further proposes that the 2012 election could feasibly act as a trigger for this. It goes on to speculate that this election 'is likely to be far more confrontational and runs the risk of being violent, with the potential to produce chaos'. President Mills' sudden death while in office in July of this year is likely to contribute further to the uncertainty surrounding the outcome of December's voting.

The UNODC reasons that, unless attempts are made to oppose the drug trade in Ghana, the legitimacy of the state risks being undermined. It is also sceptical that either of the two main parties will 'remain immune to the attractions of drug money' as the election draws near.

Kofi Annan, himself a Ghanaian, has signalled his growing concern over the proliferation of drugs being moved around West Africa. In an article written for *The Guardian* in January this year, he expressed his uneasiness over drug-funded corruption which can 'undermine good governance and the rule of law', thus threatening both democracy and security within states.

Kwesi Aning (Head of Research at the Kofi Annan International Peacekeeping Training Centre) arrived at a more worrying conclusion in claiming that the "very fabric" of Ghanaian society is at risk. "Narcotics are beginning to pose both a political and security threat to this country". He further asserted that "the trade is growing as it has been discovered that between eight and fifteen percent of the narcotics entering mainland Europe comes through Ghana".

Some diplomats and other international officials fear that certain West African countries could develop along similar lines to Mexico within the next five years. In Mexico, drug gangs have a symbiotic relationship with political parties, and this appears to be occurring in Ghana. Politicians can be bribed and coerced into the drug trade. Those who attempt to confront



trafficking may find that they meet with people and networks that wield far more power than they do. This influence appears to run through the security services. There is evidence that seizures of cocaine have vanished from police surveillance, and substances earlier confirmed by police to be cocaine were later reclassified as sodium carbonate. Along with the sabotage of efforts to combat drug smuggling, these are all common features of failing states. Dr. Clement Apaak, Convener of the Ghanaian Forum for Governance and Justice, stated that 'We must all be worried because these are the acts capable of turning Ghana into a narco-state like Mexico'. Further parallels can be drawn. Mexico also became a conduit for drugs after other more established routes from South America were closed off. The slums of Ghana's cities are ideal hunting ground for cartels to recruit members and operate in areas with little or no policing. They are able to provide local communities with facilities that the State does not supply. There is evidence that there is a growing number of addicted young people in Ghana. These same characteristics are exploited by cartels in Mexico.

The conditions necessary for Ghana to become a narco-state are evident. As Mexico has discovered, the potential impact of drug-related crime on communities cannot be understated. Like Mexico, the legitimate economy in Ghana is likely to suffer as businesses are deterred from investing in the

country. Both nations suffer widespread poverty and unemployment and the cartels provide money-making escape routes for those who are prepared to take on the risks of violence and criminality that go with drug-trafficking. And, if Mexico provides a parallel, it also seems unlikely that Ghanaian security services will be able to suppress narco-related violence, or prevent a narco-state from arising. Across the developing world, political coups often emerge out of civil unrest, and drug cartels can exploit such circumstances and expand their influence – Ghana could fall victim to such a scenario.

Some commentators have called for the establishment of a Presidential Commission to investigate the role that drugs have played in Ghanaian politics. The aim would be to develop strategies to eliminate drug-related influences from political activity. However, similar actions have been attempted in Mexico over the last decade with little success – initiatives introduced to prevent cartels accessing their politicians and security services have shown to be ineffective. Without addressing the fundamental issues that give rise to corruption in Ghana, it is unlikely that any counter-narco offensives implemented there will be successful. Until then, a contested election result may prove the catalyst for the world's latest narco-state.

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

The long strange trip

Fifty years on from the arrival of LSD in the UK and a new edition of the definitive work chronicling its history over here.

In the early 1950s, whilst innocently reviewing health facilities in Switzerland, psychiatrist Dr Ronald Sandison serendipitously stumbled upon research chemist Albert Hofmann and returned home with a box of the chemist's newly discovered compound LSD.

This year is the 50th anniversary of the first time LSD entered the UK and a fitting moment for the release of the paperback edition of *Albion Dreaming*. Dr Sue Blackmore, renowned psychologist, well known for her passionate and creative approach to neuroscience provides a heart-felt foreword. She describes the psychedelic state with all the joys and wonder, fears and mystery of a child discovering a hidden garden. There is a tangible thankfulness in Blackmore's words; a gratitude for the psycho-spiritual mental states that exist within the experience induced by LSD and its psychedelic cousins.

Roberts continues Blackmore's appreciation and respect for LSD throughout the text. There is a glossary and a list of the psychedelic movement's principle characters that makes the book accessible to all. But it is his curiosity that shines above and beyond his meticulous background knowledge. Roberts understands psychedelic drugs with an appropriate reverence and respect. He makes it clear that LSD is a force to be reckoned with, an enigmatic tool to cautiously open the mind. These drugs are an intellectual pursuit, not a plaything for the kick-seeking hedonist on a Saturday night. Or if they are to be used in that frivolous way then the lessons they teach might be even more direct and meaningful.

His admiration for the subject is born out of diligent exploration and impressive examination of the facts. The subject of psychedelic folklore is one fraught with erroneous claims and misrepresentations. Knowing this, Roberts has sought to provide an exhaustively accurate version of events – from Hofmann's first synthesis to the cutting edge research now emerging in the twenty first century. No one can promise Roberts makes no errors of his own. After all, when dealing with the subjective effects of an exploding internal universe kaleidoscopically displayed across one's vision of melting walls pouring away like a herd of technicolor giraffes onwards into oblivion, one is bound to stray from the path of objectivity at times. But *Albion Dreaming* is about as close to the impartial reality of the LSD experience one is likely to get without imbibing oneself.

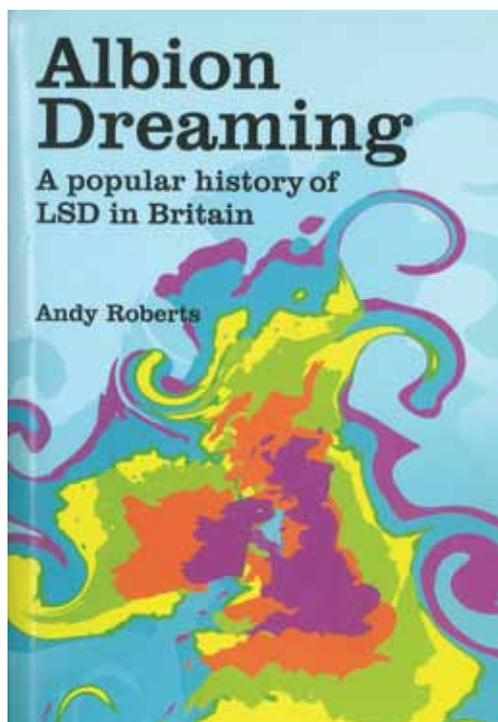
Reviews

■ **Dr Ben Sessa**, is a consultant psychiatrist and author of *The Psychedelic Renaissance*

Furthermore there is a refreshingly inherent Britishness in Robert's book. The UK may not have Woodstock and Haight-Ashbury but we do have Huxley, Stonehenge and Sergeant Pepper – not to mention the brave strides being taken by this nation into modern psychedelic research. Because in 2012 we are experiencing an undisputed psychedelic renaissance, which, if all progresses according to plan, will usher in a new era of expanded consciousness on a local and global scale to rival – if not even possibly eclipse – the considerably less-so psychedelic sixties. God (or whoever) knows such a new approach to Western living is desperately overdue. And Roberts embraces these rapid changes on the psychedelic horizon; providing alongside his duteous history of LSD an important glimpse at the contemporary emergence of new directions in psychedelic science and culture.

Drug geeks with blogs litter the psychedelic world but Andy Roberts is not one of them. His booted feet are firmly placed in the mud and forests of this sceptred isle. And as Blackmore says in her foreword Leary and friends must not be allowed to steal the show. There is a rich past of dabbling in

non-ordinary states of consciousness from these shores to be celebrated and Roberts makes sure we are left in no doubt of Britain's place in psychedelic history. So when you read this book be sure to lose your mind in Britain's green and pleasant lands. Just don't forget to be home in time for tea.



ALBION DREAMING: A POPULAR HISTORY OF LSD IN BRITAIN

Andy Roberts

Right of reply

Heroic David v Goliath drug warrior or the 'Nutty Professor'? The sacking of David Nutt provoked all shades of opinion. Inevitably he has written his own account of events and examines the evidence of drug harms for the general reader.

Reviews

■ **John Witton** is a researcher at the National Addiction Centre

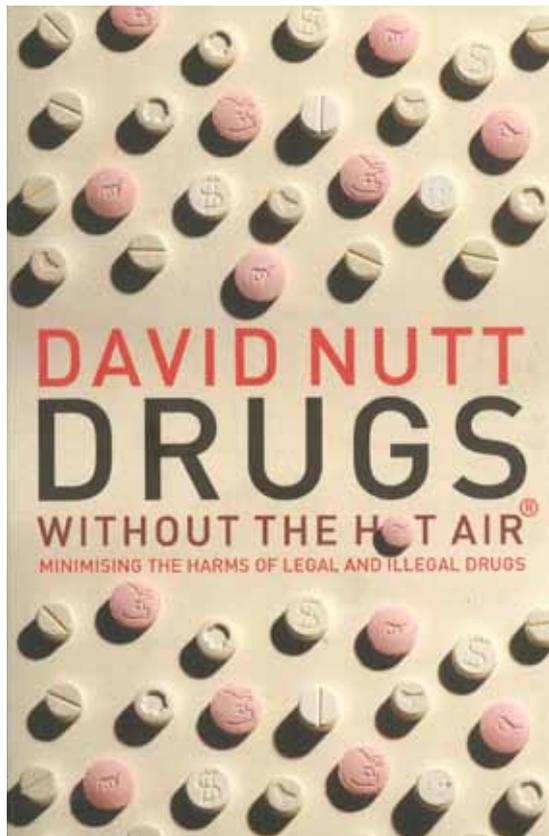
Professor David Nutt is a distinguished psychopharmacologist who has published a wide range of research papers, been involved in the strategic development of addiction research in England and has had a voice on policy making through his membership and chairing of the Advisory Council on the Misuse of Drugs. So Professor Nutt is well-placed to provide a run-through of the research on how drugs work and their effects aimed at the non-specialist reader. When his enthusiasm lets him slip into his own more biological research interests, he is at pains to take time to explain what it all means in easy-to-follow terms. So if a concerned parent or a curious teenager is looking for a reasonable up-to-date guide to illicit drugs, tobacco and alcohol or our everyday pick-me-ups like coffee to help understand our contemporary use of intoxicants and relaxants then this book might be for them.

But the purpose of the book does not stop there. As Nutt says in his book, many people are likely to recognise him as "the scientist who got sacked". It was largely for his attempts to encourage a debate on the relative harmfulness of drugs that earned him the ire of politicians who pushed for his sacking as Chair of the ACMD. And this book is a further effort to bring an attempt to scientifically measure and rank the harms of drugs to a wider audience.

While Professor Nutt is the totem of the harm ranking approach, others are involved and chapter three of the book describes the process that led to the rankings and its origins in meetings of the ACMD. The initial methodology was refined and led to the use of a multicriteria decision analysis approach, where experts from The Independent Scientific Committee on Drugs and invited specialists met to score drugs on sixteen criteria related to the harms a drug may have on an individual and others, based on the research evidence. The drugs were scored out of 100 points and weighted by the experts. Alcohol was scored at 72, followed by heroin at 55 and crack at 54, with tobacco at 26.

The method and the results have had a pretty rough ride from critics. To try and arrive at a single measure of harm when there are so many dimensions and interactions among the harm criteria used in the exercise is, for these critics, both conceptually flawed and misleading. That tobacco which is linked to so many harms scores so low in the index leads other critics to question the methods used. And with the exercise determined by a meeting of experts there is the unavoidable danger that bias is introduced into the exercise with participants with strong views and personalities determining the outcome rather than an objective reading of the evidence.

Professor Nutt tries to fend off all such attacks, acknowledging the criticisms but suggesting that they can be dealt with by further refining of the harm ranking process. I suspect that not many of the critics will be persuaded by this. But if Professor Nutt's quixotic harm ranking venture has not found many takers, his views are nothing less than thought-provoking. The usefulness of the drug classification scheme under the Misuse of Drugs Act has been under scrutiny for some time now and Professor Nutt's book is a useful provocation to foster more debate on how society views and responds to drugs.



DRUGS: WITHOUT THE HOT AIR.

David Nutt.
Cambridge UIT, 2012.

44 factsheet

Nitrous Oxide



Nitrous oxide, commonly known as laughing gas, is used in surgery for its mild anaesthetic and analgesic effects and is one of the safest medical inhalants/anaesthetics, because it has little effect on critical body functions – which is why it is a preferred painkiller for women giving birth and is used in dentistry to help relieve pain and anxiety. Favoured by the Victorians as a recreational drug, its popularity waned only to re-emerge as a recreational drug in the last few years becoming popular at parties and music festivals. National prevalence and mortality rates are not recorded. However, according to the Mix Mag Global Survey (2012), nitrous oxide was used by 27% of UK respondents and 43% of regular club goers in the past year.

users often take many 'hits' of nitrous oxide over a few hours. Nitrous oxide is normally used occasionally in a social setting, however like all drugs it has the potential for psychological dependency although this is rare.

Effects:

- Dizziness
- Euphoria
- Giggling and laughing
- Distortion of sound
- Hallucinogenic effects
- Dissociation
- Loss of balance
- Nausea
- Headaches

Although official figures are not collected for deaths related to nitrous oxide, there have been a number of deaths linked to its use, primarily due to oxygen deprivation.

Longer-term effects

Regular use can lead to red blood cell problems that could result in anaemia. There is also a risk of vitamin D deficiency with continued use in addition to a link with mood swings and depression.

The Law

It is illegal to sell nitrous oxide to under-18s, and selling it to anyone you suspect may use it for the purposes of inhalation is illegal under the Medicines Act. Whilst it is legal to sell, as a way to whip cream and possession of whippets is legal, if you are found with large amounts of whippets without a valid reason, you could be charged with intending to supply it for inhalation.

Appearance

At room temperature nitrous oxide is a colourless, non-flammable gas that is slightly sweet smelling and tasting. Recreational users often get it from whipped-cream chargers, sometimes called 'whippets', which are single-use, finger-length steel cartridges containing 8g of highly pressurised nitrous oxide.

Route of administration

In order to produce its dissociative effects, nitrous oxide is inhaled, usually by mouth.

Both whippets and crackers (a gadget which has a balloon or bag fitted) can be obtained from online suppliers and in head shops. Nitrous oxide is also found in supermarket cans of whipped cream. Other sources include full sized gas cylinders, intended for medical or industrial use.

Cost

Refills of pure nitrous oxide (whippets) for whipped cream dispensers (sold from catering shops in multiples) work out at around 50 for £14 i.e. around 28p each. Balloons already filled with gas cost around £1.50.

Dosage

A single inhalation will result in effects starting almost immediately and peaking about 10-20 seconds after inhalation and then rapidly diminishing. If the dose is repeated then effects reach a plateau about 30-60 seconds after the first breath. While the user often feels back to normal within about 2 minutes after the last inhalation some users report that effects, such as a sense of well-being, can be felt for up to 30 minutes after last use.

Patterns of use

Because the effects of nitrous oxide are pleasurable but brief, people often take it repeatedly over a short space of time;

Will intensive testing and sanctions displace treatment?

Enforce frequent drug testing and levy swift, certain and meaningful sanctions for substance use and many dependent users stop using without treatment.

Mike Ashton asks if this is the future, or just a niche option applicable to users over whom authorities can exercise sufficient leverage.

Influential US researchers have highlighted three US programmes which show that many seriously dependent individuals stop using if non-use is enforced through intensive monitoring and swift, certain, but not necessarily severe sanctions, relegating treatment to a back seat or no seat at all (1). Rather than mandating treatment, these programmes directly mandate abstinence. Since among the researchers were top White House drugs advisers, not surprisingly their perspective found its way in to the 2012 US anti-drug policy.

First of these three exemplar programmes was one for US doctors whose performance is threatened by their drinking or drug use (2). To keep practising they have to sign contracts to adhere to the programme, including completing treatment and frequent random drug testing. Substance use or any other evidence of non-compliance typically results in immediate removal from medical practice to arrange extended treatment followed by more intensive monitoring.

Second was the HOPE (Hawaii Opportunity Probation with Enforcement) programme for offenders on probation (3). Offenders are sentenced to brief jail stays for each probation violation, including illicit drug use revealed by testing; continued violations result in longer sentences. Treatment is imposed only if tests continue to be positive for drugs or a referral is requested. Compared to other offenders, those on

the HOPE programme became much less likely to test positive, missed far fewer appointments, and were dramatically less likely to be arrested.

Last was South Dakota's 24/7 Sobriety programme for drink-driving offenders, which requires twice-daily alcohol breath tests at a local police station or wearing alcohol monitoring bracelets, plus regular drug urinalyses or drug detection patches (4). Positive tests result in immediate brief imprisonment, and missed appointments in the immediate issuing of arrest warrants. Records show that over 90% of all types of tests are negative and post-programme recidivism among twice-daily tested offenders is considerably lower than among comparison offenders.

Signs of a similar approach can be found in Britain, where courts now have drug abstinence requirements at their disposal and, inspired by the US example, government is funding a trial of alcohol-detecting tags for serious drink-related offenders; detected drinking will trigger a short prison sentence.

More broadly, the UK has what is now a considerable history of implementing testing-based programmes for offenders, though generally as a way of monitoring progress and to 'grip' offenders while treatment exerts its effects. The US programmes challenge this subsidiary role, elevating testing and sanctions to the primary role and relegating treatment (if available at all) to those

unable to comply without it.

A distinctive feature of the US programmes is the strong leverage available to sanction substance use and reward abstinence: in physician health programmes, deprivation of a prestigious and well paid profession; in programmes for offenders, immediate brief imprisonment versus freedom. Results are said to challenge the view that relapse is an essential feature of substance dependence, and to demonstrate that the key to long-term success lies in sustained changes in the environment in which decisions to use and not use are made. If this rewards substance use, it is likely to continue, but the drinking and drug use of many seriously dependent individuals stops if the environment not only prohibits use, but enforces this through intensive monitoring and meaningful consequences.

The problems facing wider application include engineering or finding sufficient leverage and having both the legal authority and the resources to swiftly and certainly sanction transgressors. Without leverage, programmes risk simply siphoning non-compliant offenders into conventional penal sanctions; without sure sanctions, the programme exists only on paper and can safely be ignored by offenders.

For the full story with more information, citations and links visit:
<http://findings.org.uk/count/downloads/download.php?file=DL6.php>

SOURCE STUDIES

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NEW YORK NOTES

Our new regular columnist **Maia Szalavitz** on the panic over prescription painkillers in the USA.

The figures are startling; according to the Centre for Disease Control and Prevention, drug overdose deaths have tripled in the States since 1990; three out of four of these deaths are caused by prescription painkillers and these deaths mirror a 300% rise in sales of these drugs over the same period.

Unfortunately, America persists in misunderstanding the roots of its drug problems, which makes solving them far more difficult. When it comes to the use of prescription painkillers two myths misguide policymakers, addicted people and the public alike:

1. Most painkiller addicts were never pain patients.

Reporters love to tell the story of the poor pain patient who got hooked on Oxycontin because he just couldn't stop taking it after an accident or surgery. This tear-jerker is catnip to liberals who view the pharmaceutical industry as dedicated to exploiting innocent patients. And since drug companies so often live down to their bad image, it's easy to overlook cases that are not so black-and-white.

To make matters worse, this storyline is also beloved by addicts seeking to elude responsibility: "It's not my fault! My doctor and Big Pharma did it to me!"

But as one Florida newspaper found out to its embarrassment, the "accidental addict" narrative is rarely the full story. The man they featured under that headline as a doctor's victim didn't begin his life of crime because of pain treatment – he had a prior cocaine-dealing conviction.

However unwittingly, the Orlando Sentinel had indeed chosen a representative opioid addict: like their former coke dealer, the vast majority of people addicted to prescription painkillers were addicts before they ever asked their doctor.

One study of some 28,000 rehab patients found that 78% of people in treatment for Oxy addiction had never – not once – received a legitimate prescription for the drug. And 80% of OxyContin addicts, according to research by the National Institute on Drug Abuse, have also taken cocaine.

Unless you want to believe that pain patients are so delighted by their medical Oxy buzz that they went out and found themselves cocaine dealers, a more parsimonious explanation is that people with pre-existing addictions sought doctors to get opioids.

2. Many pain patients given opioids for chronic pain become addicted.

People who take opioids daily for a month or more will develop physical dependence. But contrary to conventional wisdom, physical dependence and withdrawal fears are not the main problem in addiction: the problem is compulsive use despite negative consequences. Many pain patients, once their pain problem has been solved, actually go through withdrawal without even being aware that the flu-like symptoms they are experiencing are linked to their drug tapering: withdrawal is only awful when it is accompanied by fear of losing your only source of pleasure and comfort, in other words, if you are addicted.

Studies regularly show that the odds that a person with no prior history

of addiction will become hooked on prescription opiates are incredibly small, up to 3%. In a recent study of some 5,000 pain patients who took prescription opioids for more than six months, a mere 0.27% showed any signs of addiction.

So, most addicts were never pain patients and most pain patients don't become addicts: this means that the problem is not in doctors' offices, but elsewhere.

So what does all this mean for the "painkiller epidemic"? The good news is that opioid addiction is relatively rare, even when large numbers of people are exposed to these drugs. The bad news is that we try to fight the problem by ignoring the facts.

Virtually all of the Obama administration's initiatives are focused on "educating" doctors and tracking their patients and prescribing. But given that most addicts aren't patients – and most patients aren't addicted – this is more likely to harm pain treatment than help addicts.

To develop drug policies that work, we need to base them on what addiction is really like, not on the stereotypes the media presents. Rather than trying to cut opioid supplies, we need to better understand opioid demand – and to directly fight overdose death with measures like widespread distribution of naloxone, the antidote that can reverse overdose.

A Bridge Not Far Enough

Walk the line (Druglink July/August) clearly demonstrated the vulnerable position that service users can be placed in when the recovery agenda is poorly understood or implemented. The change of emphasis in the 2010 Drug Strategy has done more than simply shake the complacency of some drug services who had put more effort retaining service users in treatment rather than helping them move through the treatment process. It has now become the ideologues' charter, reinforced in March by *Putting Full Recovery First*, which describes an agenda focused on "full independence from any chemical." But in many areas neither commissioners nor providers have a clear understanding of the critical concept of recovery capital.

Recovery capital has been defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD (alcohol and other drug) problems". It has been categorised as having four components; social capital, physical capital, human capital and cultural capital; with the integration of social, human and cultural – as particularly important. Recovery had previously been defined by the UK Drug Policy Commission as "voluntarily sustained control over substance use" but is now seen as "full independence from any chemical". We now have an abstinence-based policy underpinning the implementation of recovery within a framework of payment by results.

Recovery should be about the ability to integrate back into society, not being maintained in a network that is built around the problem they have hopefully resolved. Poor commissioning is

promoting the establishment of groups bound together by 'bonding capital' rather than 'bridging capital'. Bridging capital describes closer connections between people and is characterised by strong bonds. It is often provided by horizontal networks of family and socially similar others at a local level. Crucially it is good for *getting by* in life. Bridging capital on the other hand, describes more distant connections between people and is characterised by weaker ties which connect them to wider social networks – friends of friends, acquaintances – creating opportunities. It is good for *getting ahead* in life.

Increasing an individual's recovery capital can signal a turning point in their drug use and ability to benefit from treatment. However, merely relying on developing bonding capital is not going to deliver the quality and quantity of recovery capital required to deliver successful outcomes both in and out of treatment. The role of the recovery champion within this context is very exposed and vulnerable. While they may possess charismatic qualities they will frequently be poorly connected outside of their historical peer group which is key to helping people get ahead. This is characterised by the weakness of strong ties, whereas success is greater when there is strength in weak ties.

As Perri 6, (the noted British social scientist David Ashworth who famously changed his name) observed in relation to job training, in most cases it puts unemployed people only in contact with other unemployed people on the same course, who, if they are weakly tied, are links to people who cannot, in most cases, offer them many opportunities

for making an exit from poverty and unemployment. Few programmes of job training impart the kinds of skills that people need to work networks of weak ties.

Similarly, poorly supported recovery champions will put recovered drug users only in contact with other recovered drug users, who, if they are weakly tied, are links to people who cannot, in most cases, offer them many opportunities for making an exit from poverty and unemployment. Too few recovery programmes impart the kinds of skills that people need to work networks of weak ties.

To paraphrase Perri 6 again – a network that is rich in weak ties which span holes in social networks to reach acquaintances and friends of friends across many walks of life proves to be much more effective – at least in the long run – than having a narrow network of strong ties to kin, immediate neighbours and people much like oneself.

Unless commissioners and service providers clearly understand the type of recovery support they are developing and its relationship to opportunities in the wider society, then they are missing the point of the concept they are attempting to implement. In all this, the recovery champion, will fail to be the vector of recovery contagion, promoting the spread of recovery capital, but will instead remain the standard bearer for a group of highly vulnerable people prone to relapse.

■ Paul Wells is an independent commentator on drug policy

A person wearing a grey hoodie and dark pants stands in front of a weathered, grey concrete wall. The wall has some graffiti and peeling paint. In the top right corner, there is a purple circle containing the text 'DrugScope'.

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