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Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- Older users
- ACMD recovery
- Legalisation
- Krokodil

Talking 'bout my generation

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Druglink

Happy New Year... eventually

Belatedly, it falls to me to wish all our members and subscribers all the best for 2014. For this first issue of the year, we take an extended look at the situation regarding the older user. Most of the media and political attention surrounding drugs and alcohol tends to focus on young people, but as recent research indicates, substance misuse problems among older people is hidden in plain sight, but are likely to put more pressure on services as the population ages.

We look at this issue from a number of perspectives; DrugScope's Gemma Lousley summarises the findings of a report on service responses that DrugScope is publishing on behalf of the Recovery Partnership. We have conflicting views on how relevant the recovery agenda is for the older user and a look at services for the older drinker in Southampton, while Max Daly looks at another neglected group, the older recreational user. Finally, we reprint an article from 2010 concerning the overdose death at 60 of user activist Chris Drouet.

Developments in Uruguay and the USA raise the question – have we reached a tipping point in the legalisation of cannabis? It is one of the key questions put to Transform's Steve Rolles in the Druglink interview. Having failed to drum up a crystal meth epidemic in the UK, the media have turned their attention to Krokodil, whose sighting in the UK remains entirely unconfirmed. But in Georgia, the problem is all too real as Michael Bird describes.

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

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

Features

Regulars

Two more US states adopt welfare drug testing

As legalised cannabis was being noisily heralded in the US states of Colorado and Washington, less was being made in the media of events in Minnesota and Kansas.

On January 1, despite widespread criticism of the strategy, the two states became the ninth and tenth in America to usher in laws to drug test people receiving welfare benefits.

In the mid-western state of Minnesota, the new law is aimed at preventing drug users from receiving public assistance. It hopes to achieve this by compelling benefit recipients with a past conviction for a drug felony offence to identify themselves for random drug testing.

According to Minnesota state records, 1.62 per cent of the 167,000 people on the state assistance programmes to which drug testing will apply, had a felony drug conviction in the past 10 years. This compares to about 1.2 per cent of the general population.

"I don't think anyone is under the illusion that this is about saving taxpayers money," said Heidi Welsch, director of family support and assistance for Olmsted County told the *Minneapolis Star-Tribune*. "This is punitive."

Meanwhile in Kansas, the new law, expected to cost $1 million a year, will "require urine tests of any welfare recipient suspected of using illegal drugs. That could be triggered by a person's demeanor, missed appointments or police records".

Critics of welfare drug testing point to Missouri which introduced drug testing at a cost of $500,000 a year in 2013. After eight months and 636 drug test tests, the tests resulted in 20 people testing positive and about 200 who refused to comply.

Florida's drug testing scheme ended in ignominy. Of 4,086 drug tests over four months in 2011, 108 tested positive. However, a court ruling halted the programme, on the grounds it violated welfare recipients' constitutional rights by requiring them to undergo testing regardless of whether they were suspected of using drugs.

The Sunshine state spent $115,000 on the testing and was forced to reimburse welfare recipients who had lost their benefits.

In Oklahoma, 83 out of 1,890 welfare recipients drugs tested positive between November 2012 and May 2013.

Cannabis cash

America's burgeoning number of legitimate cannabis entrepreneurs fear they will become targets for robbery because banks are refusing to accept the 'green dollar'. Banks have so far shied away from providing services to marijuana businesses because they fear federal regulators and law enforcement authorities might punish them under money laundering rules.

"Carrying such large amounts of cash is a terrible risk because there is the fear that the next car pulling up beside me could be the crew that hijacks us," Ryan Kunkel, who owns five cannabis dispensaries in Washington state, told the *New York Times*. However, the US Attorney General has just announced that the government would soon be helping lawful marijuana businesses to gain access to the banking system.

Ketamine: the student drug

Students are four times more likely to use ketamine than non-students, fresh analysis of government statistics has revealed.

A study carried out by criminologists at the University of South Wales found five per cent of full time college or university students in England and Wales aged between 20-22 said they had used ketamine in the last year, compared to one per cent of non-students of the same age.

Using responses from the 2010-2011 Crime Survey for England and Wales (CSEW), the researchers found ketamine use was the only major difference in drug use between students and non-students.

Among the students, the most prevalent drug was cannabis, with 19 per cent having used the drug in the last year. Then came mephedrone (6.5 per cent), ecstasy (6.1 per cent), cocaine (5.7 per cent) and ketamine (5 per cent).

One of the biggest influences on students taking drugs was living away from their parents. These students were four times more likely to take drugs than those living at home.

Students were three times more likely to take drugs if they were non-religious and if they were frequent pub and club visitors. Men were marginally more likely to take drugs than women and white people more likely than non-white. Household income had no impact.

Top doctor criticises ministers over minimum pricing U-turn

Plans to introduce minimum pricing for alcohol were dropped by government ministers who sat on vital evidence and submitted to pressure from the industry, according to one of the country's most senior doctors.

Writing in the *British Medical Journal* (BMJ) in January, Professor Sir Ian Gilmore, the Royal College of Physicians' special adviser on alcohol, expressed his "dismay" at the way commercial interests had come before public health to derail minimum pricing.

The policy, aimed at reducing the harms of the drug, was ditched in July last year despite being backed by David Cameron. Home Office minister Jeremy Brown told parliament he lacked "concrete evidence that its introduction would be effective in reducing harms… without penalising people who drink responsibly".

However, as Gilmore points out, a University of Sheffield report commissioned and seen by the

government that detailed this evidence was mothballed until after the announcement.

Gilmore cites an investigation by the BMJ which revealed ministers and officials had numerous meetings with representatives from large drinks firms and major supermarkets – those with the most to lose from minimum pricing laws – even after the consultation had closed.

"Taking advice on health policy from those with direct commercial interests has not been successful in the past, most notably in the case of tobacco," wrote Gilmore. "We should not be surprised therefore to read that evidence-based alcohol policy in the UK has been systematically subverted by those who supply or sell the product."

In 2012 the Prime Minister said that minimum pricing would mean 50,000 fewer crimes each year, while cutting alcohol-related deaths by 900 a year by the end of the decade.

The Department of Health has denied accusations it favoured the alcohol industry during the consultation process, saying it met an equal number of times with heath campaigners. A spokesperson from the Home Office said: "A range of evidence was considered as part of the consultation on our alcohol strategy, which informed the government's decision not to proceed with minimum unit pricing at that time."

Drug elf made film as 'social experiment'

A student who became an online hit after friends filmed him taking Class A drugs while working as a Christmas elf says he did it as a "social experiment".

Police, his local council and one national newspaper expressed distaste after a film of journalism student Sam Briggs wearing an elf outfit and wrapping presents for customers at a market stall in Watford, Hertfordshire – while high on a different drug each day – was seen 500,000 times on YouTube.

Briggs, studying for a journalism degree, was filmed on separate days taking cocaine, LSD and ketamine. In the videos he appears benevolent, but struggles to carry out his work and at times says bizarre things and makes strange noises.

On his YouTube page, Briggs, who last year made a similar video high on cannabis, ecstasy and magic mushrooms while doing market research, described his films as a "social experiment". He handed in his first film as part of his journalism course work.

Briggs said he was aiming to "juxtapose the drug taking experience, set against the stark contrast of the working environment, hopefully making for an entertaining outcome."

Although the police said they would speak to him, so far they have failed to contact Briggs. He says he made the films fully aware of the fact he could not be charged by police because the footage offered no proof of drug possession. However he admitted that the experience was not as enjoyable as he had hoped and that he suffered each day after his drug use.

China's huge meth industry unveiled in dramatic village raid

A village in southern China notorious for its involvement in the production and trafficking of methamphetamine has been raided in a massive police operation involving helicopters, speedboats and 3,000 military police.

Days before the new year, they descended on the village of Boshe, Lufeng city in Guangdong province, where police say a fifth of households were " directly or indirectly" involved in the drug trade.

The authorities, which had been prevented from raiding the village for several years by blockades and armed defenders, arrested 182 people and found three tonnes of the drug, most of which was destined for distribution within China's borders.

Police estimate Lufeng city and its surrounding area is the source of a third of the country's methamphetamine supply. Police detained the village's Communist Party secretary and a local police chief for allegedly protecting the gangs running the drug operation.

A local newspaper reporter who went on the raid said: "Boshe was filled with a strange chemical smell. [We entered one] residential house and found that all the rooms apart from the bedroom were being used to make crystal meth. The rooms were packed with barrel after barrel of brownish, half-finished products giving them the appearance of soybean sauce workshops," wrote the reporter.

The Boshe raid was part of Operation Thunder, an anti-drug trade drive launched in China last year that has so far resulted in 11,000 arrests and the seizure of more than eight tonnes of drugs.

Operation Thunder police chief Qiu Wei said Boshe was the "tip of the iceberg" of the area's involvement in the illegal methamphetamine trade. "This raid is just the beginning, not the end. We will launch a second raid, a third raid and many more."

Father overdosed on morphine-like legal high

An insomniac was killed after taking an accidental overdose of a legal, morphine-like research chemical he had bought over the internet.

Computer technician Jason Nock, 41, from Birmingham had been buying the synthetic morphine substitute, AH-7921, to help him sleep for more than a year. He had almost five times the usual fatal quantity of the drug in his system when he overdosed at his home in August last year.

At Nock's inquest, in January, coroner Robin Balmain promised he would approach the Home Office to try and get the drug banned. His partner, Lea Maninang said Nock used it for insomnia but was not addicted to the drug.

AH-7921 is described in the *British Journal of Pharmacology*, as "a narcotic analgesic having high addictive liability". Its use started to be documented and discussed on drug forums in 2010 and it is now widely available for sale over the internet.

In 2013 AH-7921 was found to have been used as an active ingredient in "synthetic cannabis" products in Japan.

- A man was jailed for intent to supply 161 grams of the banned heroin-type drug 6-MAM in Guernsey. Ciaran Winterflood was caught with the substance, an organic compound of morphine with similar effects to heroin, in September.

  The court was told the amount of 6-MAM in Winterflood's possession had a potential street value of between £75,000 and £120,000 and that the drug had not been seized on the island before.

RECOVERY FROM DRUG AND ALCOHOL DEPENDENCE: WHAT DOES THE EVIDENCE TELL US?

This is the second report of the Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee. What follows is a 'plain English' summary of the report which readers are encouraged to share with/send to key partners such as Commissioners, Directors of Public Health, Police and Crime Commissioners and others to aid understanding of the key issues.

Summary prepared by **Harry Shapiro**

What is recovery?

You would think that the answer to that question is simple; somebody is recovered from drug addiction or alcoholism when they stop taking drugs or drinking. And for some people, that is exactly what it does mean. Recovery equals abstinence. But as the studies show, particularly from the USA, it isn't that straightforward. Some studies, for example, use the word 'remission' rather than 'recovery'. What that means is that the individual's drug and alcohol use has changed, so they no longer fit the clinical definitions of dependence. They may be abstinent, but they might also be using drugs or drinking in a non-dependent way.

Furthermore, even if somebody is totally alcohol and drug free, doesn't mean that they are making real progress in their lives or 'recovering'. Obviously it's a step in the right direction, but what if they have no friends, no social networks, nobody who really cares about them? What if they have no secure housing or no job and nothing to look forward to, no investment in the future? What is the most likely outcome? They will start using again.

Even the words can be misleading like re-covery or re-integration into society. These words suggest that most people in this situation are trying to get back to what you and I would regard as a normal life. But many of those with serious drug and alcohol problems have never had a normal life, they don't know what that looks like. They may have been the victims of child abuse, come from seriously dysfunctional families, never had any stability in their lives, certainly never had a proper education or held down a job. Part of their recovery is learning how to do the things that we all take for granted like dealing with authorities, filling in forms and so on.

So the ACMD Recovery Committee concludes on this point that recovery can mean different things to different people. Simply being drug or alcohol-free is not by itself recovery and involves a whole range of other important features of a decent life. In the same way

that a business needs financial capital to get off the ground, so people need other sorts of capital to get their life on track.

Drug and alcohol dependence: not just one 'condition'

There are a whole range of factors that determine just how severe somebody's problems might be; what drug (s) are they using, how frequently, for how long plus all the elements that make us individuals – our personality, our background, our economic and social circumstances and so on. In the same way that dependency is not just one problem, those people experiencing that problem are all different too.

Evidence suggests that while the road is long and difficult, many people do recover and most importantly, the more of that human capital they have, the better their chances. So if somebody had a job before they experienced problems, they have a better chance of getting back into employment later on. However, the outcomes for people do differ depending on the primary drug problem, so it is more difficult for heroin users than, for example, cocaine users – and more difficult for those who have experienced serious ill-health on top of their drug use (like hepatitis through heroin injecting or cognitive problems caused by dependent drinking). So recovery is a process, and not necessarily an end point because some people may never recover.

Health warning!

No, not about drugs or alcohol, but about the evidence itself. There is a lot of evidence out there about recovery, but it can be difficult to interpret the findings:

- It's hard to compare studies that define recovery outcomes differently; for example, some on abstinence, others on remission
- Different studies have different cut off points beyond which people are defined as successfully drug or alcohol free. The top experts suggests that sustained success can only really be judged after five years
- If you are doing long-term follow up studies over years, how do you keep track of everybody? If people are lost to the study, are they counted as successes or failures?
- As said above, levels of severity of dependence vary enormously, so trying to compare studies can be like trying to compare apples and pears.
- Having said all that, though, the Recovery Group looked at over 400 studies and within that mass of data some consistent and substantiated themes have been identified.

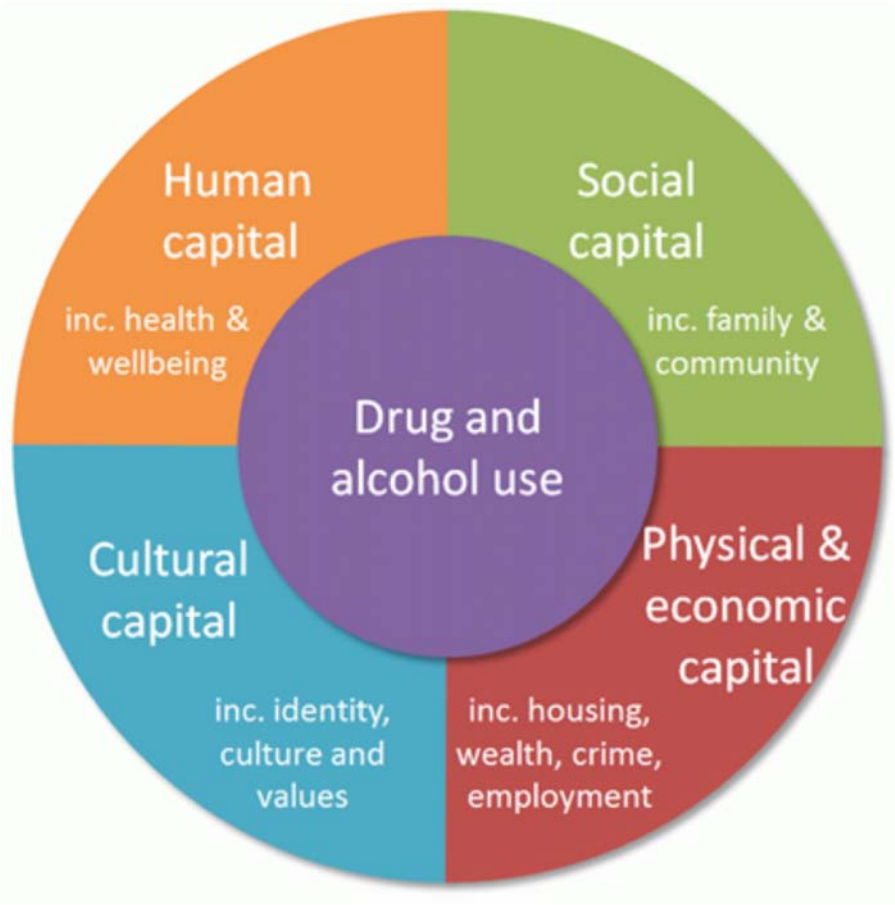
So what do the outcomes for recovery look like?

The big picture

Most of the studies come from America and use this term 'remission' – and that doesn't necessarily mean being totally drug and alcohol free, but would also include controlled use such that the person was no longer dependent. On that basis, the studies show that the average remission rates for drug and alcohol dependency are in the range of 40%-50%, taking into account small and large studies and those either side of a five year follow-up benchmark.

Are there differences between different substances?

Short answer – yes. Sustained recovery or remission from heroin dependency is the toughest nut to crack and even harder if the person was also using crack cocaine. The prognosis for alcohol dependency is more encouraging, better still for cocaine and best of all for cannabis.



This diagram summarises the factors that support or undermine the effort of individuals to overcome their drug or alcohol dependence. Drug and alcohol use is at the centre, and the influencing factors can be categorised as: human capital, physical and economic capital, cultural capital and social capital. If each of these is improved, the prognosis for successful control of the addictive behaviour improves.

Recovery and substance misuse treatment

There is evidence that some people dependent on drugs or alcohol recover without any formal treatment interventions. But most people will need some professional help and most of the evidence about recovery comes from those who have been in treatment.

Treatment 'works', so long as it is of good quality. Where this is in place, we can expect to see:

- Improvements in individual health
- Reductions in crime
- Reductions in the spread of blood-borne viruses like HIV and hepatitis
- It is also proved to be cost effective and can play an important part in the initial stages of recovery

BUT…another health warning. Drug treatment is just the start of the recovery process. By itself, it is often not enough, and the beneficial impact can fade quickly. In the UK, the treatment system is largely geared up for heroin users, so most of the available data on treatment outcomes focuses on that group. Studies have shown that it can take years to become free of dependence on heroin – if it happens at all – during which time many people will be in receipt of a prescription of an opiate substitute like methadone. There are often relapses and people can come in and out of treatment several times, trying different interventions including residential rehabilitation. That said, the evidence shows that people will often stay longer in treatment each time. Even so, it is a tough process with no shortcuts and this underlines another important point – the research is clear that any attempt to force people into detox or to impose time-limited prescribing is counter-productive and further increases the chances of relapse.

Capital concerns

Mentioned above is this idea that all of us need different sorts of 'capital' to lead a normal, productive life. To carry the financial metaphor a step further, those with serious drug and alcohol problems will have many capital 'deficits'.

Health

At the risk of stating the obvious, this group are likely to suffer a whole range of illnesses and ultimately have a shorter life expectancy than the general population. Lifestyle factors like poor nutrition, poor levels of hygiene, bad housing , violence and other factors associated with poverty and deprivation will exacerbate the health problems.

Social support

Rebuilding family relationships can be a critical part of the recovery process. But at the same time, those with drug and alcohol problems often come from troubled and dysfunctional families and families like this can also hinder recovery.

Evidence from the USA of 12-step fellowship groups demonstrates the importance of the support of mutual aid groups, although again this has to be voluntary rather than part of any programme of coercion.

Crime and economic outcomes

The relationship between drugs and crime is not straightforward, but very generally those with serious drug problems are more likely to engage in the types of crimes aimed at raising funds for drug purchase, such as shoplifting. Drug treatment assists in crime reduction, but having a criminal record will be a significant hindrance in the recovery process, especially when it comes to finding work. All the evidence shows that the employment prospects for those in recovery are not good, although probably better for recovering drinkers than drug users.

Cultural capital

This is harder to define, but is really to do with how the person sees themselves in the world, their self-esteem, and how the world responds to them. Can the person begin to see themselves in a different light other than 'drug addict' or 'alcoholic'? Will family and the local community accept that this person is trying to rebuild their life and not make judgements based on how the person used to be? The research underlies the importance of 'moving on' by building non-drug using networks and conversely, where there is stigma and discrimination, this can inhibit somebody seeking help in the first place.

So what can we conclude from all this? Are there reasons to be cheerful?

Yes. Most people will achieve a range of recovery outcomes, especially if they have support. Many people will be able to maintain abstinence or have sustained control over drug or alcohol use and it is important that supporting sustained recovery remains at the heart of the national drug strategy.

That said, we must not make the mistake that of imagining that recovery is a quick and easy process dependent simply on a bit of will power. There are many ways into addiction and also many ways out. How people make that journey and how successful they are will vary from person to person. Some people may never recover, however much support they receive, yet it would be impossible to predict who they might be, except to say that the less capital people have, the worse their chances.

So what should the response be ?

1. One size does not fit all. We need more investigations into 'what sort of recovery works' for different groups (drugs/alcohol; men/women; heroin/other drugs and so on)
2. There is no quick fix. Policy makers and local commissioners need to be wary of expecting quick results in terms of recovery outcomes.
3. Investment in treatment remains very important. But that is not the whole solution. There needs to be more broad-based investment to help build recovery capital especially for those groups like heroin/crack users whose recovery journey is the hardest.
4. Local commissioners should encourage the development of mutual aid and community-based recovery organisations
5. We need to find ways of tackling stigma in society which both discourages people from seeking help and inhibits recovery.
6. Government should be funding an in-depth examination of international recovery outcome studies and commissioning original long-term UK-based research into recovery outcomes.

To read the full report, please go to https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013

To read the first report by the ACMD recovery committee, please go to https://www.gov.uk/government/publications/acmd-recovery-from-drug-and-alcohol-dependence-an-overview-of-the-evidence-2012

No silver lining

Problematic drug and alcohol use among older people is on the rise and health services must adapt. Following a roundtable discussion on the issue last year, DrugScope is set to publish a major briefing on the subject. **Gemma Lousley** explains

Substance misuse among older people hit the headlines in November last year when Reverend Paul Flowers, the 63-year-old former chairman of the Co-operative Bank, was caught buying cocaine and crystal meth by the *Mail on Sunday*. In December, the media splashed on a story about rising numbers of people aged over 65 ending up in A&E because of their recreational drug use.

It is no coincidence that stories about older recreational drug users are becoming more frequent. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimated that the number of older people with substance use problems will more than double in Europe between 2001 and 2020.

On behalf of the Recovery Partnership, DrugScope will in February be publishing a briefing that looks at the range of issues around the subject of older people and substance misuse, from older people who are drinking above recommended limits, to those with entrenched drug and alcohol problems. It will also cover the misuse of prescribed and over-the counter (OTC) medications by this group.

Clear from the outset of our research has been the lack of homogeneity among older people who use substances problematically. They have diverse needs, and experience a number of barriers to accessing help. Therefore a range of interventions is needed to support them.

It's important to note that there is no agreed definition, age-wise, of older people with substance misuse problems. In the case of the ageing heroin-using population, those aged 40 and over may be defined as 'older', while some alcohol services for older people are targeted at those aged 55 and over. We took a decision to scope out the wide range of overlapping issues in this area, rather than starting out with a fixed definition of who 'older people' are.

Older people make up a small proportion of those in alcohol treatment – just three per cent of men and women in treatment are aged 65 and over. However, a significant number of older people are drinking at risk: an estimated 1.4 million people aged over 65 currently exceed recommended drinking limits. As Dr Sarah Wadd of the University of Bedfordshire highlighted at a roundtable DrugScope event in October 2013, it's likely that these figures will rise, as baby boomers, who have drunk more in middle age than previous generations, make the transition into old age.

Although, overall, the number of people in treatment for illegal drug use is falling, the number of people aged 40 and over in treatment is rising. Overwhelmingly, this ageing population is made up of heroin users. But illicit drug use among older people is not just about the ageing heroin-using population. A 2012 study carried out by the Institute of Psychiatry, *Prevalences of illicit drug use in people aged 50 years and over from two surveys*, concluded that "use of some illicit drugs, particularly cannabis, has increased rapidly in mid- and late-life", highlighting that "prevalence may rise as populations for whom illicit drug use has been more common and acceptable become older".

Data about the prevalence of misuse of prescription and OTC medications is limited. However, we do know that those aged over 65 use about one third of all prescribed drugs, often including benzodiazepines and opioid analgesics. While it may sound odd to talk about 'poly-drug use' in this context, this can also be an issue for older people, particularly where prescribed and OTC medications interact with alcohol.

It has been estimated that two-thirds of older people with alcohol problems fall into the 'early onset' category – people who have a long history of alcohol misuse that persists into old age. For the remaining third, alcohol problems begin later on in life, often as a result of stressful life events linked to the ageing process, including retirement and bereavement. Social isolation and loneliness have also been identified as a significant cause of alcohol problems, and substance misuse more generally, among older people.

The same broad distinction can also be made for illicit drug use. On the one hand, there are ageing heroin users in specialist treatment, as well as those who aren't 'growing out of' casual drug use. On the other, some recent studies have highlighted instances of 'late onset' use, with one 2012 study, *Treatment experience and needs of older drug users in Bristol, UK,* noting that "older people are often exposed, as a matter of course, to many of the stress factors that may trigger drug use, such as bereavement, financial restrictions, isolation and ill health". With prescribed and OTC medications, increased levels of discomfort and pain in older age play a role in their misuse by older people, which can be intentional or inadvertent.

There are particular risks associated with alcohol and drug misuse in older people. As the Royal College of Psychiatrists noted in its 2011 study, *Our invisible addicts: First report of the*

Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists, physiological changes associated with ageing mean that older people are at increased risk of adverse physical effects of substance misuse.

Physical problems associated with alcohol use include coronary heart disease, hypertension and strokes; liver problems, including cirrhosis; and cancer of the liver, oesophagus and colon. In terms of mental health problems, depression and cognitive impairment, which are common in older people, may be associated with alcohol misuse. Alcohol may also interact with prescribed and OTC medications, exacerbating side effects or causing other problems.

Long-term medical conditions, including hepatitis C, can be a particular issue for older people with a history of drug problems, although they may not be receiving treatment for these. There is also a higher risk of overdose for older drug users, especially in cases where alcohol and benzodiazepines are being used 'on top' of illicit drugs, particularly opiates.

Alcohol use can be associated with falls in the elderly, and older people with substance misuse problems may also be vulnerable to exploitation – for instance, if they are unable to leave their home as a result of mobility problems, they may rely on others to purchase alcohol or other substances for them, with associated risks of exploitation.

While policy documents such as the 2010 Drug Strategy and the 2012 Alcohol Strategy make passing references to the needs of older people, it is hard to disagree with the assessment of the Royal College of Psychiatrists, which said in its *Our invisible addicts* report: "The current situation in terms of a policy framework for the prevention of substance misuse by older people and the planning and provision of services for its treatment is generally characterised by a disturbing silence."

In light of this, it's unsurprising that frontline services don't always respond well to the particular needs of this age group. Older people can encounter a number of barriers to support: mixed-age drug and alcohol services may not feel a particularly comfortable environment for them, and some of these services may have an age cut-off.

At last year's DrugScope roundtable event, it was highlighted that residential substance misuse services regulated by the Care Quality Commission will not usually accept those aged 65 and over. Transport or mobility difficulties

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THERE CAN BE A LACK OF AWARENESS THAT SUBSTANCE MISUSE CAN BE AN ISSUE FOR OLDER PEOPLE, OR A RELUCTANCE TO ASK EMBARRASSING QUESTIONS

may stop older people from physically getting to a service, yet home visits may not be offered to address this. Those experiencing problems with prescribed or OTC medications may not know where to turn for help – and help that is available may not be well advertised.

Professional attitudes – across the range of professionals that may come into contact with older people – can also act as a barrier to help. According to *Working with older drinkers*, a 2011 report for Alcohol Research UK, there can be a lack of awareness that substance misuse can be an issue for older people, or a reluctance to ask embarrassing questions. There can also be an attitude that older people are too old to change, or a belief that it is wrong to deprive older people of alcohol because it is their last pleasure in life, even in circumstances where there are real grounds for concern.

Barriers to support can be personal, too: older people may feel embarrassed about asking for help, and some longer-term users may feel reluctant to engage with substance misuse services because of 'failure' in the past. With particular reference to alcohol, there may also be limited awareness of 'safe' levels of consumption, or levels of alcohol consumption may not be identified as a problem.

Our research highlighted a range of interventions that may be appropriate. The importance of social groups and activities was emphasised throughout the research process, as a response to the loneliness and isolation that older people may feel. The role of meaningful engagement and the importance, for those who have retired, of finding a substitute for work, was also highlighted. At the roundtable, it was suggested that a key development for substance misuse services could be making links with existing services in the community to enable this.

Outcomes appropriate to older people will not necessarily be 'recovery-oriented': for non-dependent drinkers, the goal is to reduce the risk of alcohol-related harm, which does not necessarily require abstinence, and abstinence may not be a realistic goal for some older people with long-term substance misuse problems. There is a flipside to this, however. At the roundtable, it was suggested by some participants that there is a 'dangerous myth' that recovery doesn't apply to older people with longer-term problems, and a damaging lack of ambition for them as a result. In fact, evidence indicates that older people do as well in treatment, and sometimes better, than their younger counterparts.

Home visits can be crucial. Some older people who have long-term alcohol problems may experience cognitive impairment, including dementia and Alzheimer's, which needs to be recognised when assessing them and providing support. Support from peer mentors, too, with a focus on the use of 'real peers' – older people with experience of alcohol and drug problems – can help to cut across the stigma that some older people may feel.

Although a significant number of older people are drinking at risk, the majority are not alcohol dependent, and will not need to engage with specialist substance misuse services. But professionals working across the health and social care field – including in older people's mental health services, for social care providers and in residential services – are well placed to conduct screening and deliver advice. For substance misuse practitioners too, training and workforce development is crucial, so that they are able to identify problems among older people and respond appropriately.

Gemma Lousley is Policy Officer at DrugScope

HEAD TO HEAD

Is 'recovery' relevant to older drug users?

The recovery agenda shifts the focus of treatment to a positive vision of wellbeing and freedom from dependence. But is it realistic for older people to expect a fulfilling life beyond drugs, or is it just a box ticking exercise? **Rebecca Lees** hears both sides of the argument.

Ryan Campbell *is the CEO of KCA, a Kent-based drug, alcohol and mental health services organisation. He believes that older people should not be written out of the recovery agenda and that people of all ages have the right to – and can achieve – a fulfilling life.*

"People are definitely using drugs later in life. They used to tend to stop by the time they were about 30 but now people in their 40s, 50s and beyond are using recreational drugs, and we can assume that about a quarter of these have a problem. They are the baby boomers who haven't settled down. Alcohol use later in life is another trend again. I think it's related to depression and anxiety due to life factors associated with older age.

There are hardly any services for older people. Obviously all the services are available to older people but I'm aware of very few services nationally which are targeted specifically towards them. There are quite a few alcohol and mental health services but, when it comes to drugs, really there is very, very little and I think it's because of two things.

Firstly, we don't understand the population. We are only just becoming aware of them and our needs analysis is not effective in that population. Secondly, we stigmatise older people with drug and alcohol problems. Every service provider will say it's appalling and that people should recover and have a happy and more productive life whatever their age but, increasingly, there is an attitude towards older people of 'why bother' and that young people are the future. I'm hearing people say things like 'you can't teach an old dog new tricks' and that where older people have entrenched drug and alcohol abuse patterns, the only thing is to keep them alive.

Yet I don't see any evidence whatsoever of this and, in fact, the evidence points in the other direction. The age group with the best outcomes from the 12-step programme is the 55 to 77-year-olds. There was also a study in north west England showing that people over 40 were more likely to complete a course aimed at not using additional substances. If you go around saying that something won't work, it won't work. But I think the chances for older people are exactly the same as for everyone else

and they have just as much right to a fulfilling life.

It is realistic for older people to be included in the recovery agenda, in the same way that older people should be included in all of life. Even if people are not of 'working age' they can still contribute in the ways that older people contribute to our society, as grandparents, volunteers and citizens, as well as learning new skills and getting the most out of life. We haven't undertaken any studies comparing attitudes of people of different ages, but yes, older people feel positive about their future if their future is positive, just as many younger people feel pessimistic about their futures sometimes.

Studies on wellbeing across the whole population show that, on average, people aged 50 and over have greater wellbeing than any other age group. That's partly about attitudes to the future. Where older people have factors that affect their wellbeing though, like drug and alcohol issues, their wellbeing can be very low, which is why older people are particularly at risk of depression. I believe that most of the time that's fixable.

The difference is whether older people feel that a service is for them. If it's predominantly focused on people aged 18 to 35, there can be an implicit message to older people that it's not for you. We need to understand more about the challenging patterns of drug use. It may be that people don't want a specific older person's service, so I'm not necessarily advocating setting up an Age UK drugs service. But it could be a good thing for some people. Outside of the opiate population, we know hardly anyone is accessing services and we need to know why."

I'M HEARING PEOPLE SAY THINGS LIKE 'YOU CAN'T TEACH AN OLD DOG NEW TRICKS' AND THAT WHERE OLDER PEOPLE HAVE ENTRENCHED DRUG AND ALCOHOL ABUSE PATTERNS, THE ONLY THING IS TO KEEP THEM ALIVE

Maggie Park

(not her real name), 61, is a long-term methadone user who doesn't believe that the recovery agenda works for older people. She has been unemployed since 2011, when she was made redundant from her job at a drugs helpline, and says the idea of finding a new job or coming off methadone is unrealistic.

I started using heroin in my mid-20s. I used to smoke a bit of dope but one night there was no weed and someone said 'try this instead'. It was lovely and I thought it was the answer to life. I took to it like a duck to water. I've been on methadone for a long time as I'm one of those people who always need something. People talk about coming off, but you need that bottle. You're taking something but you're not getting stoned. If I'm not taking methadone, I get wound up. I have tried to come off it, but halfheartedly, I will admit. It gives me a feeling of relief.

I should go to support groups really, but recently I've been very depressed and going to groups is different when you're older. The people there, they don't seem to know a great deal. I'm not saying that because I'm older than them but I think the whole recovery thing is 'one size fits all'. Where the money is going is not being thought through. It's payment by results, getting people in and then out the other side. I think it's just so thoughtless.

You have to understand the desperation people feel. I think that what's going to happen with this new approach is that the crime rate is going to soar. People score around here all the time but these days I don't know how people make the money to support a drug habit. I'm living day by day. We live in a council flat and it's difficult to move or make changes nowadays. I'm not good at praising myself but I was good at that job on the helpline yet, realistically, who is going to give a job to a 61-year-old woman with a history of drug addiction when there are graduates out there going for jobs in supermarkets? I have no chance of getting another job unless it's on a helpline.

I need to say this, getting old is not easy. At least I have my partner and my son but here are no happy endings, just the daily grind. It's not just for older people. My son is in his 30s and he's living with us at the moment, yet he works all the time. I see people walking around looking so downtrodden. People have been knocked off benefits left, right and centre and we are all on thin ice. When people who are on treatment for opiates go to the doctor, they are a bit scared. I have always been lucky with my GP but I had a new doctor two years ago and I'm not sure if she wants to keep treating us. Yet we are probably the least problematic group of people because we don't want to cause any trouble and we play down any problems we have.

I try to think about recovery but, the language it's couched in, it's not recovery! I always feel it's so forced. Fair play if it works, but I think anything that involves coercion is not right for people and I think a lot of recovery involves coercion. It's not 'would you like to come off methadone?', it's 'you are coming off methadone', and everyone is worried that the carpet is going to be pulled from under them. Some wonderful things are going on with the recovery thing, but recovery is going about your daily life without drugs and with a job. It's easy to be positive when you're on the outside looking in, but a lot of people my age have been on methadone for a long time and it's hard.

REALISTICALLY, WHO IS GOING TO GIVE A JOB TO A 61-YEAR-OLD WOMAN WITH A HISTORY OF DRUG ADDICTION WHEN THERE ARE GRADUATES OUT THERE GOING FOR JOBS IN SUPERMARKETS?

Rebecca Lees is freelance journalist

Deals on wheels

The number of older recreational drug users appears to be on the rise. But who are they and why are they still taking drugs? **Max Daly** investigates

Unlike most people celebrating their 65th birthdays this year, Tony Hudson will be topping up the usual food and drink with cannabis and cocaine. As he does every day, he'll smoke around an eighth of an ounce of weed at his home where he lived with his wife by the Thames in west London. And because he'll be hosting a party to mark his transition into life as a pensioner, a bag of cocaine will most likely be making a late night appearance in the lounge.

"I've been using drugs for most of my life and I've got no reason to stop," says Tony, a former plumber and now self-employed multi-media designer. "Ok one of my daughters says I can't hold my granddaughter for 20 minutes until after I've stopped smoking cannabis. And I get some funny looks from the neighbours, who are always putting air fresheners in the communal hallway, and from by doctor whenever he asks me if I smoke and I say, 'yes but not tobacco'. But these drugs never cause me grief, in fact they actually help me to function."

Compared to widespread levels of alcohol use among older people in Britain, recreational drug use is relatively rare. But it is becoming less so. Largely a phenomenon hidden from view, it is becoming increasingly apparent.

Figures released in December by the Health and Social Care Information Centre reveal that nearly 888 people aged over 65 – compared to 283 a decade ago – visited hospital suffering from poisonings relating to drugs such as cannabis, cocaine and amphetamines in 2012-13. More than half of these admissions, 473, were for people aged over 75.

The number of older people being admitted to hospitals with a primary diagnosis of drug related mental health and behavioural disorders has also increased in the last decade, from 65 to 108.

Research carried among more than 4,000 people in London by the Institute of Psychiatry published in 2012 found that use of drugs such as cannabis, amphetamines, cocaine and LSD among the over 50s had risen tenfold between 1993 and 2007.

But the rise in older recreational drug users has been expected. The statistics reflect the movement into middle and old age of the first 'baby boomers', who grew up amid rising drug use and the counter cultural revolution of the 1960s and 1970s.

Robert Stewart, who co-authored the research for the King's College study, said at the time. "The key message of this paper confirms something that has been long suspected but which has not, to our knowledge, ever been formally investigated in the UK, namely that illicit drug use will become more common in older generations over the next one to two decades. The assumption is that these people would have grown up during ages when [recreational drug use] was considered more acceptable."

Says Tony, "I've been smoking cannabis every day since 1969 when I was living in Shepherds Bush, where it was easy to come by." But over the years he's adapted his habits. Twenty years ago he ditched smoking cannabis in tobacco joints, then he decided to swap his small weed pipe for a Sherlock Holmes style tobacco pipe.

"When I gave up smoking joints my chest complaints disappeared. With my Holmes pipe, it's comfortable to hold in the palm of my hand, I keep it clean of tar, it's easier on the throat than one of those little pipes and I quite like the look of it if I'm honest."

But there is a reason, as he reaches pensionable age, why Tony smokes an ounce of strong cannabis a week at a cost of more than £11,000 a year: he can't do without it. To him, cannabis is like Valium. "When I have a smoke, which is throughout the day, I'm in complete control of all my senses, I can work and I can fully function on it, because there is no high involved," he says. "The only time I feel the drug is when I'm not using it. If I don't smoke for four or five days I start getting anxiety. It's a peacemaker, it keeps me on a constant."

Tony's use of cocaine, about once or twice a month, is more of a positive experience and it's a family affair. Like many of his friends, he started using cocaine while working in the music industry (as a recording studio builder) in the 1970s. "I'll take some coke at get togethers or parties round our house, often with my kids, nephews and nieces – as well as everyone's mates. We have had some big all-nighters here. Cocaine is very handy now I'm older, because it allows me to stay up later."

Since getting into the rave scene 20 years ago, Joanne, a 60-year-old care worker for disabled people, still enjoys a party.

Around six times a year Joanne, fuelled by MDMA powder and cocaine, goes to a 24-hour rave. "I like the psychedelic side of MDMA, mild hallucinations with good music, I go into a world of my own. I use the cocaine to keep me going for the all-day after party." Joanne admits she has gone out dancing and drug taking with her 27-year-old son. "The first time he saw me taking drugs he told me he'd always wondered what kept me going all night."

Joanne has tried most drugs, including very brief experimentations with heroin in her 30s and 40s, but cannabis has always been her main drug of choice. She got into it while travelling around India and Pakistan as a left-wing activist in 1979. "I enjoy it, like people enjoy a drink, I always have and always will. Apart from that skunk stuff, which I don't go near.

"Smoking puts a smile on my face. Sometimes it gets me over a shit day at work and it can be motivational, it's great for cleaning the house."

While she keeps her drug use fairly discreet at work, she has been out on several work leaving parties that have ended up with cocaine snorting, mainly among people in their 50s and 60s, after the pub.

"I would have thought I would have grown out of taking drugs by now. But what's changed is that I don't really view them as drugs, in terms of being illegal or controversial, anymore. Some people my age like to eat lots of cake or really love chocolate, but I like drugs. I don't see it as an issue."

I'LL TAKE SOME COKE AT GET TOGETHERS OR PARTIES ROUND OUR HOUSE [...] COCAINE IS VERY HANDY NOW I'M OLDER, BECAUSE IT ALLOWS ME TO STAY UP LATER

Does the rise in older people using recreational drugs mean there are also more selling them? Most of the older drug users *Druglink* spoke to, including Jamie, a 61-year-old IT consultant whose use and supply of cocaine is intrinsically linked to an old friends network from three decades ago, said that they were supplied by their long term friends and peers.

When police discovered that 72-year-old milkman Robert Holding had been supplying local residents with cannabis as part of his daily milk round in Burnley, it was the people he was selling to – 17 local pensioners – that most intrigued the national press.

Holding, who was given a suspended 36-month sentence for cannabis supply, said he sold the cannabis, often for no profit, to existing milk customers "because they were old and had aches and pains". They used the cannabis as painkiller, leaving him notes in the empty milk bottles with orders of ounces or eighths.

Yet, as has been discovered with the ageing cohort of heroin and methadone dependent people, the older the body gets, the less capable their vital organs are of coping and the more likely overdoses will be fatal. The growing number of older people attending A&E for recreational drugs suggests they too are taking their toll on people's health, as people's bodies become less resilient to the toxic and negative health effects of drugs.

Both general health and specialist drug treatment services will need to be adequately resourced and able to adapt to cope with an increasingly ageing cohort of drug users, warned Robert Stewart of the Institute of Psychiatry. "Health service staff providing care for older people should be aware of the possibility of illicit drug use as part of the clinical context," said Stewart, "particularly as previous research and policy reports have suggested that this is often missed."

One of the big dangers is that drug and alcohol use among older clients often remains hidden. Julie Breslin, Service Manager at the drug charity, Addaction says rising problems of alcohol abuse among older people could teach the drug sector useful lessons. "Factors such as retirement, bereavement and social isolation can make people vulnerable to alcohol problems. Men and women aged 65 and over are more likely to drink alone, to drink at home and drink every day than other age groups. This often makes alcohol problems difficult to detect until it reaches crisis point." During the last decade, alcohol-related hospital admissions in those aged 65 and over have increased by 176 per cent for men and 145 per cent for women.

The less lonely, housebound and bored older drug users are as they age, the less likely they will be to develop a problem. "At the moment I'm too busy to take lots of drugs," says Jamie, who doesn't see his drug use drifting much more into his 60s. "When I retire I will have more spare time, but I think I will be spending it doing other more interesting things, like going out on my sailboat or making things in the little workshop I've set up in my garden shed."

While many would argue differently, as a long-term user, Tony sees no real difference between a pint and a line of cocaine. "Most people have a nightly sherry or scotch at our age, so what's wrong with a joint or a line of coke? When time is getting short, you might as well do what you want, regardless of what anyone else thinks."

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

A GENERATION IGNORED

Although tackling alcohol use remains on the national agenda, many practitioners are aware they are only addressing the tip of the iceberg. Who is the main group missing from specialist services? It's the over-50s. By **Jane Ward** and **Julia Sinclair**

In 2011, the Royal College of Psychiatry published a report, *Our Invisible Addicts*, which stated that the proportion of older people in the population is increasing rapidly, as is the number of older people with substance misuse problems. It warned mortality rates linked to drug and alcohol use are higher in older people compared with younger people and that a significant number of older people consume alcohol at a dangerous level.

Older people use large amounts of prescription and over the counter medication and rates of misuse – both intentional and inadvertent – are high particularly in older women. Alongside physical health problems, the use of long-term prescription medications, especially hypnotics, anxiolytics and analgesics, are important factors in the development of substance misuse in older people. Psychosocial factors, including bereavement, retirement, boredom, loneliness, homelessness and depression, are all associated with higher rates of alcohol use.

When we tried to address these problems in Southampton we were aware that the official figures on the number of older people who had alcohol problems underestimated the true picture. Although alcohol screening is limited and their statistics exclude high-risk drinkers, the Alcohol Specialist Nurse Service at the University Hospital Southampton (UHS) identified 328 alcohol dependent patients over 50 between April 2012 and March 2013. Data also shows that only 12 per cent of dependent drinkers aged over 55 in Southampton are known to specialist community services before coming to hospital and only 16 per cent agreed to referral on discharge.

It was clear there was a need for a dedicated alcohol service for the over 50s. Southampton commissions a range of community services that form the Alcohol Pathfinder Service (APS). The APS is made up from a team of nurses, support workers and administration staff who work together with existing services to find new pathways into treatment and to help develop more efficient alcohol treatment services in the city. Each service, based around the city, has a different remit in supporting people with their alcohol consumption, for example community detox, hospital frequent attendees support and provision of wellbeing activities.

There is also another service that emerged within UHS to respond to those patients presenting across the range of acute services with complex physical and mental health conditions associated with their alcohol use. It assesses patients' needs and aims to rationalise and enhance the care that they receive. It offers treatment for patients who will not use community substance misuse services, often perceived as stigmatising and not meeting their needs. The clinic saw 80 patients in its first year and its effectiveness is currently being evaluated.

In 2012, local charity Options Wellbeing Trust, which provided counselling and support services in Southampton, submitted an application to the Lottery's Silver Dreams Fund (established to pioneer ways to help vulnerable older people deal more effectively with life-changing events), to develop and pilot an alcohol and medication support service for the over 50s.

The application was strongly influenced by *Our Invisible Addicts*, Options Wellbeing Trust's experience of providing alcohol services, as well as local needs assessments – including service user and stakeholder consultation. The bid detailed the need for new approaches to raise awareness and engage older adults to address their alcohol, medication and other substance use.

Alcohol interventions generally focus on increasing, high risk and dependent drinkers, but older adults on medication – even those who are in the 'low risk' drinking group – may be drinking at levels that are detrimental to their health and wellbeing. A key message from the Royal College of Psychiatry is for the over 65s to be drinking half the recommended levels for younger adults.

In April 2012 what became known as the Optamise project was given 18 months funding with the aim of developing a project to engage and support older adults and to share the learning from this nationally. Its project co-ordinator, three support workers, and a data and social media administrator consulted widely with adults aged over 50 and with partner agencies such as Age UK. Different initiatives were piloted and on-going consultation and evaluation has informed the delivery and learning from the project. The project has had a

number of challenges and the learning is being shared widely via its blog www.optamise.co.uk and with other Lottery projects.

There were a number of key issues that arose in the setting up and delivery of the project. It found there was considerable resistance amongst family members and services to accept that older adults have the need to address their alcohol and other drug use. There was a lack of knowledge and awareness amongst older adults, their families and professionals of the impact of alcohol and other drug use. This tied in with a general reluctance among family members and professionals to raise the alcohol question with older adults – despite knowing the impact it is having on wellbeing.

Optamise discovered that volunteering and other positive activities for older adults were a good way of sustaining wellbeing. Crucially it found the need for a range of flexible and diverse interventions tailored to the individual. Although important for all ages, this flexibility is particularly relevant for older adults. Therefore user consultation, marketing and service development are essential in setting up services.

The upshot of this research showed over 50s needed support to be delivered in the home, or local settings and communities where they feel comfortable and can access easily. In addition, literature and information needed to be tailored to this age group, while waiting times and traditional specialist misuse services were identified as barriers to engagement.

In terms of securing honorary contracts, providing supervision and access to wards, it was advantageous to work closely with the acute health sector, to ensure that there is a seamless pathway for the over 50s, especially with emergency departments and medical specialities. The same can be said of developing partnerships with community agencies, such as Sheltered Housing and Age UK.

The development of the Optamise project has led to: awareness raising and education sessions on alcohol and medication for older adults and carers in community settings, for example church halls and lunch clubs; alcohol and medication training for staff and volunteers working with the over 50s; the development of a patient information leaflet on alcohol and medication for distribution in general hospitals and community pharmacies; an electronic screening tool and referral form for primary care practitioners; and the provision of screening and advice in hospital emergency department and community settings. The project also encourages counselling, group work, wellbeing activities and volunteering opportunities for the over 50s.

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THERE WAS CONSIDERABLE RESISTANCE AMONGST FAMILY MEMBERS AND SERVICES TO ACCEPT THAT OLDER ADULTS HAVE THE NEED TO ADDRESS THEIR ALCOHOL AND OTHER DRUG USE

Monitoring and evaluation of all the interventions, support and activities through partnerships has enabled older adults to improve outcomes in a number of areas including physical and mental health, becoming more active, reducing isolation, becoming more resilient, improving family relationships, increasing independence related to health choices and helping them get involved in community activities.

Looking to the future, there is a need for a partnership approach between generic older adults services and specialist substance use services – to identify and respond to the needs of older adults together. This should be addressed through needs assessment, consultation, workforce development, and evaluation supported through the commissioning process.

However, we are in challenging times and even when pilots have identified a way forward, funding for the Optamise project comes to an end in March 2014. The team is seeking new funding from the Reaching Communities Fund, based on what has been learnt from the pilot project and the need to provide a dedicated network for older adults in Southampton and the surrounding areas – and linked with current acute and community service provision.

As part of the partnership approach, the Wessex Academic Health Science Network (AHSN) has an alcohol priority that will focus on developing, piloting and evaluating effective pathways for those not currently engaged with specialist substance misuse services. The aim for the first year is to target professionals, in primary care and acute hospital and community settings, to raise awareness of the role of all health professionals in tackling alcohol. The work will be launched at *Getting to Grips with Alcohol,* a conference funded by AHSN to engage practitioners with the idea that dealing with the health risks of alcohol is not limited to substance misuse services, but is the responsibility of all health and social care professionals.

For more information go to www.southampton.ac.uk/warc/

Jane Ward is an evaluator of the Optamise Project and **Julia Sinclair**, is Senior Lecturer, Consultant addiction psychiatrist and Interim Lead for Alcohol Wessex (AHSN)

Coming of age

Chris Drouet, co-founder of drug user magazine *Black Poppy*, died of a drug overdose in December 2009. He was 60. **Erin O'Mara**, a close friend, discusses how long term addiction is taking its toll on Britain's rapidly ageing opiate users. This is an edited version of an article first published in *Druglink* in May 2010.

The phone rang. The following conversation became one of those moments in life that you never forget. While I can't remember the exact details of that call, it was so unexpected that the shock and emotion of it completely took my breath away, leaving me inconsolable.

It went something like this: Doctor: "Erin, where are you?" (Her voice was all wrong).

Me: "I'm at home – why?' (My mind starts racing for clues as to what this could be about).

Doctor: "It's Chris. I'm afraid something's happened…"

Me: "What – hang on, you mean my Chris?"

Doctor: "I'm so sorry…". In a split second I felt I had been thumped on the insides and I couldn't stop what was coming next. I bent forward to stop myself collapsing. She continued, "It's… He…Chris's dead."

It all happened in slow motion. The doctor continued talking, her words making everything final and real despite me willing them to stop. "But are you sure? Really sure?"

She was sure, and it was final. Chris had been found by the guy staying over at his flat. He had been dead for about four days, the friend apparently paralysed as to what to do. Four days! I couldn't think straight. I kept pacing the room holding my head as though it would break, searching the room with my eyes for what? Answers? As it turned out I wasn't going to get a lot of those.

I knew it could be drug-related. The worry was that Chris would sometimes take quantities of valium on top of his methadone 'script but my god, he had been using like that for 40 years! He had stopped using benzos lately and anyway, he had such a tolerance…

I put the phone down. Tears streamed down my face, everything flashed through my mind but I kept thinking, 'How am I gonna tell his daughter? How can I tell her he's dead? She had only just tracked him down after 20 years! That's not fair! The absolute pain of hearing that sort of news is indescribable in the force of its finality. He's gone, forever.

Chris had been my soulmate. Memorable, funny, a man of few words. He was clever, talented and old school. We had co-founded Black Poppy together. With my Aussie mouth, my intolerance of injustice, sense of activism and interest in health issues, and his photographic memory and knowledge of London's drug culture from the early 60s, his humour and superb advice – we made a great team. As he supported me, Black Poppy magazine was born, and so was a marvellous writer. Chris's stories and articles would go on to be some of the best in the magazine. He was a natural. His loss felt massive and life changing.

At Black Poppy we have always lived and breathed overdose prevention. The inside outs, the upside downs and the sideways of preventing and treating overdose. Christ, we held the UK's first International Remembrance Day for drug and alcohol related deaths just the year before! But why didn't I ever honestly think that one of us might actually be vulnerable? I never thought for a million years (stupid, stupid, stupid!) that Chris would die from an overdose, he was basically so stable.

Questions about his death were soon raised, so the truth became an endless pursuit; why it took four days to report it, why things went missing from his flat. Why the police weren't interested in a proper investigation into yet another junkie death and the usual gaps in the story that seem to surround such episodes. The funeral needed working out – and then the inquest to attend.. The coroner decided his death was a methadone overdose, levels were in the fatal range, which is worked out according to what constitutes toxic levels gathered from other methadone-related deaths.

It seems he probably did the same or similar as he always did on that fateful day. He was found in bed. But it seemed to take some time for Chris to die, it wasn't quick, it happened in his sleep. This was statistically common too, three hours being the average time to die from drug-related causes. But what we did find out at the inquest was just how vulnerable Chris had become.

Chris was 60 last year. He had been

using drugs for more than 40 years. He was a creature of habit and had the same routine pretty much every day during these last few years. He was scripted on methadone, (a rather large injectable prescription,) though he had been using the same amounts for at least the last 10 years. Ok, so he sometimes scored methadone on top on his script, again in the same amounts on the same days. That was just how it was and that was just what he did and he was by no means unusual there.

Like so many older users, he fell into a routine, as well as a certain state of mind, that had left him rather cut off from those who cared about him. He felt he had earned the right to be left alone. He had grown tired of drug workers a half or a third of his age, instructing him, directing him, controlling him with a script, shrill attempts to understand his plight and orders to keep those 'appointments'.

He felt that he just didn't have it in him to try and give up after all those years and he planned to stay on opiates if possible for the rest of his life. So when he managed to settle with a GP he liked, he became the perfect patient. No trouble, no dramas, just in and out once a fortnight. I think he hardly saw the doctor: it's all pre-signed scripts these days in busy surgeries. Most don't complain, everyone wants in and out, no problems, no complications.

I know years of prison (14 years in total for primarily shoplifting offences to fund his habit) had robbed him of the energy to start again. Every time he went into prison he lost everything he had slowly built up on the outside, his accommodation, his relationships, his belongings, his work.

Like many long-term, consistent drug users, years of never really re-learning to develop natural life highs, breaking the habit of using drugs to live day to day, coping with being alone or having fun without drugs and managing debts carefully before the court letters and bailiffs arrive (which makes answering the door impossible anymore). It leads to a slow strangulation of one's life – as well as the desire to try and make a better one. There comes a point when it all just gets too hard, especially after 20, 30 or 40 years.

So I looked again at the statistics, this time with different eyes. And I felt like an idiot. The fact is, you just never think it will happen to you – especially if you have been using drugs the same way for years. But, rummaging through the small amount of research available I found, one is even more vulnerable to a drug-related death: the longer you are using (tick for Chris); the older you get (tick for Chris); if you live or use alone (half a tick); are more run down/ill than usual (tick – he had a low grade infection in his injecting site); you binge sometimes on gear or benzos (tick and tick).

The last key driver of drug deaths is a health problem. This would have been a tick if Chris had been properly tested for his health problems. Despite seeing GPs every two or so weeks for decades, it was only after he died that we found out he had emphysema and severe hardening of the arteries – both of which may have exacerbated his respiration and cardiovascular difficulties.

I NEVER THOUGHT FOR A MILLION YEARS THAT CHRIS WOULD DIE FROM AN OVERDOSE, HE WAS BASICALLY SO STABLE

To break it down further: we know that most drug-related deaths affect medium to long-term users. Long-term use and age-associated health problems combine to increase the risks. Evidence shows that while drug overdoses are not always fatal, the fatality rate increases over time due to a number of factors associated with the ageing process. When we age and lose body strength, our metabolism slows down which can result in harmful levels of a drug being absorbed into the body, causing an overdose.

The health issues that stem from long-term drug use can piggy back on general problems of aging to reduce one's overall ability to fight overdose. Pulmonary complications including aspiration pneumonitis, pulmonary oedema and pneumonia caused by heroin's depressant effects on respiration, weaken the immune system, put pressure on the cardiovascular system and subsequently may contribute to a holistic failure.

Anecdotally, I believe we are also seeing more older users with COPD (Chronic Obstructive Pulmonary Disorder), fighting asthma, chronic bronchitis, 'crack lung' and emphysema, which all add complications to respiration and oxygen levels. On the other hand, cardiovascular complications, including collapsed veins, hypoxia and endocarditis which are reported in injecting drug users cause long-term harm to the respiratory and cardiovascular systems. Multiple deep vein thrombosis and embolisms, and infections like the skin infection Chris had at his injecting site, can become extremely serious very quickly and can be fatal.

The ageing process not only increases the probability of overdose, even for long-term regular users, but it also increases the chances of an overdose being fatal. This highlights the fact that older users need a more specialized, holistic approach that takes all these things into consideration. And interestingly, while contrary evidence concludes that polydrug use is a major fact in heroin deaths, this proves not to be so much of an issue for much more long-term users.

So it can still happen when you think you know it all about drugs. Age and ill-health are two things that can really creep up on you, and one day, like my friend, you are just that bit more run down, not so fit anymore because it's been years since you exercised or ate really well, your veins are in a mess, your circulation is sluggish and – hell – you know you've smoked too many fags and your breathing is poor. And so you take your usual dose, but end up sleeping in a funny position, maybe slouched in a chair, or on your back in bed, and no one is there when your breathing takes a change. Your mate looks at you and just thinks you're stoned as usual and reckons they'll look in on you in the morning....But it's too late by then.

I'm glad we are starting to look at a person's whole lifestyle when in treatment these days. Years of very questionable drug treatment has meant many long-term users aim to avoid interacting with services as much as they are able (some are in and out as fast as possible). But I am yet to see one person that isn't willing to have their health carefully checked by a sympathetic and supportive health professional, who can negotiate with the client the difficult and often judgemental path through hospital appointments and tests.

Older users often put up with mounting health problems as a result of decades of ambivalence when they have sought treatment. We have to reverse this trend and instill in the older generation some hope of a better, healthier life, not turn the other way as they head quietly to the corner of the drug treatment system to die.

Erin O'Mara is editor of *Black Poppy* magazine www.blackpoppy.org.uk/

Steve Rolles

Transform have just published a new book setting out a public health approach to constructing a legal, regulated market for cannabis. **Harry Shapiro** spoke to Transform's Senior Policy Analyst **Steve Rolles**

Back in 2006, in your publication *After The War On Drugs*, Transform reiterated a much earlier statement that by 2020, the drug reform landscape would look very different . You said *"If you are around in 2020, the chances are that you will see drugs prohibition replaced with a system of regulated and controlled markets."* How close have we got to that? Have we reached a tipping point at least in terms of cannabis law reform?

The catchphrase of 2020 was to capture the idea that drug law reform is a generational challenge, not something that is going to happen overnight. Reform will take place by a series of increments, whether that's by individual drug or individual country, and small changes – like reductions in penalties or decriminalisation, then with cannabis, experiments with medical cannabis, then tentative experiments with very restrictive models of legal regulation and so on. Although I think the arguments for reform are pretty clear cut, it still requires a whole series of institutional reforms, legal reforms and reforms of the cultural and political mind set – and that takes time.

But in terms of where we are now, certainly with cannabis, we have passed the tipping point. Significant things that have happened: Uruguay has instigated a government-led initiative, which overtly challenges the prohibitionist consensus, both political and legal, at an international level. The fact that you have two states in the USA going down the same path means that Uruguay is not alone – and of course it's in the USA, which has been the spiritual home of the War on Drugs and cheerleader for the prohibitionist approach.

In the USA, the majority of public opinion now favours cannabis reform, despite decades of anti-reform rhetoric and probably over-emphasising the dangers of cannabis. But it hasn't stopped debate and ultimately public opinion swinging behind reform. The public simply haven't been convinced by the arguments of the prohibitionist establishment. So a tipping point has been reached on the international front, but you can't say that about the UK yet.

Or to be honest, most of the rest of the world; Africa, the Middle East, Far East and Asia.

Yes, clearly most of the world has not changed. The significant thing is that what was once a theoretical discussion, is now a political reality and multiple jurisdictions are going down that road. There are active debates in the Caribbean and South Africa for example and even in India. It will proceed at different speeds in different countries and the nature of reforms will be very different. But not only has the taboo on discussion been broken, but also on action itself. That's why to say we have passed the tipping point is a legitimate observation. The edifice of prohibition, at least around cannabis, is crumbling.

Given that the USA has led international drug policy since we have had such a thing, the Americans have been strangely muted in their response, not to say silent.

Yes, the US has been silent on Uruguay. In previous eras, if anybody did anything reform-wise on cannabis, they would be very outspoken and have long been critical of the Netherlands. But of course what has happened in the States itself makes it much harder for the Americans to be critical of others. Internally, the Federal response to Washington and Colorado has been a political calculation. They were really stuck between a rock and hard place; either they let

it proceed and were seen as weak in the face of a challenge to Federal law or try and stop it in which case, they challenge the democratic process – in Obama supporting states – , as well as the very passionately held issues about states rights. So they made a political cost/benefit analysis – what were they seriously going to do here? Send in the tanks? Have a Federal v State bloodbath and even risk losing those states in 2016? The FBI and the DEA probably favoured an amber light approach, but what they have finished up with is a green light approach: you may proceed with this so long as you adhere to these conditions. And it was fascinating for me to look at this because the conditions they laid out in the Attorney-General's memo were things like preventing cross-border trade and enforcing age controls. They were effectively engaging in the debate about regulatory controls, which is exactly the debate we think needs to be happening. They are not discussing if this will happen, but how it will happen.

It looks like one or two mores states will follow suit this year in the mid-terms, probably Oregon, Arizona, and maybe one of the east coast states as well – and possibly California. And if California doesn't happen this year, and it is unlikely, it will probably be 2016. And if California goes, then in a lot of ways, America goes – the whole house of cards comes down. At the point, the Federal government will be forced to address this issue more seriously and consider reforming Federal law as well.

Before we started the interview, you said you had concerns about the commercial model of cannabis regulation that is being rolled out in the States. What are those concerns?

What you have with cannabis legalisation is a great opportunity to start from scratch and build a regulation model that meets the needs and aspirations of all the different parties. It is pretty unusual to have that opportunity in any area of public policy. How that develops will be shaped by the political environment in which it takes place and in the USA, there is an inbuilt cultural animosity against government intervention in markets. What you have then, is the tension between a public health regulation model which is seeking to moderate or reduce use – and a commercial model which is profit-motivated which will seek to increase use or initiate new use. And we've seen that with alcohol and tobacco. We come down on the public health regulation side, but the political culture in America is much more geared to the commercial model.

Now our argument is, the intrinsically risky nature of drugs, be it alcohol, tobacco, cannabis or anything else, means that a different level of government intervention is justified than for ordinary consumer products. A lot of the libertarian cannabis campaigners in America don't care for the Transform perspective. Public health people were either very supportive or very quiet and certainly the traditional prohibitionist critics of legalisation were silent over our 2009 Blueprint. It was very interesting talking to Kevin Sabet, one of the most outspoken anti-legalisation voices in the US from *Smarter Approaches To Marijuana*. He said that if what was happening in the States was the Transform model, he'd probably be fine with it. It's the Big Tobacco, commercial approach that he fears – and it's also something we are very concerned about.

One of the things we tried to do with the book is lay down a marker saying that legalisation doesn't mean you have to go down a commercial route; there are other options. And we need to learn the lessons of alcohol and tobacco regulation – the successes and failures – and make sure we do it right this time with cannabis. In Washington and Colorado, there are more restrictions in place than for alcohol and tobacco – for example very strict advertising restrictions that aren't in place for alcohol, although they probably are now for tobacco.

A lot of progress has been made in restricting the advertising and promotion of tobacco; the ban on smoking in public places, age controls, taxation, packaging and so on. And we have seen the public health outcomes, far fewer people smoking – and that's all been done without criminalising the markets or the users. Progress has been slower with alcohol as seen by the recent BMJ editorial on the scandal of minimum pricing. But what we are seeing with cannabis, alcohol and tobacco is a convergence, a move towards more regulated markets, even though the starting points have been quite different. I actually think, and some people laugh at this, that we have an opportunity to demonstrate best practice with cannabis regulation that could inform alcohol and tobacco policy.

OK. One of the big arguments from the legalisation lobby is that there are millions to be made in taxation. But for that to happen, you need a significant growth in the commercial market for cannabis. You wont get Big Taxes unless you have Big Cannabis or maybe as a new profitable product line for Big Tobacco. And while the commercial ethos is strong in America, it is pretty strong in the UK too.

Governments are in position to set up their regulatory framework in the way they feel is it appropriate and can prioritise whatever outcomes they want. So if the priority is taxation, jobs, profits and commercial expansion, they can do that. We would say that is a mistake and instead they need to prioritise public health goals. And it is striking what has happened with tobacco; governments are effectively trying to shrink the industry because they feel the public health consequences are unacceptable. The public health consequences of cannabis are not as great as either tobacco or alcohol, but nonetheless as I said, the nature of cannabis use as intrinsically risky, justifies as model of regulation different from conventional products.

The UN Framework Convention on Tobacco Control is a pretty good model for cannabis control. This has the same number of signatories as the UN drug control treaties, but it serves an entirely different function – to regulate a legal market in a dangerous product for non-medical use. You can limit the size of companies; they are doing that in Washington and Colorado; you won't get a massive monopoly company dominating the industry. So you can limit the lobbying power of individual companies or, as they are doing in Uruguay – begin with what is effectively a state monopoly. In some US states you have state controlled liquor sales, and the Chinese government effectively owns the tobacco industry. Obviously

there is still the potential for greed and corruption, but its still better than rampant unregulated commercialisation.

Accepting the virtues of a government regulated system over a commercial free-for-all, isn't it going to be hugely expensive to establish all the infrastructures, systems, licensing and quality control protocols and so on to do something that government has no real interest in doing in the first place?

Yes, it will be expensive, tens if not hundreds of millions of pounds. But much of the existing regulatory frameworks for alcohol, tobacco and pharmaceuticals can be expanded and deployed for regulating cannabis. And there will be significant cost savings across the whole of the criminal justice system; enforcement, police time, arrests, the courts, as well as potential tax revenue, maybe as much as a billion pounds a year, although there are many variables. And the potential for annual income and savings will eclipse potential outgoings on regulatory infrastructure, certainly once the initial outlay has been spent.

Looking more broadly, whither or even wither, the UN drug treaties in this scenario of legal regulated cannabis markets?

In terms of decriminalisation – that is nominally possible within the treaties; they do say that possession and supply of cannabis should be an offence, but they don't stipulate the penalties, which can be administrative, fines etc. So it can be illegal, but not necessarily criminal. But Uruguay and also Washington and Colorado –and so in effect the USA – are clearly in breach of that – and that has to be highly significant. There is an acknowledgement at the UN level, both on and off the record, that at least around cannabis, something has to give. Quite how that plays out is unclear, but that conversation is increasingly about how the treaty system can accommodate the reality of cannabis regulation, rather than if. But it will be messy; at the UN Special Session on drugs in 2016 (UNGASS), there will be a lot of conflict and division.

Not surprising that the countries that have suffered the most in terms of violence and corruption are the ones most likely to advocate the more radical options. But in the UK, the debate is hardly happening. Fortunately, unlike Mexico, we don't have headless bodies dumped on the motorways.

I would disagree that the debate isn't happening. The Liberal Democrats are very open to discussing the issue – and Nick Clegg, who is the Deputy PM don't forget, has been very outspoken. The Lib Dems have shifted from having a progressive position on drugs but not wanting to talk about it, to wanting to engage publicly – it has moved from a shield to a sword issue. With this, they have a chance to demonstrate their modernity and liberalism and appeal to youth. Even David Cameron understands the issues intellectually – after all, he is on the record of supporting reclassification of cannabis and ecstasy – and even a debate on legalisation. The problem for him is a political one not an intellectual one.

And that's where our tabloid press comes into play. Unlike most countries, ours is notoriously aggressive and vicious. I exaggerate to make a point, but can you imagine the response, if the UK followed your public health model and in effect we had government-run cannabis outlets? To put it mildly, selling the idea politically in this country is not going to be easy.

True. We are a conservative country when it comes to drug policy. But don't forget, we have also been world leaders in harm reduction. And if you look at the tabloids, there has been a change. *The Sun* is much more open to the reform agenda. *The Mirror* has been supportive as has *The Times*. We are convinced that there is a line of argument that can work with the *Daily Mail* audience; reducing costs in the court system, reducing crime, tax revenue for the government to pay for the things they care about. They are not pro-drug arguments, they are pragmatic economic and crime reduction arguments.

Finally, the advent of legal highs has raised issues about the efficacy of the traditional control regime. Does this provide an unexpected impetus towards the kind of regulatory response that Transform are advocating?

The legal highs phenomenon is an accelerated version of the futility of prohibition. Even if the institutions like the ACMD could be more nimble and ban things more quickly, it wouldn't change anything – new drugs would just appear that much faster. The evident futility of enforcement responses to NPS has forced the issue on alternative approaches, most notably in New Zealand. Because the country is not on ordinary trade routes, drugs like cannabis, ecstasy and cocaine are expensive, so a much more developed legal highs market has emerged. They tried the banning route which didn't work, so instead they have put the onus on manufacturers to establish that their products are within acceptable safety parameters, at which point they can be sold within a strictly regulated framework, similar to what Transform recommended in our 2009 Blueprint.

Some of the first drugs to come through the system will be synthetic cannabinoids. So bizarrely you'll have legal, regulated fake cannabis, but real cannabis, which by most accounts is less risky, is still going to be illegal. I asked the Minister who pushed this through about the strangeness of that situation and he agreed, but he said it should highlight the anomaly and push the wider debate forward.

If they can demonstrate that this model of controlling legal highs is significantly better than trying to deal with a chaotic unregulated market, it will provide a proof of concept. But of course, it is worth making the point that there would be little or no market for fake cannabis, if there was a legal, regulated market for real cannabis. Legal highs are a problem that has largely been created by prohibition in the first place. More prohibition is never going to be the answer.

How many drinkers should be in treatment?

England's alcohol treatment caseload could represent just 7% of its problem drinkers who need treatment or 40% and stages between. Maybe it depends on the story you want to tell. By **Mike Ashton**

Depending on the criteria, Britain's performance in ensuring needy drinkers enter treatment can look anywhere from abysmal to excellent. Let's start with how many are in treatment. The handiest figures are for England, where about 110,000 adults were in specialist alcohol treatment during 2012/13. Based on a 2007 survey, this amounts to about 7% of all 1.6 million drinkers experiencing harm from their drinking, operationalised as an AUDIT alcohol problem screening test score of 16 or more. We can narrow this down further to the approximately 1 million adults who also score as at least mildly dependent on alcohol on the Severity of Alcohol Dependence Questionnaire (SADQ-C).

On this basis, numbers in treatment represent about 10% of the drinkers who might need this help. Based on a not very relevant Canadian model, in 2009 the UK Department of Health estimated that provision should be made for 15% of dependent drinkers to access specialist treatment, a figure accepted by NICE, Britain's official authority on health interventions. However, the model was not based on an assessment of the proportion of all dependent drinkers who might profit from treatment, but largely on the relapse rate (defined as a return to drinking) after treatment. Not only is the 15% questionable, but also the estimate of numbers dependent; by design, the questionnaire used to assess this was not based on clinical criteria.

Putting that serious concern to one side, its results can nevertheless be used to narrow down further to the numbers who perhaps ought to be in treatment. NICE has calculated that 260,000 adults are at least moderately dependent, signalled by their scoring at least 16 on AUDIT and 15 or 16 (both figures are given in the NICE report) on the Severity of Alcohol Dependence Questionnaire (SADQ-C). On this basis numbers in treatment represent over 40% of the 'really' in-need population.

Now we have a range from treatment capturing numbers equivalent to an abysmal 7% of harmful drinkers, up to a creditable 40% or more of those also at least moderately dependent. The lower figure can be justified as the percentage of all those who *might* need help, the higher as perhaps closer to those who really *do* need treatment to overcome their dependence. That higher figure gains support from US findings that three quarters of dependent drinkers remit without treatment and just 10% most clearly need and most often access this kind of help. NICE also appears to draw the line nearer to (and perhaps even above) the moderate dependence level, which would imply that England has the capacity to treat 40% or more of the in-need population.

Another reason why unmet need is not necessarily so huge as it appears is that structured specialist treatment is not the totality of support available to problem or even dependent drinkers.

So while we may suspect that capturing 110,000 of the UK's problem drinkers in treatment is not enough, there is no clear way to determine whether and the degree to which this is the case. Good waiting time figures have (in respect of drug addiction treatment) been used as an indicator that treatment supply is keeping up with demand. Good waiting times for alcohol treatment may mean the same, but perhaps only because need is not reflected in demand because dependent drinkers are divorced from routes to treatment – much as a hungry population may not result in demand for bread if they can't find their ways to the bakers or don't like the bread they bake.

That this is at least partly the case for England was suggested more strongly by the report on alcohol treatment for England in 2011/12. It expressed concern at how few people had successfully been referred to specialist treatment by GPs or accident and emergency departments, despite the fact that around one in five people seeing a GP is drinking at risky levels, and an estimated 35% of emergency attendances are alcohol-related: "An aim for the coming years is that these two key routes will become more active in identifying and referring people who need treatment for harmful drinking and alcohol dependency".

If there was cause for concern then, there is even more cause now. The following year referrals from GPs fell from 14,330 to 13,541; accident and emergency department numbers increased from 872 to 1066, still a small proportion of the potential. Down from 15,202 the previous year, in 2012/13 these two sources accounted for 14,607 treatment starts – a movement in the wrong direction, suggesting that in England, screening and intervention rates and/or quality in these two prime settings remain inadequate.

Where would you draw the treatment need line? Harmful drinking, at least mildly dependent, moderately dependent, or severely dependent? Does it depend on whether you *want* to portray Britain's treatment access performance as abysmal or as excellent, perhaps depending in turn on whether you wish to argue for more resources or contain expenditure? Is severity of drinking/dependence the right way to draw the line? How about the duration of heavy drinking, whether the patient wants treatment, or how many patients we want to *afford* to treat?

Dane law

It took 35 years of campaigning for the authorities to accept drug consumption rooms in Denmark. Could it happen the UK? **Blaine Stothard** finds out

The Danish expression, *ting tar tid* (things take time) is exemplified by the long series of events leading to the opening of drug consumption rooms in Denmark.

In September 2011 a citizens' initiative in Copenhagen's Vesterbro district opened a mobile consumption room in a converted ambulance at the same time a national election campaign was up and running. The first weeks of the experiment, which had not been officially sanctioned, were dominated by two concerns: would the intended clientele, of people who inject drugs, use the service? How would the authorities respond?

The general climate was favourable: days after the first mobile DCR took to the road, the national emergency service, Falck, donated a second ambulance, quickly converted and added to the fleet. The election outcome was the formation of a Social Democrat led coalition government which, true to pre-election promises, introduced legislation to amend existing drug laws needed to permit and fund drug consumption rooms.

During parliamentary debate on the issue, the government quoted evidence from other countries showing DCRs contribution to reducing drug-related deaths. The opposition parties maintained the prohibition and zero-tolerance position which they had practised when in government. Parliament approved the legislation in June 2012, by 63 votes to 43 in an assembly of 189, legitimising the mobile consumption rooms and leading to the opening of building-based DCRs in Denmark.

Denmark has a relatively high number of drug related deaths for its small 5.5 million population. In 2005 there were 275 deaths, in 2011 there were 285 (a high point), but in 2012 there was a significant fall – to 210.

Local commentators welcomed the fall in the number of deaths, but have been cautious about identifying reasons. At the end of 2012 the two building-based DCRs in Copenhagen had been open for just two or three months, the mobile consumption rooms for fifteen. Commentators emphasise that it is too early to ascribe the fall in deaths to the opening of the DCRs, pointing rather to changes in demography and drugs use patterns – and that the numbers of deaths recorded in Copenhagen itself in 2012 rose slightly. As of December last year, none of the four Copenhagen DCRs reported deaths on their premises.

Initially staffed by volunteers, the mobile DCR, called a *fixelance*, worked to establish its presence and services amongst people who inject drugs and, implicitly, to avoid criminal justice interventions. The agency Gadejuristen (Street Lawyers) provided teams of lawyers ready to intervene if police or other officials seemed likely to question the legal basis of the service, or appeared to discourage service users by their presence. That this didn't happen was a relief to *fixelance* staff and supporters, but also a reflection of the changed social and political climate in Copenhagen towards drug injectors and other socially excluded groups. Service commissioning and provision in Denmark specifically includes users' dignity, self-worth and autonomy, not merely crime reduction.

Using the new legal powers approved by parliament, Copenhagen City Council now operates and funds the mobile DCRs. The first ambulance, known as Fixelance 1, has now been replaced with a purpose-built vehicle and has since been exhibited at the National Museum in Copenhagen. Since the opening of the building-based DCRs, the two *fixelance* vehicles now extend DCR facilities to injecting hot-spots in other areas of the city.

In 2012 the Vesterbro citizen's initiative published its report, *Fixerummet som fik hjul, (The consumption room gets wheels)*. It describes a 35 year period during which the conditions and needs of people who inject drugs and the concerns and, often, hostility of local residents, together with changing local and national political climates and policing practice, finally resulted in the introduction of the mobile consumption rooms and the amended law. Things did take time, but with the changed political climate brought about by the new government, events moved fast. Two building-based DCRs opened in Vesterbro in the autumn of 2012; building work on a third is currently in progress; one DCR has been opened in Århus and one in Odense.

Disappointingly, the Danish Focal Point 2012 report included the building-based DCRs but made no mention of the innovative mobile rooms or the citizens' initiative behind them – the outcome was recorded but not the process.

The district of Vesterbro, for 40 years the principal Copenhagen open drugs market, is becoming increasingly gentrified. This process began with the sale of public housing by the then Conservative-controlled City Council in the mid-1990s. Despite gentrification, the district continues to host agencies and services for groups of socially excluded people who are attracted to, if not resident in, Vesterbro. And with the closing of Kødbyen, the wholesale meat market, premises have become available for social use – direct service provision for homeless people and premises for NGOs and small social enterprises.

The first building-based DCR, Sundhedsrummet (Health Room), opened in October 2012. The second, Skyen (The Cloud), opened later that year in Mændenes Hjem (The Men's Home), originally a hostel for homeless men but in spite of its name open to all. Mændenes Hjem has historically provided services to meet the needs of homeless people, including drug and alcohol users, identified through its core work.

Skyen has two sections, separated by an airtight door in a transparent partition wall. The first provides eight places for injection; the second six places for smokers. On my visit in October 2013 all places were in use by a mainly male clientele. Staff in the room recorded who attended, sometimes using pseudonyms, and what they were using. The majority were either smoking crack cocaine or injecting powder cocaine.

Many users were Swedes, reflecting the increased movement, at all social levels, between Copenhagen and south-west Sweden since the opening of the Oresund bridge between the two countries. Conversations with staff and users confirmed the recent increase in cocaine use, the poor quality of the cocaine, and the consistently good quality of heroin. Mændenes Hjem reports between 350 and 500 visits per day.

WHAT IS AT ISSUE IN THE UK WOULD SEEM TO BE POLITICAL WILL AND A RELUCTANCE TO CONSIDER USERS' NEEDS AND VIEWS

Regulations clarifying the 2012 law permit smoking and injecting in DCRs, in contrast to the prescribed heroin programme, introduced in 2008, which does not permit smoking of pharmaceutical heroin. This regulation is seen as excluding some long-term opiate users – who consider reverting to injection a retrograde step in their using behaviour – from attending such programmes. Campaigners continue to argue for medically prescribed heroin to be smoked.

The citizen's initiative approach to harm reduction in Copenhagen is being mirrored by campaigners in Birmingham. An Independent Consortium on Drug Consumption Rooms, established by an outreach drug-worker last spring, is developing a proposal to establish DCRs in the UK's second city. The consortium is working to gain support from local councillors and relevant agencies by presenting the case for DCRs and pointing to the evidence of benefits from cities where they operate. Consortium members include a local GP, a lawyer and drug and alcohol service providers.

The proposal aims to restore some dignity and autonomy to people who inject drugs; reduce drug-related deaths; and alleviate needle litter. The consortium is conducting surveys of public opinion, largely receptive to the idea, and disseminating the results using social media. Off the record, other services and agencies, including senior police officers, have expressed their support, although statutory agencies have been reluctant to communicate with the consortium: an initial meeting with commissioners was inconclusive. The Health and WellBeing Board is liaising with the consortium, which receives advice and support from the National AIDS Trust and Release.

Brighton and Hove City Council's proposals to consider opening a DCR, announced in April 2013, attracted much media attention. The Council had accepted the recommendations of a report it commissioned from an Independent Drugs Commission. One proposal was that Brighton Safe in the City Partnership undertake a feasibility study into how a DCR would assist in reducing drug-related deaths.

In response, the Leader of the House of Commons asserted that the proposals were in breach of national law and international conventions, a position reiterated by a Home Office statement in January 2014 in response to an inquiry from *Druglink*: "The Coalition Government has no immediate plans to allow drug consumption rooms, which would in fact breach existing UK laws." In June, the Brighton Health and Well-Being Board approved the continuation of this exploratory work, a proposal that is supported by the local police commander. The Commission will re-convene at the end of April to review the responses to its proposals.

Experience in Denmark and elsewhere suggests two responses to the UK government's rejection of DCRs. Firstly, obtaining a second opinion. Legal opinions obtained by Danish drug law reformers challenged government interpretations of both national and international law. Secondly, national governments have the power to amend national laws if they do not permit DCRs. International conventions do not prevent DCRs operating in other jurisdictions. What is at issue in the UK would seem to be political will and a reluctance to consider users' needs and views, not international law.

Policy informed by and responsive to users' needs and experience is more likely to engage users than policy and provision determined by policy makers unwilling to recognise the reality of users' lives. UK strategy documents contain an assumption that drug users are not complete, independent or autonomous citizens. They are expected to accept the government's route to 'recovery', rather than their own.

Moving responsibility for drug policy from the Home Office Minister for Crime Prevention to the Department of Health could be a first step to adopting more realistic and humane, rather than punitive, judgemental and stigma-reinforcing, drug policies. As the Danes say: ting tar tid...

Blaine Stothard is a prevention specialist. His second language is Danish

Krokodil sinks teeth into Georgia

The use of krokodil, a harsh homemade heroin alternative, is spreading from Russia to oppressed communities in Georgia. **Michael Bird** reports from Tbilisi.

Trees are poised to blossom along rows of Soviet-era blocks of naked concrete at the edge of Georgia's capital Tbilisi. We park our car in a driveway and I exit with Giorgi, an ex-user of the drug known in Russia as krokodil, a homemade desomorphine, often made with codeine and petrol. It got its name, crocodile in Russian, because of the scaly skin tissue damage it can cause. Giorgi, now a social worker for addicts, is carrying a black plastic bag of fresh needles and alcohol swabs.

We enter the open gash in a block where a door once swung. Inside the corridor one light works, while six others are blown out. We find the lift. Its cabin is deep and nearly pitch-black. The elevator jangles upward. It will only stop at the tenth floor of 14.

"You have to know," says Giorgi, "if the police storm the room, everyone inside will be arrested, including you."

"I don't think the police are following me," I reply.

"Don't worry," he laughs. "If the police are following you, I will know. I have had experience."

We leave the lift and mount concrete steps that rise at the side of the block, giving a view onto the city, framed by the green hills around Tbilisi. On the eleventh floor, we knock on the door. A dark, heavy-set man lets us inside. This is Andrei, who is 40. He pounces on the bag of needles. There are two others – both in their late 30s – Yuri and Boris. All are unshaven, with short hair and dressed in dark Adidas tracksuits. "Take pictures," Andrei says. "But no faces."

There is an open plan kitchen and living room. The table is scattered with matches, an empty packet of pills and a bottle of drain cleaner called Krot, which in Russian means 'mole'. The TV shows the news. Georgian President [he has since left office] Mikhail Saakashvili is in Washington DC talking with US vice-president Joe Biden.

WE CANNOT FIND HEROIN. I USED TO TAKE OPIUM, BUT WE CANNOT FIND THIS EITHER. THE ONLY CHOICE IS KROKODIL

"I do not want to be on krokodil," says Andrei. "Heroin is much better, but since Saakashvili came to power, we cannot find heroin. I used to take opium, but we cannot find this either. The only choice is krokodil."

Andrei has already ground up tablets of the codeine-based pain reliever Codasan into a brown powder. He mixes this with Krot and half a litre of petrol in an empty plastic beer bottle. He says he wants to join a programme of taking methadone, but it is too expensive.

While Andrei shakes the bottle, Yuri beckons me over. He has a pile of yellow matchboxes with pictures of zebras. With a razor he is scratching off the side of one, liberating the phosphorus onto a dinner plate. I ask Yuri if he wants to find a job. "There is no work," he says.

He mixes the phosphorus with an alcoholic solution, which he lights up. The flames twist across the dinner plate, leaving a dust stuck to the ceramic, which he scratches off with a razor. Andrei shakes the petrol to separate the pure codeine from the powdered tablets. Inside the bottle, the petrol floats to the top, the codeine to the bottom. He tips this vertical, allowing the heavy mixture to pour into a second, empty coke bottle. With Boris holding the base of the beer bottle, Andrei uses a needle to extract every drop of codeine. He empties this onto a plate on top of a pan of boiling water and rising steam.

"This," says Andrei proudly, "should be desomorphine." The toxic opiate – an intense version of morphine – is a paste stuck to the plate, which Andrei removes in stripes with a razor. He drops the mixture – similar to a blot of red paint – into a small phial. Afterwards, the men combine the desomorphine with iodine and phosphorus into a solution which they melt on the coffee table over a small flame. They share this into three small needles.

I am about to ask Andrei another question, but the men stand up. Their

tracksuit bottoms are open and they are injecting into a vein above the thigh. They put down their needles and slump into the chairs. The mood is sullen. No euphoria. No relaxation.

Later, as we drive through the streets, Giorgi tells me in every block in this area are apartments with krodkodil users – injecting up to five times a day. The neighbours complain. The police arrest the users. They spend time in prison. But they return to using.

Badly made krokodil is famous across the ex-Soviet states as a drug that causes oxygen to stop flowing to the body's extremities. If wrongly injected under the skin, this can cause a bruising. Giorgi shows me a large black patch around his anklebone. "It was almost gangrenous," says Giorgi. "I went to hospital. The doctors drained the tissue." Amputations among krokodil users, most commonly a foot or a hand, are common.

Giorgi's clean needle outreach programme reaches around 700 krokodil injectors in Tbilisi. Most are between 20 and 40 years old, but he is seeing more teenagers trying krokodil. What is more, overdoses are increasing.

"In 15 years of using heroin and opium, I have not seen as many cases of overdosing as in one year of using krokodil," says Giorgi. Users are now finding out how lethal the drug is and understandably, most want out. "Ninety per cent are willing to get on methadone treatment. Everyone wants to get rid of it."

Before 2003, Georgia was an embattled and corrupt nation losing control to graft-hungry officials, petty thieves and a heroin epidemic. Following his victory in the Rose Revolution in 2003, incoming President Mikhail Saakashvili re-engineered his country as an Economist readers's paradise – with open borders, low regulations and strong policing.

This led to strong growth, but high unemployment. Meanwhile those deviating from puritan ideals – people such as pickpockets, minor tax dodgers and drug users – were shut up in prison. Under Saakashvili, police swept users off the streets and judges locked them up.

The arms of law and order operated an assembly line of targeting, testing and convicting users and throwing them into forced detox. At the height of this pressure there were queues of accused users outside clinics waiting for their turn to urinate in front of a police officer. Since 2006, around 100,000 have been subject to arrest, detention and forced testing.

The police had quotas of drug users to catch and received incentives to seize as many as possible. "There is a joke," says Giorgi, who was picked up over 50 times. "Two policemen in Tbilisi are sitting in a car. One sneezes. Instead of saying 'to your health', the other policeman says 'I hope you catch a lot of junkies'." By 2012, Georgia's prisons were hosting 24,500 inmates – a rate higher than Cuba, Belarus or Russia. Around 3,000 of them were arrested for drug possession or 'drug consumption'.

MICHAEL BIRD

Now, dealers rarely exist on the street. Heroin is not available. The street trade has to some extent been replaced by DIY drug makers and Big Pharma. Now two-thirds of injecting users in Tbilisi are using krokodil, while the remainder use the stimulant vint – a methamphetamine-like drug made using ephedrine from cold and flu remedies. Cold and flu drug Actifed became the fourth biggest selling drug in Georgia in 2009, possibly boosted by users of vint. Addicts say that now there is only one drug dealer in Georgia – the pharmacies.

Georgia is now experiencing the aftermath of a decade-long war on drug users which it seems no-one is winning fast. In 2009, according to the NGO, Alternative Georgia, there were 40,000 injecting drug users in Georgia. In 2012, there were 45,000 – a 13 per cent rise. "Restriction and fear of imprisonment does not work," says senior researcher at Alternative Georgia Irma Kirtadze.

Georgia's new government has an action plan to combat the rising number of drug users and it shows signs of fresh thinking. "We will keep the severe policy of sanctions under criminal law for traffickers," says Justice Minister Tea Tsulukiani, who chairs an interagency council on drugs. "We are determined to continue communicating with the young generation that using drugs is not something which they can be proud of." She wants to change the prosecution of the users. "We intend not to decriminalize drug use, but to depenalise it," she says, "to reduce sentences for simple users."

NGOs believe a combination of treatment for sufferers and social assistance would reduce drug use. In Georgia around 500 drug users have free access to methadone, while a further 1,500 must pay for the opiate substitute. They argue the best option would be for all methadone to be free.

Giorgi feels he knows where the blame lies. He organized a protest in front of the Russian Embassy, where he berated Russia for its lack of methadone programmes and free syringe distribution – and therefore the source of krokodil.

"We were chanting 'shame Russia!'" he says. "30,000 people died in Russia due to krokodil. We wanted to express our solidarity with the victims."

But he concedes that this demonstration was not against trafficking, dealing or the cultivation or production of drugs. Instead it was a new kind of protest – one that targeted the sharing of cooking skills. "That information on how to use," he says, "comes from Russia."

A longer version of this article appears on www.theblacksea.eu.

Michael Bird is a journalist and writer based in Bucharest, Romania

Street scientist

Reviews

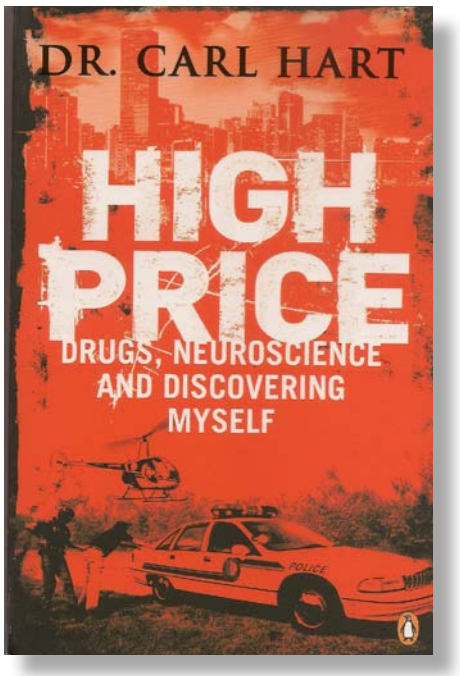
HIGH PRICE: DRUGS, NEUROSCIENCE AND DISCOVERING MYSELF
Carl Hart
Penguin, 2013, £9.99

BUY NOW

Neuroscientists usually start and finish their research in the lab. Their expertise in psychopharmacology is rarely matched with an understanding of how drugs are used in the real world. Carl Hart is exceptional in combining direct knowledge of the social circumstances of drug use with high-level skills in neuroscience. His brilliant book, written with journalist Maia Szalavitz, challenges much of the conventional, mistaken wisdom in this area. Hart moves between personal memoir and scientific debate, showing how the lessons he learned growing up on the streets of Miami pointed the way for him to make discoveries about drug users that many people would find astonishing.

Are you one of the many who believe that chronic crack users are so enslaved by the drug that they are incapable of taking rational, long-term decisions? Hart's research shows what happens if you take these people off the street and provide decent food and shelter. In these circumstances, they are perfectly capable of declining the opportunity to use their drug of choice, preferring to save the cash they are offered instead. The myth of the demon drug that destroys communities is exposed for what it is: a convenient scapegoat for the problems of deindustrialised cities, where unemployment and despair were already endemic before crack became the latest way to blame poor people for their poverty.

Hart provides an unsparing account of a childhood lived between the houses of various family members struggling to provide stability. In contrast to many of his friends and family, early successes in school and sports gave him a reason to stick with his studies, then to escape into the US air force. He describes the impressive determination that helped him overcome his initial lack of economic, social and cultural capital to become a professor at Columbia University. But he does not make the mistake of so many self-made men – to think that because he made it, anyone else can too. Some of this was just luck – there were times when he came close to arrest. His friends who were caught were sucked into the downward spiral of exclusion, unemployment and crime that is the monstrously huge US criminal justice system.



Of course, the pains of imprisonment fall most heavily on African-Americans. Hart confronts discrimination head on. So deeply entrenched is the racism of the police officers he encounters in his hometown that he finds it surprising to be treated with respect by British bobbies while stationed here. He reports his naivety when, returning to the USA, he hopes his US air force ID will save him from harsh treatment. As his friend tells him 'that shit don't work' for the Florida police. Some of the many humiliations and obstacles placed in the way of black people are valuably documented, from both personal experience and academic research.

The story of Hart's progress into academia is dotted with references to fascinating studies, demonstrating the adverse effects of criminal justice interventions on young lives, the increasing understanding of the complexities of drug actions in the brain (it's not just about dopamine) and refuting several prevalent misunderstandings. My own previous belief that cocaethylene (the product of combining alcohol and cocaine) is more dangerous to the heart than cocaine alone is also challenged by a study Hart includes.

In the book's final sections, Hart discusses his increasing awareness that US drug policy has been doing more harm than good by funnelling hundreds of thousands into the criminal justice system, a process which only deepens the social inequalities that structure drug problems. He took the brave decision to go public with his concerns by joining the board of the leading drug policy reform campaign the Drug Policy Alliance – a decision other US scientists have refused to take, fearful for their careers and research funding. Hart is not an unquestioning supporter of the cause. He writes about the tendency for US reformers to focus on the liberalisation of middle-class marijuana use rather than the policies that cause the greatest harms to black people; and to prioritise their campaigns over objective dissemination of scientific evidence on drugs.

It is refreshing and important to see a US neuroscientist prepared to stand up and argue for less harmful drug policies. The combination of personal and scientific stories makes *High Price* fascinating – it deserves to be read by every researcher, policy maker, professional and concerned parent with an interest in drugs.

Alex Stevens, Professor in Criminal Justice, University of Kent

THE MYTH OF THE DEMON DRUG THAT DESTROYS COMMUNITIES IS EXPOSED FOR WHAT IT IS: A CONVENIENT SCAPEGOAT FOR THE PROBLEMS OF DEINDUSTRIALISED CITIES

Tackling the hard stuff

This book is excellent, not least because it is much needed and long overdue.

Part of the Social Work in Practice series, at around 300 pages the book is easily digestible, consisting of ten core chapters and a short concluding chapter. The first three chapters are summative and discursive and tackle the core issues in working with this prevalent group of social care clients, including an important chapter on working in partnership with substance use services.

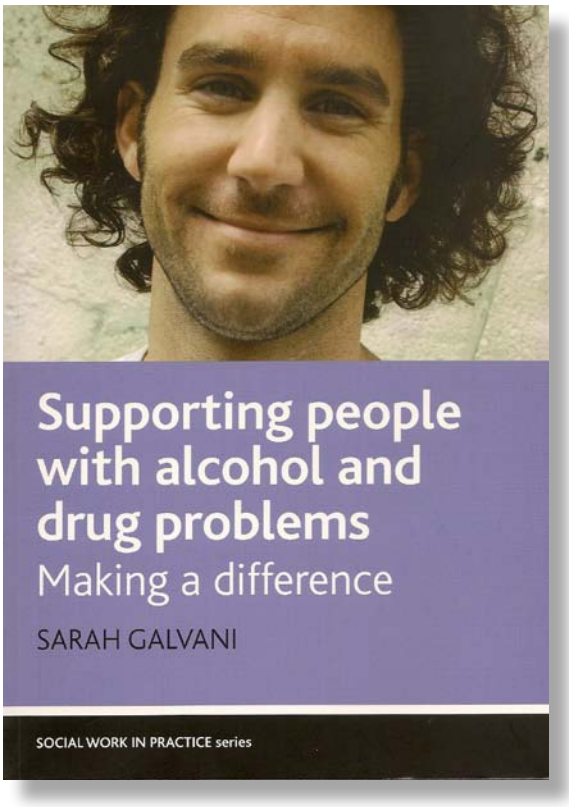
There are then seven chapters which discuss social care practice with sub-groups of social care clients who may experience alcohol and drug problems: namely, clients from black and minority ethnic groups, clients who are parents (considering how parental substance use problems also affect children and families), clients who are also experiencing domestic abuse or mental health problems, older people, younger people, and clients with disabilities.

All of this serves to highlight for social workers that working with alcohol and drug problems can and will come up in all areas of social care practice and that all social workers should be prepared and competent to tackle such issues. The holistic focus of the book, in considering a range of population groups, commonly co-occurring issues and the impact of such problems on families, is therefore highly appropriate, making it relevant to both generic and specialist practice.

It is still the case that social worker training and qualifying courses do not adequately prepare them for engaging with clients with drink or drug problems. Given the prevalence of substance use problems within social care practice and the complex nature of working with these clients and their families, this book makes a vital contribution to the change which is urgently needed to better prepare social workers for this part of their work.

Along with its obvious relevance for student and frontline social workers, this book will also be applicable to managers and other senior staff, practitioners at relevant partner agencies and also to commissioners of services who should be considering the role of social care in local treatment frameworks.

It is well written and laid out. I like the use of case vignettes, boxes, exercises and questions. It achieved the correct balance between academic detail – it is well sourced and referenced without being overwhelming in this regard – and practice discussions. I am already referencing this text. As I was reading the book I made several notes about things that are relevant to my work and I know that I will keep on using and referring to the book.



Reviews

SUPPORTING PEOPLE WITH ALCOHOL AND DRUG PROBLEMS: MAKING A DIFFERENCE

Sarah Galvani

Bristol: Policy Press, 2012

BUY NOW

This book has a dual purpose: as both a core academic text and a guide to practice. However, good though it is, this book cannot single-handedly drive forward the changes to social care practice that are needed. It is essential that others also take the proverbial bull by the horns to ensure that social workers are adequately trained and supported to respond safely and efficiently to clients with alcohol and drug problems and their families. In addition, this enhanced practice should be delivered in partnership with other key services.

Sarah Galvani is a knowledgeable and experienced social worker, academic and researcher, which makes her well positioned and informed to write this text. There is no doubt in my mind that this book will live up to its title by 'making a difference' to social care training and practice.

THIS BOOK HAS A DUAL PURPOSE: AS BOTH A CORE ACADEMIC TEXT AND A GUIDE TO PRACTICE

Lorna Templeton, Independent research consultant specialising in addiction and the family

48 factsheet

DrugWatch

AMT

Drug overview:
Alpha-methyltryptamine (MT/AMT) is a currently legal new psychoactive substance. It is a long acting, synthetic psychedelic.

Background:
AMT was originally developed as an antidepressant in the 1960s by the company UpJohn. In the 1990s AMT resurfaced as a drug of recreational use made available over the internet. It was first seen in the UK in February 2011.

Appearance:
AMT is an off white or yellowish/orange powder. The consistency can be either clumpy or fine. It is also found in tablet form. These are commonly referred to as pellets to avoid accusations that they are medicinal products. They are small blue pellets typically containing 30mg freebase powder.

AMT or 5-IT has been discovered in tablets sold as Ecstasy including pale pink tablets with a cherry logo and white tablets with a Mitsubishi logo but due to the complications of distinguishing between the two in analysis it is not confirmed which is the definite active ingredient in these tablets.

Cost:
Pellets cost approximately £5 per 30mg pellet. The powder form (purity unknown) costs approx £30 per gram and is available in amounts from 100mg at £7.50.

Route of administration:
AMT is often consumed orally, either by swallowing pellets, wrapping powder in a cigarette paper (bombing) or by taking a small bit of powder from tip of a moistened finger (dabbing). The powder form can be smoked; the onset is much faster by this method.

It is possible to inject this substance or administer rectally, although these methods appear to be rare for this substance. Due to the intensity and or dose/response curve for AMT, IV administration would likely be very dangerous.

Dosage:

Oral		Smoked	
Threshold	5-15mg	Threshold	2mg
Light	10-20mg	Light	4-5mg
Common	20-40mg	Common	6-10mg
Strong	40-60mg	Strong	10-20mg
Heavy	60-100mg		

Pellets are reported to contain a dosage of 30mg.

Typical effects and side effects
These are some of the typical effects and side effects experienced by people who use AMT, not everyone will experience all effects listed and many can be dose dependent.

Physical:
- Increase in energy
- Increased heart rate
- Blurred vision
- Restlessness
- Yawning
- Dilated pupils
- Decreased appetite and difficulty eating
- Vision obscuring visuals at high doses
- Nausea and vomiting
- Impaired coordination
- Muscle aches
- Headache
- Jaw clenching
- Insomnia

Mental:
- Mood enhancement
- Empathy
- Visual patterning
- Closed eye visuals (CEV)
- Mild open eye visuals (OEV)
- Music appreciation
- Anxiety
- Paranoia
- Agitation
- Panic
- Mental confusion
- Repetitive thoughts
- Racing mind
- Disturbed dreams

Onset, duration and after effects:
Oral doses have an onset of 30-120 minutes and peak at 3-5 hours. The duration is generally 10-14 hours although higher doses can last longer. After effects can be felt for a further 1-5 hours. As the effects can take over 2 hours to fully develop orally, it is not uncommon for users to re-dose in error thinking they have not taken enough initially. When smoked, the onset is significantly quicker at 10-30 seconds with typical duration between 8-12 hours.

Comedown effects
Some users report experiencing a stimulant-like comedown, where they may feel an energy drain, low mood or experience flu-like symptoms and general tiredness/lethargy. This typically happens a day or two after use, which some users call the "Tuesday blues". Some anecdotal reports suggest AMT has less of a hangover than drugs such as MDMA although this is not an indication of long term safety.

Patterns of use:
Patterns of use appear to be similar to drugs such as LSD. There seems to be little tendency to re-dose quickly unless a user believes they have not taken enough to experience full effects.

Long term effects/known harms:
AMT is a relatively unknown substance and little is known about the long-term effects and potential harms. AMT has the potential to cause serotonin toxicity especially at high doses or when mixed with other substances especially stimulants. AMT in conjunction with anti depressant/anxiety medications (SSRI/SNRI) has the potential to precipitate this condition.

Serotonin toxicity can be fatal if not recognised and dealt with both quickly and effectively. Symptoms include hyperthermia (overheating), hyperreflexia (over responsive reflexes), clonus (involuntary muscular contractions and relaxations), hypertension (high blood pressure), dysphoria (mental distress) and mydriasis (dilated pupils). Due to muscle tension being triggered by the condition, there is a potential of developing Rhabdomyolysis (muscle tissue breakdown) which can cause severe kidney damage and can be fatal. It is therefore dangerous to restrain individuals, as increased agitation will lead to increased muscle tension trying to break free from restraints. Treatment can include cooled IV fluids, benzodiazepines to control agitation, rapid cooling via ice packs, oral cyproheptadine (anti-histamine with anti-serotonergenic properties) and anti-psychotic medication in severe cases.

Two alerts regarding AMT were issued in 2012 after information was received regarding deaths in the United Kingdom and Norway. Two cases indicated that AMT was the only drug found in the system and the other included multiple substances.