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Druglink

Look at the whole board

It has become something of a mantra that in the last ten years, drug use in the UK has been steadily falling, that the heroin population is ageing and that young people's drug problems are more likely to centre on cannabis and alcohol than Class A drugs. In general, this is based on reasonable statistical evidence and reports from services. But it isn't necessarily the whole picture. Cocaine use spiked among 16-24 year olds in 2007 and while it has been in decline since, it went up again in 2012, a trend which was repeated for MDMA and ketamine. While these are figures for just one year, nevertheless, it still happened. MDMA deaths have been rising steadily since 2009 and may reflect the presence of high strength varieties of the drug in circulation, both in the UK and some of the supplier countries like Holland and Belgium. Reports from outreach drug workers suggest that problematic use of synthetic cannabinoids is emerging among vulnerable young people in some parts of the country, in ways usually more associated with heroin than cannabis.

Some of these issues are under the radar because people are not coming forward to services or, with MDMA, many of the harm reduction messages have been lost over time. Others, such as those regularly using anabolic steroids, are just not accounted for in any strategy, local or national. How significant is any of this? Very hard to say at present, but the drug scene does remain in a state of flux. Successful chess players do not just focus on the immediate piece to move, they plan ahead; the only way to do that is to look at the whole board.

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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

2 **Are synthetic cannabinoids the new heroin?**
2 **New York Times backs cannabis legalisation**
2 **EU rule against medicines control of NPS**
3 **Obituary: David Turner, 1949 – 2014**

Features

4 **The futures market**
Marcus Roberts considers an analysis of the interplay between crime, heroin and poverty in the past – and what it may look like in the future

7 **Driven by loss**
Three parents whose children died after taking drugs talk to **Max Daly** about how their grief has driven a desire to take action

10 **Crime-Busters or PCC Plods?**
According to former detective sergeant **Geoff Monaghan**, most Police and Crime Commissioners are not hitting the mark

14 **NICE of you to notice**
Are users of image and performance-enhancing drugs finally getting the help they need? **Joseph Kean** and **Jim McVeigh** weigh up the evidence

16 **Scary monsters**
Neil McKeganey asks if public health practitioners are starting a new moral panic over e-cigarettes

18 **TEN...and you're out**
Unlicensed raves are popping up all over the UK. **Peggy Whitfield** examines why some promoters are choosing to go down the illegal route

20 **Joint ventures**
Medical and recreational marijuana is now big business in North America. **David Ader** takes a look at the new economy of pot

23 **Drug and Alcohol Findings: What do the patients want?**
The **Findings** team analyse what policymakers mean by 'patient-centred care' and the implications for the drug and alcohol sector

Regulars

25 **Reviews**
28 **Factsheet**

Are synthetic cannabinoids the new heroin?

Druglink has learned of increasingly problematic use of synthetic cannabinoids (SC) among some young people who, now in their late teens, have been using the drugs heavily for 3 – 4 years, spending what limited money they have and appearing pale and emaciated, reminiscent of heroin users in documentaries from thirty years ago. Some users have reported to agencies that they have been suffering withdrawal symptoms, although others dispute this.

SCs are often presented in the media as 'legal cannabis'. But as a recent paper in the *Journal of Addiction Medicine* claiming the existence of an SC 'withdrawal syndrome' reported, "these synthetic cannabinoids are not actually synthetic replicas of THC, but are of a wide range of similar compounds with similar side chains. In other words, SCs have no relation to cannabis other than the fact they impact on the same receptors in the brain – and more scientifically should be called synthetic cannabinoid receptor agonists or SCRAs. SCRA does not exactly roll off the tongue, but it is useful in helping to underscore the point to both users and professionals that in their effects, these substances are very different from cannabis."

The paper only reported on two cases and a possible third, but whether or not there is a withdrawal syndrome associated with SCs is probably beside the point when set alongside the obvious problems they are causing in some areas. When *Druglink* conducted its 2013 Street Drug Survey, it was noticeable that the demographic for SC use was primarily young teenagers living in areas of economic and social deprivation, such as the north east – where people were also more likely to be able to buy the whole range of new legal drugs from outlets other than head shops. By contrast, other surveys and information from older, more affluent users attending clubs and festivals indicate a lack of interest in these substances.

UK DrugWatch coordinator, Michael Linnell says, "Any drug can be used 'addictively', but synthetic cannabinoids seem to be used in a highly compulsive way and are causing problems for those who get into it in a big way. Are the new heroin users already with us? Yes, and have been for a while, just using different drugs. I am not so sure about an actual withdrawal syndrome, but neither is there a physical withdrawal from coke, but that doesn't mean it is any easier to quit than heroin."

New York Times backs cannabis legalisation

In an editorial comparing the cannabis ban on 1920s Prohibition, the *New York Times* has come out in favour of the legalisation of cannabis, saying that the evidence was 'overwhelming' that moderate use of cannabis was less dangerous than either alcohol or tobacco.

The editorial was aimed at the Federal government in the light of action by several states either to allow medical use of cannabis, or go one step further and legalise recreational use. The paper maintains that criminalising otherwise law-abiding citizens while at the same time generating profits for organised crime was akin to the years of Prohibition and was 'socially unsustainable'.

The editorial went on to say that this call for reform was not taken lightly by the board, who had considered suggesting that the government wait to see how reforms pan out in the various states, but concluded that enforcing this law shouldn't be at the whim of whoever was in the White House. However, the editorial also stated that it was not optimistic about Congress taking action.

- See article *Joint ventures* on pages 20 – 22.

EU rule against medicines control of NPS

Following a case brought in Germany, the EU Advocate General Yves Bot has determined that laws and regulations aimed at the control of medicines cannot be used to control new psychoactive substances (NPS) because they fall outside the EU definition of a medicine. The relevant EU Directive from 2001 defines a medicine as any substance administered to humans "with a view to restoring, correcting or modifying physiological functions by exerting a pharmacological, immunological or metabolic action". NPS fall outside this because as recreational substances, they are not being administered to cure any illnesses.

DAVID TURNER 1949 – 2014

David Turner, my friend and colleague, has died after a long struggle with cancer. David was, without question, one of the most significant figures in UK and European drug policy over the past 50 years. Colleagues, friends and family will miss his easy charm and clear thinking.

Originally from North-West England, David came to the addictions field in London in 1971. He began his career – initially as a volunteer and later employee – in the New Horizon day centre in London where he worked alongside Jon Snow; now anchorman at Channel 4 News. By the mid-1970s David was head of the Standing Conference on Drug Abuse (SCODA), the umbrella organisation for voluntary sector agencies in the drugs field and Secretary to the ACMD. When the ACMD published its game-changing *Treatment and Rehabilitation* report in 1982, David's hand was clearly discernable in most of its recommendations.

During this time, he was a huge influence on the emerging UK drug treatment scene. He was a member of innumerable drug service management committees including: Phoenix House, Suffolk House, Ley Community, Lifeline, Hungerford Project, Community Drug Project, Inward House etc. He created the Scottish branch of SCODA, which would later become the Scottish Drugs Forum. And all his work was characterised by his understanding of individual hurt and his compassion for drug users. It was David who first said, "…a war on drugs must, inevitably become a war on drug users". When the harm-reduction bandwagon began to roll in the early 1980s, it was David who argued that harm reduction meant both preventing the harm drug users might do to themselves and the harm they might do to others. He had the foresight to see that these two objectives might not always be compatible and had the potential to fundamentally change the nature of drug treatment.

And when the UK Government introduced its Community Care legislation and refused to ring-fence local authority funding for drug misuse, it was David who saw that

this would marginalise residential treatment. Much to the Government's acute embarrassment, he campaigned publicly to reverse that decision which undoubtedly cost him his job at SCODA.

David went on to become a huge influence internationally, working with the International Council on Alcohol & Addictions; the World Health Organisation; Centro Italiano di Solidaretà Roma; the European Federation of Therapeutic Communities; the World Federation of Therapeutic Communities (WFTC) and the Vienna NGO Committee on Drugs (VNGOC). In his work with these various organisations, David was a powerful compassionate presence, usually working quietly in the background.

Much of his work attracted no byline but David seemed genuinely to have had no interest in such things. I once remarked to him that it was a pity that he hadn't published more. "Oh that's not what I do," he laughed. "I think I'm better occupied trying to make things work." And it was true that this was where he excelled. Elena Goti, the Argentinian psychiatrist, worked with him on VNGOC told me, "I can summarise his work very simply. He was our brains!" After the WFTC Institute in Genoa in 2010, when it seemed inevitable that the organisation might collapse into recrimination over the issues of harm reduction and religious affiliation, it was David who patiently talked for hours with the main protagonists and produced the masterful WFTC Genoa Declaration.

For all that, I will remember him most as my friend and loyal companion. He was an immensely witty and entertaining companion – he didn't tell jokes but his asides and anecdotes were often hilarious. During one conference, a rather pretentious presenter chose to quote Pink Floyd's *Brick in the Wall*. "We don't need no education", he declaimed drearily and David leaned towards me and whispered, "Oh yes he does. He just used a double-negative!"

He was a kind, compassionate, funny, clever man who saw it as his duty to use his intelligence and insight to support and care for a group of people for whom he genuinely cared. Most of all I will remember a modest man who never boasted of his achievements and never criticised failings in others. When I met with his family at his funeral in Barrow-in-Furness, I was surprised to find that they knew very little about his professional life and his huge significance to the field. "Well, he never talked about it much," one family member told me, "…we just used to say, 'David does something with drugs, but in a good way!'" He would have liked that, I think.

■ **Rowdy Yates** is President of the European Federation of Therapeutic Communities and Senior Research Fellow, Scottish Addiction Studies at the University of Stirling.

THE FUTURES MARKET

Crime, heroin and poverty underpinned the growth of the sector. But with change happening at every turn, **Marcus Roberts** takes stock

A new Home Office research report by Nick Morgan considers *The heroin epidemic of the 1980s and 1990s and its effect upon crime trends – then and now*. It asks whether the 'significant drugs epidemic, or wave of epidemics, through the 1980s and early 1990s' can help to explain a rise and subsequent fall in crime for which 'no definitive explanation has been produced'. Morgan finds that 'the epidemic may have had a significant impact on acquisitive crime in England and Wales', helping to explain why crime rose in the 1980s and early 1990s and has been falling since the mid 1990s. He concludes that – even allowing for a declining and ageing population – 'OCUs (opiate and crack users) continue to have the biggest impact on acquisitive crime trends', and 'the potential for further crime reduction is large'. This argument is not heard as much in current debate about drug treatment, even though it was the dominant trope for the best part of a decade.

The latest drug treatment figures confirm that while the majority of people in drug treatment have problems with heroin, there has been a marked decline in heroin use among new entrants. In 2005-06 there were almost three times as many heroin users starting treatment for the first time as users of other drugs, by 2012-13 this had been reversed, with non-heroin users new to treatment outstripping heroin users by two to one.

DrugScope's former Chief Executive, Martin Barnes, argued at our last Annual Conference that this 'wave of epidemics' could be said to have given birth to the 'drug sector' itself. He also highlighted a further link with deprivation that is less prominent in Morgan's discussion: the influx of heroin in the late seventies and eighties corresponded with social dislocation, and it was in some of the worst hit areas that heroin did most damage, from the inner cities to the Welsh valleys.

THE RESHAPING OF A YOUNG SECTOR THAT HAS EMERGED...AT LEAST SINCE THE 1980S, ... IN RESPONSE TO THE IMPACT OF A PARTICULAR DRUG IN A PARTICULAR CONTEXT AND AT A PARTICULAR TIME

Before the 1980s, heroin was not widely available (while crack was unknown) and there was no comprehensive specialised treatment system. By 2012-13 there were over 190,000 adults in drug services in England, with a central funding pot of £570 million for community and prison services, topped up by significant local investment.

This growth was in response to 'problem drug use', defined as dependence on heroin and/or crack cocaine. From the late 1990s, the expansion of the sector was turbo charged by exactly the kinds of arguments rehearsed by Morgan, which spoke directly to New Labour's commitment to be 'tough on crime and tough on the *causes* of crime'. This configuration produced the National Treatment Agency (NTA), the National Drug Treatment Monitoring System, the pooled treatment budget, regular catch ups between the Chief Executive of the NTA and the Prime Minister in the Blair years and a concerted cross-Governmental programme of action, led by the Home Office and guided by national drug strategies. It also produced *the* evidence base. The formula that says that £1 spent on drug treatment produces £2.50 in savings is based on evidence for the impact of *certain* kinds of treatment on *problem* drug use and the bulk of that saving was a result of reduced crime (and so, for example, the National Audit Office's assessment of the impact of the 2008 Drug Strategy was called *Tackling problem drug use*).

It is possible, then, to trace a paradigm that – at least, politically – drove the birth and expansion of the drug sector

as we know it in the UK, with the key co-ordinates being: 'problem drug use' (heroin and/or crack), deprivation and offending.

This paradigm also produced a reaction, which has contributed to the reshaping of the sector. A recent report from the Recovery Committee of the Advisory Council on the Misuse of Drugs comments that the first New Labour drug strategy in 1998 led to 'a substantial expansion of treatment for those with heroin dependence and in particular an expansion in methadone and other opioid-assisted treatment in England and Scotland'. What was criticised in the late 2000s as an over-reliance on opiate substitute treatment reflected both the focus of the system on heroin and the attractions of a treatment approach that was evidence based. It also – arguably – provided a relatively inexpensive crime reduction tool, but was not being used widely enough as a platform for integration and recovery at that time. It is worth noting that New Labour's second Drug Strategy – *Drugs: protecting families and communities* (2008) – promised 'a radical new focus on services to help drug users to re-establish their lives', including housing and employment. With hindsight, it is striking that this was described as 'radical' and 'new' just over five years ago.

There have been a host of paradigm shaking developments since, particularly with the election of the coalition Government in May 2010, swiftly followed by the publication of a drug strategy – *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life*. These include changes that are philosophical and ideological (e.g. 'recovery' and 'localism'), institutional and structural (e.g. the replacement of the NTA by Public Health England), economic (e.g. 'austerity'), epidemiological (e.g. falls in demand for heroin treatment), composition of the sector (e.g. growth of big providers), trend and market changes (e.g. new psychoactive substances or NPS), club drugs, emerging drug issues (e.g. performance and image enhancing drugs or prescription and over-the-counter drugs), the equalities agenda (e.g. services for women or older people), legal developments and rumours of legal developments (e.g. the Home Office review of NPS or the increasing international interest in cannabis regulation) and new policy issues and agendas (e.g. drug and alcohol misuse as a dimension of 'multiple need' or 'multiple exclusion').

Above all, of course, there is a bringing together of responsibility and budgets for drugs, alcohol and tobacco within a broader public health framework. If the impact of drug treatment on crime secured unprecedented investment from the 1990s, the relocation of substance misuse issues in public health brings the costs associated with alcohol misuse (and tobacco) much more sharply into focus. It is estimated that alcohol-related harm has an overall cost to the NHS in England of £3.5 billion annually.

So what does all this mean? It is hardly news that we are in a period of wide-ranging and far-reaching change

affecting drug and alcohol policy and services. It is illuminating, however, to consider this as the reshaping of a young sector that has emerged and developed in the UK in the last 50 years and, to a significant degree, at least since the 1980s, has done so in response to the impact of a particular drug in a particular context and at a particular time. In this sense, these changes go to the foundations of the drug sector, and could amount to a fundamental shift in its co-ordinates and direction of travel. What follows are some reflections prompted by Morgan's analysis.

First, given the effectiveness of crime reduction arguments in levering in the political interest and investment that built the modern drug treatment system, and their salience to the priorities and concerns of local communities, it is tempting to mobilise a new analysis that suggests that the impact of treatment on crime may be sufficiently large to explain overall crime trends.

Less crime is a good thing and the contribution that drug services make to cutting crime brings huge benefits to communities, including some of the most deprived. But a disproportionate emphasis on this argument would feel a regressive step given the emergence of a recovery narrative that has started to shift the political debate about drug treatment beyond a deficit model that is exclusively about fear/risk, and towards an asset model that is also about hope/potential. If the principal argument for getting people into treatment services is that they are responsible for a lot of crime, then this will tend to reinforce the barriers to them moving out of treatment and on with their lives.

IF THE PRINCIPAL ARGUMENT FOR GETTING PEOPLE INTO TREATMENT SERVICES IS THAT THEY ARE RESPONSIBLE FOR A LOT OF CRIME, THEN THIS WILL TEND TO REINFORCE THE BARRIERS TO THEM MOVING OUT OF TREATMENT AND ON WITH THEIR LIVES

Another question is who an argument for investment to reduce crime should be addressed to. In the late 1990s it addressed a key priority for a Government that set national targets and ring-fenced budgets. It may have less direct and immediate purchase when pitched at a Director of Public Health or local Health and Wellbeing Board, given their focus and responsibilities (this is one reason why DrugScope has championed the involvement of Police and Crime Commissioners and other criminal justice representation on Health and Wellbeing Boards). Perhaps the point to be made here is partly that the impact of drug treatment on overall crime trends is so profound that this should be a priority for crime reduction policy and spending, over and above public health investment.

Second, the recent ACMD Recovery Committee report concluded that 'many people have periods of dependence or problematic use of alcohol or drugs in their lives that most overcome'. However, for people 'with little recovery capital or dependent on some types of drugs (especially heroin), recovery can be much more difficult and many will not be able to achieve substantial recovery outcomes'. Paradoxically, then, it may be that recovery is hardest to achieve for many of the problem drug users for whom the drug sector was primarily developed in the UK and largely achievable for the wider group of people experiencing alcohol or drug problems that it has more recently reached out to encompass. A practical conclusion is that the development of the recovery model needs to be balanced with models and interventions that provide the best possible support to enable those less likely to achieve 'substantial recovery outcomes' to realise their potential, particularly as many of this group move into older age.

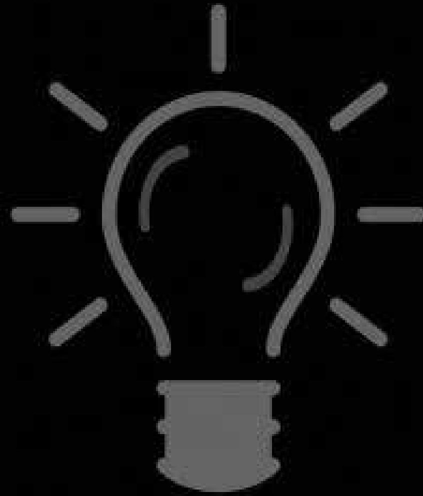
Third, the formation of the drug sector in the UK brought investment and support to excluded individuals, families and communities. There is widespread anxiety that a public health focus could divert money away from marginalised people with entrenched needs and towards population-wide interventions – this is particularly concerning with the pressures on public health budgets, particularly if drug and alcohol spend is a 'zero sum game'.

This is, of course, a concern. It should be noted, however, that there are a range of ways in which drug and alcohol use can contribute to exclusion, stigmatisation and marginalisation. DrugScope's work on 'multiple need' with the Making Every Adult Matter coalition illustrates this, with drug and alcohol issues figuring in the lives of people experiencing severe and multiple disadvantage in a variety of ways, often not involving problem drug use – with, incidentally, significant cost benefits for criminal justice services. This agenda is attracting significant investment (e.g. over £100 million through the Big Lottery Fund's 'Fulfilling Lives' programme) and increasing political interest (e.g. featuring in both the Government's Social Justice strategy and Institute of Public Policy Research's *Condition of Britain* report, which mapped out a policy agenda for Labour). In addition, drugs and alcohol may impact harmfully on other marginalised groups – such as sections of the LGBT community or elderly people – in ways that do not match the problem drug use pattern.

The long term future of drug and alcohol services is not being played for a fixed pot of money anyway (if only it were). The case that we develop today will affect the amount of investment available in five, ten or fifty years time. Looking at the bigger picture, there is a need to speak to both the crime reduction agenda and other issues and priorities that can engage the attention and commitment of local communities. Recent changes provide us with opportunities to position our sector by developing its offers and narratives both to challenge stigma and exclusion and to reach into all those areas of policy and practice to which drug and alcohol services and interventions are relevant – which is to say virtually everywhere, and including a better balance between early intervention and resolving chaos.

Finally, Morgan states that 'the other main policy conclusion is that preventing a future epidemic is crucial'. This is particularly pertinent at a time when new drugs and patterns of drug use are emerging all the time, but that isn't to say that an older problem can't become a new one again. Look no further than the United States, where a new heroin epidemic is being linked to misuse of prescription pain killers and an influx of cheap heroin, much of it from the Mexican drug cartels. In a recent BBC article, Jack Riley, a regional head working for the US Drug Enforcement Agency in the Chicago area, commented that 'heroin addiction is probably at its all-time high' in parts of America, adding 'I've been doing this for thirty years in virtually every corner of this country and if anything can be likened to a weapon of mass destruction in a family, on a community, on society, it's heroin'.

■ **Marcus Roberts** is DrugScope's Chief Executive



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Driven by loss

Fiona Spargo-Mabbs, Anne-Marie Cockburn and Maryon Stewart were all left shocked and grief stricken when their children died after taking drugs. But they all have something else in common too. They are campaigning and agitating to make sure other parents do not have to go through what they did. By Max Daly

Daniel Spargo-Mabbs was 16 when he took ecstasy for the first time on January 17, on his way to an illegal rave on an industrial estate in west London. He had told his mother, Fiona, he was going to a party near the family home in Croydon, south east London. The drug caused his body temperature to rise to 42 degrees. Each of his internal organs and systems stopped functioning in turn over the next few hours.

"By the time he was transferred to a specialist liver intensive care unit that Saturday afternoon, his lungs, liver, kidneys, heart and circulatory system had all failed," says Fiona. "We sat with him over the next two days and watched him slowly die. We were in complete shock and trauma, and still are to a great extent. It was all too hard to process. When Daniel died, part of us also died."

Daniel's sudden death meant Fiona and husband Tim found themselves in the middle of a media storm. They had

to make a quick decision – did they pull the shutters down to deal with their grief in private, or did they risk exposing their raw emotions in public in order to send some kind of message?

"The level of media interest immediately following Dan's death took us completely by surprise," says Fiona. "But we decided we needed to talk, to tell other people about the risks out there to children and young people. We had such a sense that if this had got Dan, then it could get almost anyone, and we felt driven to warn people, to do anything we could to stop this happening to another family, and so we took every opportunity to speak out that came our way, and have continued to do so."

A week after Dan's death, friends of Fiona and Tim, who are committed Christians, suggested they should start a charity to consolidate their message about the risks of drugs. So they began the process of setting up the Daniel Spargo-Mabbs Foundation, with the support of family, friends, the church and the wider community.

Fiona, a manager in adult education at Croydon Council and her husband Tim, a learning disability charity worker, decided to focus on education, both in and out of school, as the primary means of making change. They are planning a three-pronged approach: a peer mentoring programme for teenagers, workshops for parents and extra training for teachers. They also want to support schools to provide drug education that is more embedded and longer-term than it is at present. "We know that one-off interventions that present shocking facts can be very effective, but usually only in the short-term," says Fiona.

"This is still very early days for us in every sense," says Fiona. "Dan died only six months ago, we've been spending the last few months doing a lot of groundwork, talking to specialists and other related charities and professionals, finding out what's out there already, gathering information and building links."

Last term they delivered Personal and Social Development sessions to a few hundred year 9 and 10 pupils locally, which have had a really positive response from both pupils and teachers. They will be working with around 165 year 11s after their GCSEs this summer, from schools across Croydon and Sutton, and hope to send at least some of them back into their schools or sixth form colleges as ambassadors for the Foundation.

They have just signed contracts with award-winning playwright Mark Wheeler, who they have commissioned to write a play about Dan's story. They also plan to work with university students ands set up under age club nights. In terms of policy, they want effective drugs education as a statutory requirement for all schools.

Fiona and Tim are part of a growing number of parents – including Jim Lee, the father of Nancy Lee, 23, who died after a long term ketamine use in March, Anne-Marie Cockburn, the mother of Martha, 15, who died after taking highly pure MDMA in July last year, and Maryon Stewart, whose daughter Hester, 21, died after taking GBL in 2009 – who have decided to speak out and take action after the deaths of their children from 'party drugs'.

REGARDLESS OF THE DIFFERENT AVENUES WE HAVE GONE DOWN, THE PARENTS OF CHILDREN WHO HAVE DIED FROM DRUGS HAVE THE SAME GOAL: WE ALL WANT TO AVOID SOMEONE ELSE BEING IN THE SAME POSITION AS US

They are not the first. The parents of Leah Betts, who died after taking ecstasy on her 18th birthday in 1995, famously called for her drug supplier to be sent to the gallows. Their campaign sparked a hard-hitting anti-drugs movement, but was abandoned 10 year later when they declared they had been betrayed by the government.

Anne-Marie Cockburn came to a very different conclusion after the death of her daughter. Within a week of Martha's death from snorting half a gram of highly pure crystal MDMA, Anne-Marie began trawling the internet. She says she was desperate to learn as much as possible on the issue of drugs – a world in which she had so suddenly been plunged.

"A lot of our knowledge about drugs is fed by sensationalist headlines, it's basically propaganda," she says. She discovered that behind the political rhetoric, the newspaper stories and the "overly loud" voices of ex-addicts calling for zero tolerance, there is a wealth of robust research on what works and what doesn't. "So I decided to look at best practice around the world. I would love to live in a perfect world where no one takes drugs, but they do. The recreational drugs industry is huge because of the demand.

"The conclusion I came to was to take a sensible approach, based on realism and regulation, safeguarding and harm reduction. Everyone bangs on about drug education, but if a drug hasn't got a label on the bottle, what's the point?"

She says not all parents in her position have reached the same conclusion, but they are driven by a similar wish. "Regardless of the different avenues we have gone down, the parents of children who have died from drugs have the same goal: we all want to avoid someone else being in the same position as us," says Anne-Marie.

Over the last year, Anne-Marie, who was a single mother to Martha, has expressed herself in a series of calm, eloquent and powerful interviews in the national press. She has also published a book, *5,742 Days*. "I was offered media training but I didn't want to have it. What I say is authentic and I want to get my message to normal people."

Grief is still a big part of her life. "There is nothing more motivating than the agony of loss to get me out of bed every morning." But she says her views are borne out of rationality rather than anger. "This is about being peaceful and having a conversation. I've been to too many meetings with polarised debate, just noise. Sometimes a very quiet voice carries in the wind."

Anne-Marie wants all psychoactive drugs to be treated like pharmaceuticals – regulated and labeled, accompanied by drug education to inform and encourage children not to go down the drug route. Until then she wants drug testing facilities to be readily available.

What has most surprised her during her journey since Martha's death one year ago? "When I speak to people who believe in prohibition, within five minutes they have changed their mind. They are not being polite, it's just that most people do not know the basic facts."

Now she has had her say in the media, she feels the time is ripe to take on the politicians, whom she accuses of using prohibition as a way of "shoving everything under the table".

"Prohibitionists can spout any statistics. But come with me and stand by Martha's grave and tell me prohibition works. I will write to Theresa May and David Cameron. I want to make politicians feel incredibly uncomfortable.

But I will not let them meet me and pat me on the arm and offer me a nice cup of tea. I want to ask them – what are you going to do about it?"

Maryon Stewart has five years experience dealing with the government and its drug policy. Since her daughter Hester took GBL and died in 2009, she has became the unofficial but highly organised flag bearer in the fight against legal highs. When Hester died, very few people had heard of legal highs and mephedrone was yet to hit the mainstream. She started campaigning in a knowledge vacuum.

So while Fiona is focused on education and Anne-Marie is calling for a complete overhaul of our drugs laws, Maryon and her charity the Angelus Foundation has homed-in on the issue of legal highs. As with the other two, the death of her daughter came out of nowhere.

"It's a surreal situation to be in, even over time it doesn't sink in that your son or daughter is not coming back again. If you use drugs repeatedly then you expect the worst, but for Hester, a cheerleader who studied molecular medicine at Sussex University, it wasn't supposed to be like that," says Maryon, a well-known nutritionist.

Already well acquainted with some national paper and TV journalists, Maryon, was whisked off to a hotel by one newspaper to escape the media, which was camped outside her front door.

"I have spoken to other parents and we all agree, had there been an awareness campaign about drugs, then our children would probably all still be alive," she says. "The reason I started to campaign is that I wanted desperately that other parents would not have to go through the same nightmare."

Within a fortnight of her daughter's death, Maryon had sent a letter to home secretary Jacqui Smith demanding why the government had not taken the advice of experts and banned GBL. But the day before she was due to meet the home secretary she resigned. Instead she saw her successor Alan Johnson, whose initial eagerness to help was stymied by red tape. Because GBL is used to make paint stripper, fear from getting sued by paint stripper firms ensured the ban was delayed by six months.

And this has been the story so far for Maryon in terms of changing government policy. She says progress has been "woeful". A review into 'legal highs' set up by drug minister Norman Baker is due to report in September. Despite her dismay, the Angelus Foundation has been prolific, being involved in spreading awareness about the dangers of 'legal highs' in the form of newspaper campaigns, short educational films and the Why Not Find Out website. In May music fans visiting the homepages of the UK's main music festivals saw a black window except for a grey light bulb and the message "Don't be in the dark about legal highs".

Maryon believes proper education and inter-departmental strategy is needed. She says the New Zealand experiment, to regulate legal high makers, was a promising idea but has been derailed by bad implementation.

"Kids want to have fun and don't want to mess up their lives. A lot of them are not risk takers but they are being made to take risks," says Maryon.

"Politicians pay lip service to the issue of 'legal highs' at meetings. But I don't think any of them think it is important enough. Only until they lose a child will they take it seriously. I have letters from David Cameron and Nick Clegg promising action, but it just isn't happening. How much longer is it going to take?"

www.angelusfoundation.com
www.dsmfoundation.org.uk
www.whatmarthadidnext.org

■ **Max Daly** is a freelance journalist

Crime-Busters or PCC Plods?

Former detective sergeant **Geoff Monaghan** has some trenchant views on the policing plans of Policing and Crime Commissioners.

The Police Reform and Social Responsibility Act 2011 provides for the replacement of police authorities with directly elected Police and Crime Commissioners (PCCs), with the aim of improving police accountability by 'reconnecting' the public with policing.

Briefly, in accordance with section 1 of the Act, the core functions of the PCCs are to secure the maintenance of an efficient and effective police force within their area, and to hold chief constables to account for their functions. In particular, PPCs must hold chief constables to account for their delivery of the police and crime plans (PCPs). The PCP, drawn up in consultation with the chief constable and local communities, sets out the priorities of the PCCs and reflects their wider community safety responsibilities.

Despite the initial widespread approval and accompanying fanfare leading up to their elections in late 2012, PCCs are now in the firing line and politicians, academics and the media are raising questions regarding their effectiveness and usefulness. In its report *Policing for a Better Britain*, published in 2013, the Independent

Police Commission (IPC) didn't pull any punches and described PCCs as a "failed experiment". Even the Home Secretary, Theresa May, who introduced the system of elected PCCs as part of her police reform measures, is on record as saying that their first year had been "a little mixed" when it came to holding forces to account.

Leaving aside problems such as the political and legal fallout following the suspension of the chief constable of Lincolnshire, the dismissal of the chief constable of Gwent, allegations of cronyism and questions regarding their accountability and competency, I'm concerned that many PCCs have fallen short of expectations in terms of their PCPs. To be blunt, I believe the majority have failed to deliver on their promises to produce innovative and feasible PCPs and that their ill-conceived plans stand little chance of bringing about significant reductions in crime or improving community safety. In turn, I believe their failure will reflect poorly on local police services, thwart government attempts to increase public confidence levels in policing and very likely fuel the blame game culture which increasingly dominates debates regarding the state of policing in Britain.

On reading the 41 PCPs, I was struck by the fact that few PCCS provide any detail as to how their aspirations will be realised and in terms of tackling volume, drug and organised crime, there is little evidence of innovative thinking. Indeed, few go beyond the hoary phrases cherished by senior police officers and politicians alike: e.g. "[We will] enhance the investigation of serious violence, burglary, hate crime and rural crime to solve it and deter offenders" (Northumbria PCP) and "[We will] reduce the impact caused by drugs and alcohol through intervention, education and enforcement activity" (Merseyside PCP).

Surprisingly, many of the plans are poorly written and a number of them include language more suited to the tabloids rather than public policy documents. The following examples are especially worthy of mention. Adam Simmonds, the PCC for Northamptonshire unashamedly writes: "There will be a focus on eradicating drugs and reducing acquisitive crime." Eradicating drugs? I'm not nitpicking over sloppy prose – Simmonds is obviously serious in pursuing a policy of eradication because he's set up a "new Office for Drug Eradication". It's difficult to imagine a better example of the unaccountable in full pursuit of the undoable. He continues: "There will be a huge change in activity in respect of drugs." "Drug markets will be dismantled, with strong intelligence [and] proactive enforcement…". Presumably, prior to his appointment, local officers ignored drug markets, favoured weak intelligence and rejected proactive approaches such as executing search warrants and running test purchase operations.
Simmonds continues; "There will be a drive to increase the use of the Proceeds of Crime Act to ensure that crime never pays." In truth, crime often pays; according to the National Audit Office (NAO) at least £99.65 of every £100 generated by the criminal economy during 2012-13 was kept by the perpetrators. Instead of platitudes, Simmonds could have echoed the research findings regarding confiscation orders and said something like "The lack of coherent strategic direction and agreed success measures, compounded by weak accountability and a flawed incentive scheme, combined with poor performance and cost information, lack of knowledge, outdated ICT systems, data errors and ineffective sanctions, has persuaded me not to include confiscation orders in my performance targets." Political suicide? Certainly, there are risks in making such a statement, but no more so than the risks attached to the eradicating drug misuse idea.

> IN ITS REPORT *POLICING FOR A BETTER BRITAIN*, PUBLISHED IN 2013, THE INDEPENDENT POLICE COMMISSION DIDN'T PULL ANY PUNCHES AND DESCRIBED PCCS AS A "FAILED EXPERIMENT"

In terms of improving community safety in general, Simmonds has this to say: "Doing what has always been done is not an option." Really? So no concerted efforts to prevent and reduce crime? No plans to combat terrorism, organised crime and domestic violence? No drive to increase arrest rates? No 'visible policing' strategy? No interest in promoting road safety? Well, no. In fact all these objectives are part of his plan, so clearly there is a commitment to carry on doing what has always been done. In general terms, how could it be otherwise?

Other PCCs have also fallen into the trap of making ill-considered sweeping statements. This one is from the Lincolnshire plan: "When a crime is committed, we will ensure that those responsible are quickly identified and progressed through the criminal justice system in a fair and timely way." And so is this: "We can make Lincolnshire a no-go location to commit crime." Talk about raising unrealistic expectations.

PCCs are also tasked with ensuring that police forces are responsive to the needs of the public and have gone to some lengths to stress that their PCPs reflect this. Of course, in a democratic society we expect nothing less – but tailoring policing policies and practices, which are underpinned by statute, Codes of Practice and national guidelines, to suit the wishes of local residents, is easier said than done. This is especially true in cases where the wishes of residents are rather vague. In her Foreword to the North Yorkshire PCP, the PCC Julia Mulligan notes with approval that as part of the consultation with local residents, 3 out of 5 wanted a "harder line taken with criminals" and the majority "wanted more offenders charged rather than cautioned". However, she has nothing to say as to how North Yorkshire police will operationalise residents' aspirations. This is a glaring omission, because it's difficult to see how, in an attempt to meet Mulligan's expectations, the local police could systematically circumvent the guidance on charging issued by the Director of Public Prosecutions (DPP), or the Ministry of Justice guidance on 'simple cautions' or the DPP Codes of Practice regarding 'conditional cautions'. Creating arbitrary 'blanket policy' regarding charging and out-of-court disposals is not within the gift of PCCs.

In any case, police discretion regarding policy and practice covering simple cautions and other out-of-court disposals has been significantly curtailed in recent years on the back of Ministerial and Association of Chief Police Officers (ACPO) guidance and statutory provisions such as section 37 (B) (7) of the Police and Criminal Evidence Act 1984. Of course, Mulligan could argue that, prior to her appointment, inappropriate cautions were the order of the day – but she doesn't offer any evidence to support this notion and it's unlikely that this was the case.

Unsurprisingly, all the PCCs talk about ensuring 'high-visibility policing'/'visible policing presence' – that is to say, ensuring that patrolling uniformed officers are regularly seen by people living and working in communities.

Whilst acknowledging the fact that the presence of uniformed police officers serve to reassure communities and deter some forms of offending, it seems to me that on the back of shrinking or static numbers of officers and ambitious (if not unrealistic) performance targets, it's becoming increasingly difficult for forces to meet the public's expectations regarding high-visibility policing. Perhaps it's worth pointing out that PCCs' expectations regarding marked increases in arrest and prosecution rates could well undermine their attempts to maintain, let alone increase, the idea of high-visibility policing. Why? Because 'thief-takers' by definition spend much of their time in police stations: writing and trawling intelligence reports, booking-in, searching and interviewing arrestees, interviewing witnesses, completing crime reports and preparing prosecution files. They also spend a good deal of their time attending courts, obtaining search warrants and giving evidence. Proactive policing almost always involves covert policing work: e.g. static and mobile surveillance and recruiting, tasking and managing informants – activities which, by definition, escape the public's attention. And then there are the numerous training courses officers are now required to attend. Against this background, I believe the comments relating to high-visibility policing should have been more nuanced.

In fairness, some PCPs are rather good. The plan for Hertfordshire, with its punchy and memorable title *Everybody's Business*, is well written and generally free from clichés and sweeping statements. The report also contains some interesting ideas, such as the introduction of a website which will allow victims to search images of recovered stolen property. And it's refreshing to see that the PCC and Chief Constable have settled on realistic performance targets: e.g. a 2% reduction in crime for 2014.

The plan for North Wales is also well written and the PCC's 'three stages to a crime' approach provides an interesting and novel framework on which to build concomitant strategies and tactics. Surrey's plan deserves attention because its framework rests on the notion of 'zero tolerance policing'. The PCC, Kevin Hurley, a former Detective Chief Superintendent, clearly has a mandate for this approach because he appeared on the PCC ballot paper as the *Zero Tolerance Policing ex Chief,* a registered political party of which he is the leader. Thankfully, his plan sets out what he means by 'zero tolerance policing': "Zero tolerance is not about locking criminals up and throwing away the key. It is about making sure that the police – and partners – always do something about anti-social behaviour whenever they encounter it. It is about laying down a marker of what is – and what is not – acceptable behaviour in our society." However, whether he and Surrey police have sufficient resources to realise their ambitions is questionable – "always doing something" carries a huge price tag. Still, this is nothing less than our communities expect.

I ANTICIPATED SEEING CRAFTED, WELL-GROUNDED, PRAGMATIC PLANS, FREE FROM PLATITUDES AND ERRONEOUS THINKING. IN THE MAJORITY OF CASES, I WAS DEEPLY DISAPPOINTED

In summary, I was hoping the PCCs would demonstrate their willingness to innovate – to introduce new ideas, methods and approaches on the back of established frameworks. I expected they would draw on the wealth of research available to them and learn from the successes and failures of previous crime and drug strategies. I anticipated seeing crafted, well-grounded, pragmatic plans, free from platitudes and erroneous thinking. In the majority of cases, I was deeply disappointed.

Concerning the future of PCCs, the IPC (which was chaired by Lord Stevens, a former Commissioner of the Metropolitan Police Service) has this to say:

"Following a careful evaluation of the evidence, the Commission concludes that the PCC model is systemically flawed as a method of democratic governance and should be discontinued in its present form at the end of the term of office of the 41 serving PCCs."

On the basis that the majority appear to be struggling to deliver coherent plans, I tend to agree with the IPC recommendation. In the meantime, I would urge the Police and Crime Panels, chief constables and local partners (including drug services) to take another look at their PCPs and, where necessary (i.e. the majority of cases), urge their PCCs to consider re-writing parts of their plans and re-thinking most of their targets.

■ **Geoff Monaghan** is a former detective sergeant in the MPS, who served on the Central Drugs Squad and the Specialist Intelligence Section at New Scotland Yard and from 2005-11, worked for the United Nations Office on Drugs and Crime in Russia and Vietnam. He is a Research Fellow with the Semeion Research Center for the Science of Communication in Rome.

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IMAGE AND PERFORMANCE-ENHANCING DRUGS (IPED)

NICE of you to notice

A significant official under-reporting of steroid use is just one of the challenges facing those workers trying to assist many hidden groups of IPED users. By **Joseph Kean** and **Jim McVeigh**

For anyone who trains in a gym and has been brave enough to venture into the free weights area where the monsters live, you will know that steroid users are everywhere. The Crime Survey for England and Wales has steroid prevalence at 50-70,000. But we know (and have hard data to support it) that in areas which have been proactive in service provision for some time, the numbers of registered steroid users usually accounts for somewhere in the region of 1 to 1.45% of that population (1600 registered users in a city or town of 110,000 for example).

Although, a crude calculation, if you extrapolate that figure across England and Wales it is easy to see that the official estimate is a long way off; even adding a zero would still not come close enough to the numbers those of us on the frontline suspect.

National media are quick to mock the shallow 'Geordie Shore-esque' qualities of the user with their shiny hairless bodies and too tight tops, yet we only need to turn a page or two or move along the shelf in WH Smiths to find a plethora of 'mass freaken muscle' articles and images of men close to deformity to which we should apparently all aspire to. The affliction of unachievable goals pushed in your face was previously only for women; but no more. Now the pressure is on for men everywhere you look.

So where are we with research into the health consequence of steroid use? Studies to explore steroid use are now appearing more frequently and appear also to be targeting the areas that we actually want to know about. Until these happen however, there are currently still only a few areas where we really know the effects of steroids.

Firstly, that blood borne viruses are present in steroid users, and at levels now alarmingly comparable with opiate users. Last year's paper by Hope and colleagues published in the *British Medical Journal Open*, showed that 1 in 18 steroid and IPED injectors have been exposed to hepatitis C, 1 in 11 have ever been exposed to hepatitis B and 1 in 65 have HIV. Data published by PHE earlier this year show even higher levels of HIV amongst injectors of anabolic steroids and associated drugs

Secondly, that long term steroid use damages the heart: in November 2013, Harrison Pope and colleagues published evidence from the first ever study on long term steroid users which indicated, that long term use negatively impacts on the heart and in particular that steroids are "associated with premature coronary artery disease and systolic and diastolic left ventricular dysfunction".

For years now we have been seeing local and high profile cases of steroid users dying from heart related disease at ridiculously young ages and this makes complete sense if you take into account the effect of the drugs themselves combined with associated activities that also stress the heart such as fasting and dehydrating.

Thirdly, unlike years ago, when well connected users could obtain genuine products, there are virtually no legitimate pharmaceuticals available to users. The only suppliers now are underground laboratories. Some products will contain the correct ingredients, with minimal adulteration and approximating the stated strength. Some won't and some won't even come close.

So with the research spelling out the risks, why are we so behind with service delivery? There is some progress. Practitioners in services now have a relatively useful tool in the guise of the recent NICE Guidance (PH52 Update) which, for the first time ever, is pushing for appropriate services for this long-neglected group.

Since the publication of the guidance in March however, it appears the news has only trickled down to the occasional commissioner and everyone seems to be waiting for everyone else to do something. Geographically, the North of England (together with Scotland and Wales) appear, in the main, to lead the way in relation to interventions and service provision. Requests for specialist steroid training delivery for staff in services are at an all time high and at most needle exchanges, steroid users are more than happy to engage with harm reduction staff.

However, there are still totally unacceptable situations among a population that still do not see themselves as drug users:

The picture (above) was taken in a

gym; it's a sink in the bathroom area where numerous injections take place every day. The cord is from a garden machine that had been used to 'suck up' large volumes of discarded needles and debris within the gym.

You would hope that people in gyms like this would have access to some form of decent harm reduction advice or drug services? Well, they don't.

Twenty years ago, a conference which acknowledged that caring for steroid users should now be part of mainstream drug work, outlined the adverse effects of high dosage anabolic steroids, the perils of the illicit steroid market and the development of appropriate interventions for steroid users.

Now, the poly-pharmacy is far more complex and fast-moving than could ever have been imagined back then. We have a much more diffuse population of users in every demographic: ex heroin and crack users wanting to no longer appear malnourished and pasty skinned, East European influxes with a lengthy historic culture of strength sports, Asian men with already existing cultural image consciousness, female users of anabolic agents combined with melanotan and dietary agents, to name just a few of the new groups. We are a long way from evidenced based best-practice. But this should not be a barrier to delivering interventions based on sound harm reduction theory, evaluating their effectiveness and, most importantly, engaging and communicating with service users and potential service users.

Percentage of NSP clients using IPEDs in the North of England-2014

Area	Percentage
Middlesbrough	67
Kirklees	60
Sheffield	62
Newcastle	52
Sunderland	60
Bradford	41
Halton	86
Liverpool	83
Sefton	43
St. Helens	34
Warrington	86
Wirral	77
Manchester	60
Bolton	52

Data provided by NSP service providers/ managers via pied-forum@googlegroups.com (Kimergård & McVeigh, 2014)

YOU WOULD HOPE THAT PEOPLE IN GYMS...WOULD HAVE ACCESS TO SOME FORM OF DECENT HARM REDUCTION ADVICE OR DRUG SERVICES? WELL, THEY DON'T

There are many examples of good work out there; Yorkshire and Humber have a Regional Steroid and IPED Reference Group and Workers Forum with over 30 people and every district represented. There is a National Forum that has recently formalised a core group and board (but has an uneven distribution of membership across the United Kingdom) and NICE have only recently showcased an excellent piece of work delivered by the Cambridge Centre in Scarborough.

So the message to policy makers, commissioners, service managers and practitioners is that there are huge numbers of steroid users accessing needle exchanges – and there are a whole lot more of them out there who are not. In needle exchanges right across the north of England (where data are available) the majority of clients are not users of heroin and definitely not novel psychoactive substances, but are injectors of drugs for which there has been virtually no investment in research or service development in the last 20 years.

Joseph Kean is a Senior trainer/ consultant at NineZeroFive.Org.
Jim McVeigh is Acting Director, Centre for Public Health, Liverpool John Moores University.d

Case Study: The Cambridge Centre, Scarborough

Staff at the Cambridge Centre's needle and syringe exchange programme (NSP) were aware that there was a significant and growing number of IPED injectors outside of treatment. Through local discussion and with key national partners, including The Bridge Project and Exchange Supplies, it was agreed that we needed to set up a peer exchange scheme within the local gym and facilitate a Cambridge Centre worker-led 'gym clinic 'to provide the more sophisticated interventions such as BBV (Blood Borne Virus) testing and educated harm reduction IPED information.

The Cambridge Centre has facilitated peer exchange in the past to IDU's (injecting drug users), however it was clear that extra training for staff and peer's needed to be arranged specifically for IPED.

Staff from both the Cambridge Centre and the local gym attended comprehensive training on IPEDs. This enabled us to identify gaps in knowledge and practice and up skill all who attended, whilst also establishing a relationship with the gym staff and supporting them throughout. The relationship with the gym was further enhanced by the Cambridge Centre team manager and dedicated IPED workers visiting the gym to liaise with gym staff building confidence and trust whilst establishing professional respect.

The gym owner made a generous offer to allow the Cambridge Centre's mobile needle exchange worker to use facilities at the gym, to foster a working relationship with gym staff and clients. The clinic would take place weekly in situ with the mobile needle exchange worker being the main contact between the staff and the Cambridge Centre.

It was decided that the 'gym clinic worker' could offer interventions specifically around:

- BBV dry blood spot screening for HIV/ AIDS HCV/HBV;
- Safer injecting work, site rotation, appropriate site injection and paraphernalia use;
- Harm reduction advice;
- Referral into wound care services at the Cambridge Centre;
- Referral into sexual health services at the Cambridge Centre and distribution of condoms.

The gym peer exchange scheme has been running for a number of weeks. We have seen an uptake in NSP from a hard to engage client group. The owner of the gym (who from the start was far sighted enough to embrace a novel way of facilitating harm reduction) has felt confident and supported enough to promote the service on his company's social media sites, through leaflets provided by the Cambridge Centre and by word of mouth at the gym itself.

SCARY MONSTERS

Have health professionals started a new moral panic over e-cigarettes? **Neil McKeganey** thinks they have.

There are few things more powerful than the narrative of fear. The concern that something may be harming us in ways that we might have been unaware, and that action should be taken to limit its occurrence, is a foundational tablet of interventionist public policy. The narrative of fear can be equally strong when it comes to new items that emerge in our social world and about which we know relatively little.

E-cigarettes are a good example of the narrative of fear in action. There are a whole host of things we do not know about e-cigarettes. We don't know much about the impact of their long-term use (hardly surprising given that their use has only become widespread in recent years), we don't know a great deal about why people are attracted to them, why they might try them, persist with them, or reject them. We don't know whether e-cigarettes appeal because they look like cigarettes or because they smell and taste nothing like cigarettes. We don't know whether e-cigarettes are a way of reducing smoking or increasing nicotine intake. I saw an advert recently for e-cigarettes that said "vaping" a single e-cigarette is the equivalent of smoking 40 cigarettes. I don't know if that advert is targeted at the person who wants to stop smoking or the person who wants to increase their nicotine intake. You could say it is deliberately ambiguous to appeal to both.

There is so much that we don't yet know about e-cigarettes, but what seems beyond doubt is the fact that they are substantially less harmful than smoking combusted tobacco. What we also know is that e-cigarettes are being consumed by an increasing number of people. Within the United States it has been estimated that 2% of smokers had used an e-cigarette in 2010 with that figure rising to 30% by 2012. Within the UK, a survey undertaken by Action on Smoking and Health found that the level of e-cigarette use among smokers had increased from around 3% in 2010 to 13% in 2013. With that rate of growth there is a very real possibility that over the next ten years e-cigarettes might overtake combustible tobacco. If that were to happen the tobacco industry could find itself facing a stark choice – either get into e-cigarettes big time (which they are beginning to do now) or face the inevitable disappearance of their primary market.

On the basis that e-cigarettes are safer than smoking combusted tobacco you might have thought that they would have been given at least a cautious welcome by those concerned for the health of the public. But in that you would be very wrong. In a recent interview in the *New Scientist* magazine, the Chief Medical Officer for England, Dame Sally Davies, identified e-cigarettes as one of the major threats to public health. Similarly, the Welsh government looks set to ban e-cigarettes in enclosed public spaces. In shops, airplanes, offices and restaurants across the world e-cigarettes have been the subject of informal but non-negotiable restrictions often on the basis of little more than the inconvenient fact that to the untrained eye they may be barely distinguishable from smoked cigarettes. These reactions are about as far from offering e-cigarettes a cautious welcome as it is possible to get- short of an outright ban.

The narrative of fear around e-cigarettes is not so much that they might be harmful in themselves but that they might result in smoking being re-normalised. There are two possible ways in which this 're-normalising effect' might be happening. First, if people using e-cigarettes are inclined to move onto smoked tobacco. Within that scenario e-cigarettes would be acting like a gateway drug to combustible tobacco. But is there evidence that such a gateway effect is even occurring or is this largely a theoretical anxiety? A recent survey of 19,414 e-cigarette users found that 99.5% of those surveyed were already smoking tobacco when they started to use e-cigarettes, and that most of those who were using e-cigarettes were doing so as a way of reducing or quitting smoking. Similarly, recent research from University College London found that e-cigarettes had a stronger effect in quitting smoking than over the counter nicotine replacement patches. On the basis of those results, e-cigarettes look less like a gateway into smoking than a possible road out of smoking.

The second way in which e-cigarettes might be 're-normalising' smoking is through young people being encouraged to take up smoking as a result of seeing increasing numbers of other people doing something that outwardly looks like smoking, even if it is not actual smoking. This is a much more nebulous effect and much harder to prove one way or another. To date there have been no

ACCORDING TO *THE LANCET*, THE INVOLVEMENT OF THE TOBACCO INDUSTRY IN THE E-CIGARETTE EQUATION HAS DELIVERED PUBLIC HEALTH PRACTITIONERS WITH AN UNEXPECTED "MORAL QUANDARY"

studies that have actually shown that this effect is even occurring. However for the narrative of fear to take hold you don't actually need evidence. What you need instead is a plausible story that some untoward effect might be happening and in the very plausibility of the alarm you are raising, you have a reason for interventionist control. You could even say that the narrative of fear thrives best in the absence of evidence since there are few things more fearful than the threat you can't assess, and there are few things that gets public health practitioners more exercised than a perceived threat to the public health.

Persuade people that something might be harmful, or that it might lead to something that is even more harmful, and you are one step away from accepting the case for regulated control. Once you have accepted the narrative of fear, only the dangerously cavalier would reject the proposed controls. But when the thing you are limiting access to (e-cigarettes) is less harmful than the thing you are saying it re-normalises (smoking), you face a bit of a dilemma in answering the question of why you are not banning the more harmful thing in the first place. If smoking is so dangerous that you are fretting about the thing that might re-normalize it, why don't you just ban smoking? To do that of course would be to jeopardise the billions in tax revenue that tobacco generates for governments across the world. Far better, you might say, to tackle the thing that may be re-normalising smoking and which is not generating you much in the way of tax revenue anyway.

However it is not only the public health practitioners that are getting into lather over e-cigarettes. In a move that is virtually unheard of in addictions research, the leading journal *Addiction* recently ran an editorial calling for greater oversight of research around e-cigarettes, conceding that in some cases the claims being made around e-cigarettes cannot be trusted. "Current research and commentaries on electronic cigarettes", they point out, "vary widely in quality, accuracy and objectivity". The authors of this editorial go on to note that what is needed now is more rigour and oversight "to ensure that interpretation of evidence is guided by data, not emotions, and that strong statements based on weak evidence are avoided." E-cigarettes, they say "may offer a way out of the smoking epidemic or a way of perpetuating it; robustly designed, implemented and accurately reported scientific evidence will be the best tool we have to help us predict and shape which of these realities transpires". In nearly thirty years of drugs research I cannot recall an editorial, in such a prestigious journal, calling into question the very integrity of the scientists carrying the research and conceding the need for greater oversight of their work.

However the fears around e-cigarettes have to do with more than the content of the vapour lifting languidly from the electronically illuminated cigarette tips or the impact of e-cigarettes on individual's behaviour. In a word it has to do with the involvement of the tobacco industry. The tobacco industry is now closely involved in the production and sale of e-cigarettes, buying up e-cigarette companies with increasing frequency and clearly preparing itself for the possibility of a mass flight from tobacco. According to *The Lancet,* the involvement of the tobacco industry in the e-cigarette equation has delivered public health practitioners with an unexpected "moral quandary". Increasingly public health practitioners are facing the dilemma of whether to embrace e-cigarettes as a result of their evident public health benefit or reject them as a way of avoiding "colluding" with what *The Lancet* describes as "one of the industries most devastating to health".

It would be a tragedy of epic proportions if the negative views of the tobacco industry were to impede individual's access to what may turn out to be the single most influential means of reducing tobacco related harm. Those whose antipathy towards the tobacco industry leads them to a negative view of e-cigarettes may feel that they are remaining true to the tobacco control mantra, but in doing so they may find themselves promoting the very harm they have dedicated themselves to reducing. It is too early to say whether the tide will turn in favour or against e-cigarettes but what is certain is that there will be much more soul searching to come before the place of e-cigarettes in tobacco control and tobacco related harm reduction is finally determined.

■ **Neil McKeganey** is Director of the Centre for Drug Misuse Research, Glasgow.

TEN... AND YOU'RE OUT!

"Young revellers pictured passing balloons of 'hippy crack'."

Ever more restrictive club regulations has seen a return of unlicensed raves..
By **Peggy Whitfield**

The above are recent headlines from national daily papers in the UK: illegal raves are back in the headlines again, and once again, for all the wrong reasons. Stories of violent disorder, anti-social behaviour, and sadly, several drug-related deaths of teenagers have been well-publicised in the press, but the truth behind the headlines is more nuanced.

Illegal raves and free parties have been a ubiquitous part of British life since the late '80s. Free parties were born out of the acid house musical movement and the so-called second "summer of love" in 1988, coupled with the explosion of MDMA as a recreational drug, free parties could be found in all corners of the British Isles, as Tom Jones,* a rave veteran of these heady days, explains:

"Free parties came to prominence in the late 80s/early 90s. They were free, not necessarily always free of cost but certainly free from commercial influence. The crowd that frequented them was not all "crusties" with dogs on strings, but a very diverse bunch of people … These parties were not necessarily politically engaged, but they did take place at a time when young people (those born from the late 1960s onwards) felt completely alienated not only from society as a whole, but also from a Government that was almost ludicrously positioned to the right and also seemed not to give a flying fuck about ordinary people."

The parties got bigger and attracted largely negative media reporting which invariably concentrated on the attendant drug culture. Eventually the government reacted by introducing the Criminal Justice Bill, ostensibly banning free parties. The raves mostly moved out of the fields and into the newly established clubs of the '90s, and thus club culture as we know it was born.

Today's rave scene looks very different. The introduction of the Temporary Events Notice license (TEN) has allowed promoters to take their parties out of more traditional club venues and into a wide variety of spaces, such as warehouses, disused factories and even churches, provided they can meet fire regulations, health and safety inspections, police checks and local authority guidelines. This is to ensure that electronic music parties can go ahead, but in a safe manner and without causing upset in the local community. Of course, if parties are put on without the consent of the authorities, the safety of

attendees cannot be guaranteed, as Mike Smith (not his real name), an electronic music promoter explains:

"I do believe that illegal parties are more dangerous than legal ones. In going through the process of licensing, the council and the police check your background in events and make sure that you are adhering to health and safety policy. These events are obviously more regulated so it is pretty much unfeasible for a licensed event to go ahead that is unsafe. When a party is illegal it is purely down to the individual who organises it to take care of the people attending … Events of this nature would of course be more dangerous than an event that has been approved by the council and the police."

So if the introduction of the TEN license has made putting on parties easier, why are people still throwing illegal raves? There are a variety of reasons. Mike, who has put on licensed and unlicensed parties in the UK, gives one perspective:

"Certain venues fall outside of what the council believe are safe. I do believe things are over-regulated here but I guess from their point of view, too much safety can never be a bad thing. I have gone outside of their regulations at times to create something different. I have used certain venues that would not pass their criteria. In my eyes, simple awareness of the problems at hand can quite easily turn an 'unsafe' space into a safe event space for people."

Other promoters are sometimes forced to go down the route of unlicensed raving due to TEN licenses being revoked at the last minute by the authorities, days before the event is to take place. Promoters spend a lot of time, effort and money in creating a party; hiring sound systems, elaborately decorating venues and flying in DJs from all over the world to play there. To be told on extremely short notice that the venue cannot be used, sometimes for the smallest of health and safety reasons, or because too many people 'may' turn up, is galling. Many promoters, if they have the resources and contacts, will find an alternative venue and carry on regardless.

Then, of course, there are promoters who have no interest in obtaining licensing for their parties. Sometimes they don't have the money to pay for the increasingly expensive rental of spaces or jump through all the hoops that the authorities demand. For others, such as promoters within the free party scene that more closely reflects the counter-cultural, alternative philosophy of the parties of the '80s and '90s, it's integral to the nature of the event that it occurs outside of the law, free from restrictions, without the knowledge of the authorities.

Much of the media tends portray illegal raves as hotbeds of drug use, but there is generally little difference between drug use at licensed and unlicensed events. Big licensed clubs in the UK will give you a pretty intensive body search on your way in and will confiscate drugs from you if they find them and may refuse entry. Unlicensed raves are a little different. Most will have some form of security, and many will search you, but this to check for weapons, rather than drugs. Although the rave scene is not known for violence it is deemed better to err on the side of caution.

"Police hunt for eight people over Croydon death rave."

There is not generally more drug use at an illegal rave than a legal rave, although the one exception to this is probably cannabis, as it's very hard to get away with smoking a joint in the smoking area of a licensed rave. For many people, one of the benefits of an illegal rave is that you can smoke inside the venue, whether that's a cigarette or a spliff. Drug use is, however, far more open at an illegal rave than at a legal party, as the security at such events are there purely to ensure there is no trouble, rather than to police an individual's consumption of drugs. That said, security and promoters will step in, as they do at licensed parties, if someone appears to have taken too many drugs, or are too drunk. Responsible security and promoters generally always ensure that if someone is too wasted, on whatever substance, that they get put into a cab, or given medical assistance, if necessary. Unfortunately, tragedies do occur, and people do die from drug related reasons. But drug deaths do not occur because the raves were illegal; licensing would not have made any difference. However, both of the recent deaths in Croydon at illegal parties were teenage boys.

Raves are not for children, they are for adults, who are more cognisant of the risks they are taking. People who regularly go to raves tend to buy their drugs in advance, from a dealer that they trust. They are far more cautious about buying drugs from random people they meet at a party, and often realise fairly quickly if what they are taking is not what is said to be, or cut with other substances. Teenagers simply don't have the knowledge, judgment or experience to be in a rave environment, and this greatly increases the risk of something going wrong.

But what about the police response to illegal parties? It's actually fairly common for the police to allow an unlicensed party to continue, as long as the party is not too large or too loud and they are satisfied the party is safe as shutting down a party can often cause more problems than it solves. A Metropolitan police officer told me:

"Illegal raves and drugs go hand in hand, but we are more concerned about health and safety than drugs, particularly if the structure of the building hasn't been checked. If the premises are insecure and unstable, and something was to happen, like the roof caving in, it would be a massive incident, and the first thing that people would ask is where were the police? The police are also concerned with everything that can result from illegal raves; residents being disturbed, the negative effect it has on community relations if the police don't shut it down or are seen not to do anything, ravers driving under the influence of drugs or alcohol, putting themselves and others in danger, and dodgy cabs with the risk of sexual assaults."

Illegal raves go on every weekend, in fields and cities all across the UK. The majority pass by unnoticed, as they are problem free. The few that do hit the news stands are there because something has gone wrong. Promoters need to do their best to ensure that their parties are as safe as possible, and the people who attend these parties need to be aware of the potential risks, as illegal raves are not going to go away any time soon. A growing number of people are attracted to unlicensed parties, as they want to dance without having their ID scanned or intrusive body searches, in places with minimal commercial influence. And of course, for some, taking drugs with a reduced risk of arrest holds its own attractions.

■ **Peggy Whitfield** is a freelance journalist

Joint ventures

As both the medical and recreational marijuana businesses in North America grow apace, **David Ader** explores the pot at the end of the rainbow.

With Colorado and Washington's experiments with recreational cannabis legalisation filling acres of newspaper space, the continued rapid development of the medical marijuana industry has slipped under the radar. The industry is best established in Canada, where the market is projected to be worth more than a billion US dollars by the end of the decade. Unlike the US, medical marijuana is unequivocally legal throughout Canada, meaning risk-averse investors don't have to worry about the long arm of the law. In fact there are suggestions that much of the investment in the budding Canadian industry comes from the US, with businesses and their backers hoping to perfect their techniques and grow larger, ready to take on the US market if and when federal restrictions are removed. Canada is pursuing a route that looks familiar to existing pharmaceutical regulation; companies must apply to the government regulator Health Canada for a licence to produce cannabis. So far 850 companies have applied, and 13 have been granted licenses, and are then legally able to supply anybody who has a prescription, making a tidy profit in the process. One big Canadian producer, Tweed Marijuana Inc, is now valued at over $100 million.

Money like that attracts investors, and Privateer Holdings are the first private equity company specifically formed to invest in the cannabis industry in the US and Canada. Fortune magazine excitedly reported the completion of their latest funding round, which raised $50 million to add to the $22million they already had in the bank. One of Privateer's companies has just invested a sizeable portion of that, spending $20million on a state-of-the-art facility in British

Columbia, Canada, to grow licensed medical cannabis. Opened in April, the facility is already shipping legal medical marijuana direct to customers. The size of the untapped market is what investors are so excited about – one market research report estimates the US legal cannabis industry will reach a value of $10 billion within five years. Even this is only a fraction of the size of the current market for illegal cannabis, thought to be worth $40billion.

It may be a riskier investment in the US, but there's no shortage of companies looking to get involved. A quick look at the cannabis industry's trade association website shows the polished logos and blandly professional names of these new companies, some of which give little hint that they deal in a product still very much illegal under federal law: Organa Labs, MMJ America, Verde. These companies portray themselves as part of corporate America, comparable to biotechnology, chemical or pharmaceutical companies and at a very far remove from the usual stereotypes of cannabis producers as either criminal gangs or grown-old hippies. United Cannabis Corp (market value over $100 million dollars) have recently announced the appointment of an executive called John C Hunter III to their board of directors, who spent over 40 years at Monsanto, working his way up to the very top table. Best known for producing controversial genetically modified crops, as well as pesticides and herbicides – including the notorious Agent Orange – Monsanto are an enormous American agriculture and biotechnology company, with $15 billion revenue in 2013. The appointment of one of their most senior executives gives a clear indication of where United Cannabis Corp see their business heading. Another cannabis company has a CEO from an even more establishment background; Cannabis Sativa Inc is now run by Gary Johnson, former Republican Governor of the state of New Mexico. Another prominent businessman, Jamen Shively, previously corporate strategy manager at Microsoft, is seeking to create the first cannabis 'Starbucks' – a national cannabis chain in the US, starting with medical marijuana outlets in three states, and aiming to sell both recreational and medical marijuana under the same brand. He's also attracting a lot of media attention, and irritating others in the industry, who fear his high profile and bold claims will attract negative publicity.

Despite the bad press around some captains of the cannabis industry, confidence in the legal status of their companies is growing. Recently a bill approved in the House of Representatives – backed not only by Democrats but many Republicans too – forbade the use of federal funds to undermine cannabis providers or 'patients' where supply or use is legal in the state. President Obama himself shows little sign of wanting to interfere in Colorado or Washington.

The talk from the many policymakers in favour of legal cannabis in the US often stresses the business benefits – jobs created, profits raised and tax collected – a contrast to the UK where the debate focusses almost exclusively on public health and community safety. But there are concerns about the increasing power and wealth of this new industry.

This emerging 'American model' of cannabis production, where huge private companies run with only minimal regulation, carries serious risks. Will profit-seeking override public health, with 'Big Cannabis' behaving as irresponsibly as 'Big Tobacco' or 'Big Alcohol'? In this scenario, companies will use advertising and marketing to target the impressionable and the young, and encourage people to consume as much cannabis as they can. Imagine cannabis on special offer in the run-up to holidays or sports matches, and available in twenty different flavours. Profits which are channelled back into lobbying and well salaried non-executive directorships for policymakers, with powerful vested interests resisting future regulation. This nightmare is only imaginary at the moment, but there are worrying omens. Colorado has already seen intense debate about what constitutes acceptable marketing, with concern particularly focussing on 'edibles'. These products, considerably more sophisticated than the space cakes for sale in Amsterdam, include cannabis infused chocolate bars, sweets and even fizzy drinks. You can even get medical marijuana for your dogs and cats – sold as 'Canna-biscuits', naturally they're gluten-free and organic.

Even among pro-legalisation campaigners there's an ambivalence towards the direction the industry is going – Alison Holcomb is Drug Policy Director of the American Civil Liberties Union and campaigned to legalise cannabis in Washington, but wrote to the Liquor Control Board to voice her concerns: "Large industries that have large overheads and are interested in maximising their profits are going to target their advertising in ways to promote marijuana use, not simply meet current demand where it currently exists."

How you feel about this is probably determined in part by your attitude to public health versus individual choice. It's not uncommon to think that the 'nanny state' has no business telling us how to live our lives. Perhaps if we want to spend our money on wine or weed, that's our prerogative, harmful though it may be to our health. Counter-intuitively, there could actually be potential for any increase in cannabis consumption to reduce population level health harms. Whilst the 16,000 people in the UK last year who started treatment for cannabis problems show its very real potential for harm, the level of mortality and disease does not come anywhere near to those from the legal drugs alcohol and tobacco. So it's possible that public health might actually be improved if people swapped their whisky for weed. But the very fact that alcohol and tobacco are used by, and kill so many people is proof for some that potentially addictive drugs need to be exceptionally tightly controlled, and kept far away from the advertisers, marketers and lobbyists of big business.

In Colorado, the first state to legalise recreational cannabis, some businesses are already 'lawyering up' in an attempt to reduce the taxes paid on recreational cannabis, in what may be a crucial test of the ability of the state to restrict a now legal industry in the face of well-funded opposition. Currently a 15% excise tax is added to the standard 12.9% state sales tax, with some claiming that this is at odds with the wording of the legalisation proposition that was approved by voters. The original proposition called for marijuana to be taxed 'in a manner similar to alcohol', but the complainants argue that alcohol attracts significantly lower rates. Other US states will be paying close attention to the result.

Meanwhile in Uruguay, which will be the first country in the world to fully legalise recreational cannabis possession and use, an altogether different route is being taken, with much stricter regulation and monitoring. It now appears, contrary to earlier reports, that Uruguay's legal cannabis will not be grown directly by the state, but also by for-profit companies. Nonetheless there are huge differences between the stricter Uruguayan model and the comparative free-for-all in Colorado and Washington. Uruguay intends to tightly restrict the total quantity of cannabis grown by licensed companies, sell only to people who have registered with the government, and also impose limits on the amount that can be bought per month – although individuals will also be allowed to grow up to six plants of their own. The Uruguayan model may

be much more public health focussed than its US equivalents, but the cannabis producers will presumably still be motivated to sell as much as they can, and it's not clear yet what restrictions there will be on advertising, marketing or lobbying.

In the UK, of course, cannabis remains totally illegal whether for recreational or medical use, and there's no sign that this is set to change any time soon. That's not to say there haven't been any developments though. GW Pharmaceuticals, makers of Sativex, a cannabis-derived medicine licensed in the UK for the treatment of multiple sclerosis, appear to be going from strength to strength. Whilst Sativex is based on THC, the most important psychoactive compound in cannabis, GW have other medicines based on CBD, the other significant compound, that are at various stages of regulation too. As their cannabis-based products are being licensed in more and more countries around the world, their stock price soars along with it – up by more than 1000% since they launched on the NASDAQ in May 2013, with the company now valued at $1.4billion.

They represent much more than just another cannabis company though. In fact, their success is a huge threat to medical marijuana and with it the emerging legal cannabis industry around the world. Medical marijuana is legal in many more American states and countries than recreational cannabis. But if GW Pharmaceuticals can show that their products are as effective a medicine as smoking cannabis, they will surely be prefered. By following the traditional route for regulation of medicines, Sativex has been able to stay almost entirely free from controversy; there's little risk of diversion to the illicit market, it isn't carcinogenic as it's taken as a mouth spray rather than smoked, and unlike medical marijuana it has gone through exactly the same rigorous trials for effectiveness and safety as other pharmaceutical products. Sativex represents the pharmaceutical industry successfully appropriating the medical benefits of cannabis, and it would be surprising if other big pharmaceutical companies weren't already attempting to develop their own cannabis-derived medicines. United Cannabis Corp and Tweed Marijuana Inc may be doing very well, but you wouldn't fancy their chances of competing with the big beasts of 'Big Pharma' – the likes of Pfizer, Roche or GlaxoSmithKline each have revenues of around $50 billion. And it's not just Big Pharma that the aspiring Big Cannabis sector needs to look out for. After all, there's already a £500billion global industry that specialises in growing psychoactive plants for smoking, and it's easy to imagine Big Tobacco eyeing up a new and lucrative legal cannabis market, especially given declining rates of tobacco smoking in the developed world.

The debate around cannabis policy has generally skipped over the finer details, focussing only on the two extremes of imprisoning users versus an unregulated free-for-all. This has always been unhelpful, but is especially so now that some countries and states have set in motion various degrees of decriminalisation and legalisation for the medical and recreational use of cannabis. It seems essential now that the debate includes the intricacies of how a legalised system would look; which companies or organisations would produce legalised drugs, how would they be regulated, where would the profits end up, should there be limits on how much people can use, are we prepared to see adverts for drugs on TV? Jon Collins at the London School of Economics and Stephen Rolles at Transform Drug Policy Foundation are both in favour of legalisation backed up by strong regulation, and have authored two of the more serious attempts to answer those questions and discuss how regulation ought to look, and how the risks of a new and powerful Big Cannabis industry can be minimised. The complexity of the subject is borne out by the reports, Ending the drug wars and After the war on drugs: Blueprint for regulation, being 84 and 232 pages respectively.

Admitting that the effects of policy changes cannot be predicted with certainty, Ending the drug wars exhorts governments not to interfere but to observe the likes of Colorado, Washington and Uruguay: "Let the experiments run. The places that legalise cannabis first will provide – at some risk to their own populations – an external benefit to the rest of the world in the form of knowledge, however the experiments turn out." The experiments in North and South America are now very much underway, and politicians, public health professionals and stockbrokers the world over will be watching closely.

■ **David Ader** is Communications Officer at DrugScope and Assistant Editor for Drug and Alcohol Findings

What do the patients want?

Mike Ashton and **David Ader** of *Drug and Alcohol Findings* on the importance of patients' wishes, and the difficulties inherent in discovering what those are.

"Do listen to your patients; always have them at the centre of your thinking, that's what makes the big, big difference." That's how the NHS Institute for Innovation and Improvement headlined their webpage on patient-centred care, which exhorted healthcare providers to try to consider services from the point of view of the service user. It's a simple idea, that the patient's wishes and experiences are an important – perhaps even the most important – aspect of healthcare, but it's also a world away from an older and more paternalistic view that doctors and other highly qualified professionals know more about what's best for patients than the patients themselves. Of course professionals will be better informed about many aspects of healthcare, but patient-centred healthcare is about making sure that patients are able to make use of professional expertise to achieve their own goals, rather than simply following doctor's orders.

No doubt some healthcare providers have been following similar principles for many years, without using any particular buzzwords to describe them, but it's clear that health policy is currently more concerned than ever with the patients' experiences of care, and whether these match up to their wishes. The Royal College of GPs, the Royal College of Nursing, the National Institute for Health and Care Excellence and The King's Fund to name just a few have all stressed the importance of focussing on the patients rather than just medicine and diseases. The Government's response to the Francis Inquiry into failings at Mid-Staffordshire Foundation Trust was even titled *Hard Truths: the journey to putting patients first*. With so much talk about patient-centred care, it's worth looking for a more specific definition about what exactly it entails. One paper in the *British Medical Journal* listed a number of conditions, the first three points were that it must "explore the patients' main reason for the visit, concerns, and need for information; seek an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues; find common ground on what the problem is and mutually agree on management".

It seems that everybody is agreed on the importance of patients' wishes, and affirming this now seems almost mandatory in policy statements or guidelines. That makes those wishes contested territory; commentators committed to certain treatment goals will appeal for validation to what is seen as the ultimate authority – the patient. In turn that makes research on patient perspectives critical, and sometimes also contested, as knowing 'what the patients want' becomes invaluable information.

For drug treatment in the UK, the prime example comes from Scotland, where researchers from the Drug Outcome Research in Scotland (DORIS) national treatment evaluation study have differed over the implications of their findings. Like the National Treatment Outcome Research Study (NTORS) in England, this sampled patients entering different types of treatments and observed their progress during and after normal treatment delivery. The debate around DORIS started with the "surprising" finding that 57% of Scottish drug treatment clients selected abstinence as their sole goal for changing their drug use, seemingly the first time any large-scale British research project had asked this fundamental question. For the lead author it was a sign that we have failed to match patients' ambitions and instead prioritised harm reduction. Rather than the reservations expressed in the scientific paper, he said "The drug users in the Scottish research have spoken with admirable clarity." But armed with more in-depth findings from England, a colleague saw it differently. It was, she said, unclear what patients meant when they ticked "abstinence/drug free" in response to the question, "What changes in your drug use do you hope to achieve by coming to this agency?" Did they mean free from all drugs, or just the one(s) causing them problems? Free now or in the future? An aspiration rather than what even the patient would see as a realistic goal? It might also be asked whether the finding really was "surprising"; 44% of patients were starting drug-free and/or explicitly abstinence-based treatments and the same proportion were in prison, where abstinence would normally have been the only sensible objective. Rather than a surprising mismatch, the paper can as easily be read as showing patients' objectives match those of the treatment they are entering and the constraints of the setting.

Still, the seeming contrast with the supposed finding that just 3% of Scottish methadone patients emerged from treatment drug-free was headlined as proving treatment fails patients, and used by politicians to justify what the

media described as a "Cold turkey plan for Scots addicts." Their case was sharpened by the further contrast with what was portrayed as a corresponding figure of 25% drug-free after methadone treatment in England.

All this was sloppy at best, deliberately misleading at worst. The iconic '3%' figure came from a DORIS report which documented the progress 33 months later of 695 (all who could be re-interviewed) out of 1033 problem drug users who started treatment in 2001 and 2002. Read the Findings analysis, and you will see that it was based on patients who had entered methadone programmes only after leaving their first treatment during the study period. That makes it particularly pertinent that in DORIS as in other studies, over the years patients rarely confined themselves to a single modality, complicating the assessment of just what it was which led to the eventual outcomes. It becomes a matter of choice whether such patients' progress is attributed to the initial non-methadone programme, whether transfer to methadone is seen as indicating the initial treatment had failed and their progress was due to the follow-on care, or whether the whole treatment journey is seen as the active ingredient.

In contrast, the 'corresponding' 25% figure for England more conventionally related to the initial treatment – enough to invalidate the comparison. But there was more. The definition of abstinence in Scotland meant patients must be free of both any illegal drug and of prescribed methadone. In England, they could have been on methadone and/or using cannabis. DORIS researchers adjusted for numbers still on methadone but not taking any illegal drug, raising their estimate for abstinent (ex) methadone patients in Scotland to 11%, a fact ignored by the press reports. They did not further adjust for cannabis use or make clear that the comparison was invalidated because based on the initial treatment in England but not in Scotland. Incorrect press reports appear to have remained uncorrected. Scottish apples were being compared with English pears, and then with the supposed ambitions of Scottish patients, which in reality were not at all clear.

Though important, misreading of the DORIS findings should not obscure the fact that, however the individual defines it, stopping use of some drugs (especially those so problematic that they have driven them to seek help – in the UK, normally heroin and/or cocaine) is a common goal, and that for substitute prescribing patients, it often extends to eventually being free of legal substitutes too. Surveyed in 2007 – but specifically about their *long-term* goals in respect of drug use – 81% of responding drug treatment clients in England who used heroin wanted to stop doing so; for cocaine, the figure was 73%. But only minorities wanted to cease using cannabis, alcohol or benzodiazepines and 51% methadone. Given the question, fewer would have wanted to stop their methadone right now or in the next weeks or months.

Ambivalence about taking medication in the form of a desire to be free from having to take the pills or concern over their side-effects and efficacy is commonly observed in long-term prescribing, not just for opiate addiction, but for chronic physical and psychiatric conditions. Such is the scale of this problem that it is a recognised and major concern for clinicians, who fear it leads patients to decide not to take or to prematurely cease or cut down medication, to the possible detriment of their health. That opiate users prescribed methadone or other substitutes share this ambivalence should not be a surprise, especially given the unusual burdens the treatment often entails, such as supervised consumption and daily attendance, the stigma attached to regularly consuming opiate-type drugs (even legally prescribed), and the fact that the treatment marks the patient as an 'addict'.

...HOWEVER THE INDIVIDUAL DEFINES IT, STOPPING USE OF SOME DRUGS (ESPECIALLY THOSE SO PROBLEMATIC THAT THEY HAVE DRIVEN THEM TO SEEK HELP)... IS A COMMON GOAL, AND THAT FOR SUBSTITUTE PRESCRIBING PATIENTS, IT OFTEN EXTENDS TO EVENTUALLY BEING FREE OF LEGAL SUBSTITUTES TOO

The controversy around ascertaining on a national scale the short and long term goals of people in drug treatment serves to highlight the importance for practitioners of finding out, individually, what their patients really want. Of course it can be a grey area, perhaps the patients themselves may not be totally clear about exactly what they want, or feel conflicting urges. Or maybe some patients' wishes appear over or under-ambitious when compared with the experience and assessment of professionals. This all takes us back to patient-centred care, and remembering that it isn't only a buzzword for policy documents, but at its heart is about the simple – which is not to say easy – business of talking to patients. To paraphrase from the definition quoted above, practitioners need to understand the patient's world, their whole person, their emotional needs and their life issues. With that understanding combined with their own experience and expertise, professionals and patients can work together to find out where patients want to go, and how best to help them get there.

■ This article is adapted from a Drug & Alcohol Findings Hot Topic written by **Mike Ashton**. For more relevant results from the Findings Effectiveness Bank, see this search.

All the young dudes

Three books with different takes on drugs and young people

Technically speaking, we've come a long way from shock horror posters on the classroom walls. So what new opportunities do social media bring to the world of drug education? By **Richard Ives**

Reviews

DRUGS AND POPULAR CULTURE IN THE AGE OF NEW MEDIA
Paul Manning
Routledge 2013

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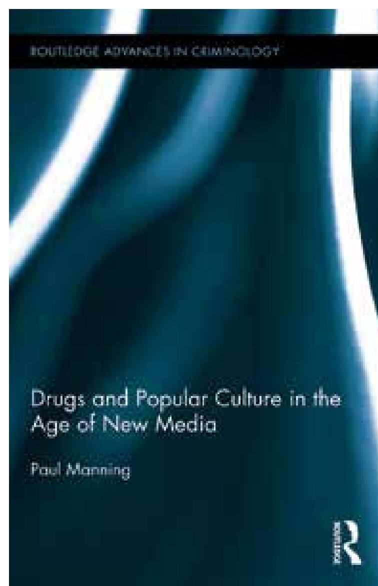


The development of 'new media' presents challenges to drug education. It provides new ways of communicating with young people about drugs but demands more investment (e.g. to make high-quality films) and higher standards of presentation: the scruffy leaflet is no longer acceptable. The distribution of new media on platforms like YouTube allows internet users to comment on the educators' offerings, often critically, and to re-edit and re-post the films to subvert the message.

This also makes it difficult for academics who want to analyse this phenomenon and present their findings. This interesting but curious book – in the fast-moving world of the internet inevitably outdated before it was published – attempts to capture the complexity and describe the development of 'new media', putting it in the context of the twists and turns of government drugs policy and the dizzying pace of youth culture.

This mixture of material fits rather uncomfortably into a book which might have been better published as the three rather separate elements it compromises. It is, firstly, a historical overview of approaches to drug education using new media. This would have made an interesting short book or long journal paper. Given the quantity of (useful) examples that Manning gives of drug education media, it would also have made an ideal e-book with hotlinks to the educational materials that he discusses. In the absence of such links, he is forced to describe the materials in some detail. Although his descriptions are good, I frequently had recourse to the internet to check out the actual material – he doesn't provide links. He focuses on government-developed material such as in Britain's *Frank*, or the USA's excellent 'above the influence' campaign, but doesn't have much to say about local authority initiatives, those from charities such Re-Solv (on volatile substances), or private sector initiatives.

The second element of this book is equally interesting: threaded through the descriptions of media work is a thematic discussion of the development of drug policy in relation to prevention and young people, which describes youth cultures and explores topics such as the 'normalisation' thesis of drug use and the 'self-narrativisation', by which people construct their 'project of self'.

Then there is the third element: chapter six departs from the style of previous chapters. It too might have made a good journal paper. It describes an investigation of YouTube films about drugs. About 300,000 were identified, with about 100,000 classed as 'drug education videos.' After categorising and describing the films under the headings 'the celebratory,' 'the cautionary,' 'consumer DIY discourses,' 'reflective discourses,' and 'drug education and satire' the chapter concludes that: 'Young people have to draw on the resources at their disposal; they need to become rational calculators of risk and critical evaluators of mediated discourse at a pretty early stage in their lives because "new media", and mediated popular culture, are part of their everyday lives.' (p174.) But I was left wondering if, in the conflicted world of drugs, this is a realistic expectation, or whether it asks too much of young people.

Manning's style is engaging and the book is a good read, albeit marred by some overly-long sentences and some off-putting expressions (such as 'intoxicative substances' on page 1). Each chapter ends with a 'summary' which is not my idea of a summary because it doesn't always summarise what has preceded, and new ideas are sometimes introduced at this point.

Despite my criticisms, I would recommend this book to those interested in how drug education has evolved and responded to changes in drug use and drug cultures, changes in young people's attitudes to drugs, swings in public opinions, and government policy evolution. The problem for the publishers is that this is, I suspect, a small market. If Manning has the time and energy, a series of electronic posts based on his undoubtedly scholarly work might achieve wider dissemination of his ideas.

■ **Richard Ives** is a drug education and prevention specialist and the founder of Educari.

Still no magic bullets

A veteran of the drug education wars returns to underline the messages that are still being ignored. By **Blaine Stothard**

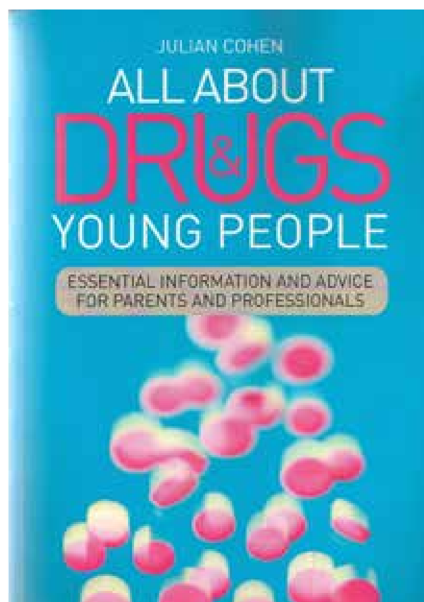
Reviews

ALL ABOUT DRUGS AND YOUNG PEOPLE
Julian Cohen
Jessica Kingsley Publishers, 2014

By his own admission, Julian Cohen has been working with young people and their substance use 'for almost 30 years.' This is a history reaching back to a time before national drugs strategies were introduced in the UK, and to a time when the use of amphetamines and volatile substances were attracting media headlines and professional attention. Not unlike today's interest in legal highs and the similar range of informed, concerned, alarmist and sensational responses.

Because of the author's long association and involvement with young people's substance use and the options for response, publication of this title raises expectations about content and quality. His role poses questions about the ways in which young people might be 'consulted' about their substance use and have their voices represented to a wider audience – of parents, practitioners and policy makers. The direct route – questionnaires, surveys, qualitative interviews – is what might be expected. But there is also a place for the acquired experience and knowledge of long-standing practitioners such as Cohen to draw their own conclusions and lessons from their cumulative time spent talking with and, crucially, listening to young people.

The expectations raised are fully realised in this considered volume, although the lessons and conclusions will make uncomfortable reading for those who persist in believing that there is a 'silver bullet' approach to young people and substance use which will forever 'prevent' them from doing it. What marks Cohen's book is a constant referral to and recognition of reality, including the role of alcohol, slowly and carefully explained and reinforced in a pragmatic, almost banal, fashion. Cohen's 'solution' to young people's substance is, essentially, one of supporting young people, socially and emotionally, and emphasising harm reduction messages. In this respect, he adopts the 'message' identified in the Netherlands in the 1970s and 1980s by Willy de Haes. It's sobering that his conclusion about the responsibilities of society – and parents – to their young people have not been fully understood or adopted by UK politicians.



Cohen makes clear in his introduction that he is not making comments on or recommendations about drugs policy. There are, however, policy implications throughout the text. For me, one of the pleasing features of the book is its constant reinforcement of messages and advice on support, understanding, welfare, concern and communication, and that substance use is a reality to be managed, not a behaviour which can be prevented. What is puzzling is that such messages and knowledge need to be repeated twenty and thirty years after they have been 'learnt.' This does not reflect well on political understandings and indicates a reluctance or stubbornness on the part of policy makers to apply knowledge and evidence to policy and practice. This is shown in the lack of preparation of many workers in the substance use field in their professional training, initial and in-service, and the lack of awareness of existing knowledge and examples of what is frequently referred to as 'best practice.' This could be taken as demonstrating a dismissal of professionalism and knowledge in much of the social work and caring professions by policy makers and commissioners. It may also call into question the seriousness with which those two groups approach many social policy matters.

Cohen's easily accessible and readable book might help counter this lack of investment by providing clear advice on what to do and why, when confronted with young people's substance use, along with references to key texts and organisations which can add to worker's knowledge and skills. This book will be valuable and reassuring for face-to-face workers and those concerned about or affected by young people's substance use. It has implications for policy workers which one can only hope will be heeded and acted on one day.

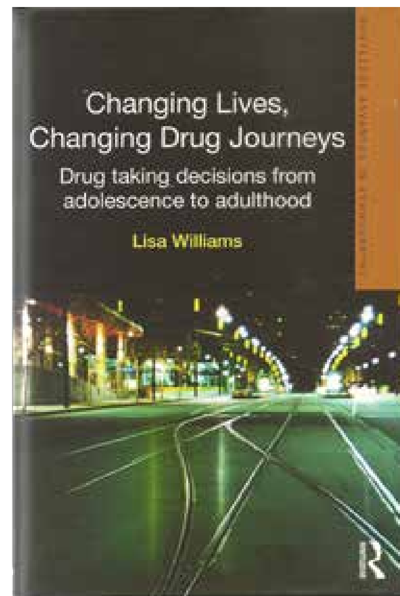
Blaine Stothard is *Druglink's* book reviews editor and a prevention specialist.

Lost in transition?

Andrew Brown considers the non-linear drug journeys of those rarely seen by drug services

Reviews

CHANGING LIVES, CHANGING DRUG JOURNEYS
Lisa Williams
Routledge, 2012



Why do some people choose not to take drugs, others to take them, and how do their decisions about which drugs they feel comfortable using and the levels of use develop and change over time? This is the heart of the story told in *Changing Lives, Changing Drug Journeys*, which uses interviews with 19 young adults over the course of their adolescence and young adult lives to help us consider the complex paths and considerations that facilitate their decision making.

Williams' interest is in the stories of those who seldom come to the attention of drug services despite, in some cases, describing daily drug use. She examines the differences between the motivations, friendship groups and other life circumstances that lead young adults to either choose not to take drugs, or to change the drugs they take and quantity they use.

It has been twenty years since I picked up a sociology textbook. Reading the early chapters of Lisa Williams's book I remembered both why that was and what I enjoyed about the subject. The density of language that comes with the territory and the nuanced differences of positions of some of the leading theoreticians is difficult stuff for a lay reader. But equally, having a guide who can set out some of the most important thinking which has helped shape our response to and understanding of contemporary drug use proves to be immensely helpful.

The journeys of those who abstain from all drug use are perhaps the least complex. Williams' interviewees explain that the strong influence of parents alongside a fear of the consequences of using – particularly death – and valuing things which were seen to be incompatible with drug use (for example sport) sustain them in their early decision not to take drugs. One young man describes a school trip where his roommate, a long-standing friend, tried to pressure him into using cannabis. The resentment that caused led to the ending of the friendship.

But for others that Williams interviews, being in and around friendship groups or having partners who use drugs was where their drug journeys started and could change the amounts and types of drugs used. Interviewees describe the importance of peer experience, place and cultures (clubbing in particular) in determining their drug use, and how moving in and out of the scene and places that they associate with drug use changes their patterns of use. The emphasis of transitions as important in drug journeys will be familiar to those of us who have been involved in thinking about adolescent drug and alcohol use. One interviewee describes how a move from one part of the country to another is used as an opportunity to reduce or stop the use of stimulants; while another saw the break-up of an intimate relationship and falling in with a slightly younger group leading to increased use.

What is striking to me is that while those interviewed all make some assessment of risk – and this changes over time – it seems that familiarity with the effects and side-effects of drugs creates complexity in the journeys that are described. While an experience of LSD which was described as frightening led one user to decide the risks were too great, another heavy user of amphetamines who was told that unless she stopped using she had 12 months to live found that she was back using the drug (at much lower level) after a 2 or 3 year break.

Where the book is particularly helpful is in examining the assumption that experimental drug use in adolescence and early adulthood is a relatively short lived and contained period and that, left to themselves, most drug users will mature and move on. While this may be true, what Williams's interviews show us is that this isn't linear. As with problematic use, there are triggers that lead to relapse as well as ones that lead people to reduce their use or stop, temporarily or permanently.

In addressing a group of drug users who haven't been the traditional focus of drug policy (as well as those who abstain) but who make up the majority of users in the country, Williams has produced a narrative that helpfully reminds us of the complex interplay of experience, relationships and place that help shape their decisions.

■ **Andrew Brown** is Director of Policy, Influence and Engagement at DrugScope. He was previously Director of Programmes at Mentor UK

50 factsheet

Etizolam

Drug overview:

Etizolam is a benzodiazepine analogue. It has gathered some popularity on the new psychoactive substance (NPS) market in the UK and Europe. It has a broadly similar pharmacological profile to benzodiazepine drugs such as diazepam. A 1mg tablet is equivalent to a 10mg diazepam (Valium) tablet, so about ten times the strength.

Brand Names:

Etilaam, Etizest, Etizola, Sedekopan, Depas, Pasaden.

Legal status:

As a prescription drug, Etizolam is unlicensed in the UK and is not controlled under the Misuse of Drugs Act.

Appearance:

Etizolam typically comes in 1mg and 2mg tablets which are often described as 'pellets'. Its appearance can vary depending on the source of purchase. A popular brand name Etilaam sold online comes in a foil strip packet with 1mg dark blue 'sugar pill'-sized coated tablets. There are other tablets in circulation which are lighter blue (similar to blue diazepam colour) and can display the markings EZ9. The 2mg are often small dark pink coated tablets. Tablets may also simply come loose in a zip-seal plastic bag. It is also possible to purchase in powder form, which is often white. Anecdotal reports suggest that it is rare for users to purchase the powder form in the UK.

Cost

Etizolam varies in cost, depending on the form and quantity purchased. They can range from £1 for single tablets (or in quantities less than 10), to as low as 5p per tablet at larger quantities. 100 tablets typically cost around £40. The powder form ranges from approximately £10 for 50mg,to £950 for 20 grams.

Route of administration

Etizolam is generally consumed orally, by swallowing tablets or powder placed into gel capsules. It can also be taken under the tongue. There are reports of snorting and rectal administration although this appears to be rare on the UK scene.

Dosage

Recreational oral dose:	
Light	0.5 mg
Common	1-2 mg
Strong	3-4 mg
Heavy	5 mg +

Onset, duration and after effects

Oral doses have an onset of 30-60 minutes and peak at 3-4 hours. The duration is generally 6-8 hours although higher doses can last longer. Usual after effects are between 1-5 hours although many users report few after effects, especially if they have had a 7-8 hour period of uninterrupted sleep after use.

Typical effects and side effects

These are some of the typical effects and side effects experienced by people who use etizolam. Not everyone will experience all of the effects listed and many can be dose-dependent. Overall, etizolam is reported to be well tolerated with little side effects when prescribed.

Physical
Decrease in energy
Decreased heart rate
Impaired coordination
Sleepiness
Respiratory depression
Blurred vision
Yawning
Constricted pupils
Decreased appetite
Nausea and vomiting
Muscle relaxation
Dry mouth
Headache
Involuntary eye closure
Rebound insomnia (prolonged use)

Mental
Mood enhancement
Relaxation
Reduced anxiety
Lowered inhibitions
Sedative effects
Mental confusion
Short term memory loss

Comedown effects

Some users report malaise after use but the majority of people who use on an occasional basis suggest there is little comedown or hangover. Using on a more frequent basis can lead to rebound anxiety and/or depression, with difficulty sleeping, problems falling asleep or waking early.

Tolerance, dependence and withdrawal

Benzodiazepines such as etizolam which are more rapidly eliminated from the body are less likely to accumulate and there is evidence to suggest that etizolam is less likely to induce tolerance and dependence compared with other benzodiazepines.

However, dependence may develop with regular use of benzodiazepines, even in therapeutic doses for short periods. If benzodiazepines are discontinued abruptly after regular use, withdrawal symptoms may develop. Administration of regular doses of benzodiazepines can result in physical dependence, characterised by a withdrawal syndrome when the drug is discontinued. With larger doses, the physical dependence develops more rapidly.

Withdrawal symptoms include: anxiety, insomnia, headache, dizziness, tinnitus, anorexia, vomiting, nausea, tremor, weakness, perspiration, irritability, hypersensitivity to visual and auditory stimuli, palpitations, tachycardia (fast heart rate) and postural hypotension (drop in blood pressure on standing). In severe and rare cases of withdrawal from high doses, patients may develop affective disorders or motor dysfunction: seizures, psychosis, agitation, confusion, and hallucinations.

Long term effects/known harms

Etizolam is entirely metabolised by the liver and so is contraindicated in those with liver function problems. Loss of hypnotic effects and increased tolerance may be experienced with long term use. There is also a risk of dependence and addiction with repeated use.

Benzodiazepines commonly cause drowsiness, ataxia (neurological conditions which affect balance and coordination), dysarthria (difficulty speaking), nystagmus (involuntary eye movement) and blepharospasm (involuntary closure of eyelids). Coma, hypotension (low blood pressure), bradycardia (slow heart beat) and respiratory depression occasionally occur but are seldom serious if these drugs are taken alone.

Benzodiazepine respiratory depressant effects are more serious in patients with severe chronic obstructive airways disease. Severe effects in overdose also include rhabdomyolysis (breakdown of muscle tissue) and hypothermia.

Co-ingestion of alcohol and other central nervous system depressants potentiates the effects of benzodiazepines and can increase toxicity.