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Druglink

Truth to Power

This issue focuses on that most fraught of subjects – the evidence base for drug policy and practice. We have an interview with Professor John Strang whose important report on medications in recovery was published in 2012, but who spent six years as part of an international project determining what we could really say about the main pillars of any drug strategy – enforcement, treatment and prevention. Even those on the editorial group didn't like some of the results. We also have a debate among two academics arguing the merits or otherwise for our sector of the gold standard research tool – the randomised control study. And finally a review of the Cochrane Handbook on alcohol and drug misuse.

Of course, the scientific methodology cannot be too rigid and there is an argument that an equally rigid adherence to the evidence base can stifle innovation and be an excuse for doing nothing. And you have to allow for the political dynamic in any consideration of public policy. That said, respect for the collected body of peer reviewed evidence is particularly important for the ideologically polarised world of addiction treatment and recovery whether from inside the sector or beyond. And this is likely to remain an issue for ever and a day because people with serious drug problems continue to be regarded as a homogenous lump of 'problem' who you just 'do things' to and they are expected to be grateful that anybody is paying them any attention at all. That is so wrong on so many different levels and must be challenged at every turn wherever it is coming from.

Harry Shapiro
Editor and Director of Communications and Information

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Milking the drug market

A Parliamentary Committee in New Zealand has heard claims of children as young as 14 becoming addicted to legal highs like the synthetic cannabinoid K2 and of being able to purchase drugs from dairies.

The Health Select Committee was hearing submissions for the Psychoactive Substances Bill which would see the regulation of legal highs, meaning producers have to prove their products are safe before they can be sold – a world-first regime.

A local mayor Janie Annear told the Committee, "I visited a dairy which had $225,000 worth of stock before Christmas. Two months later it only had $20,000 left. Dairies are becoming the drug dealers of our communities". If passed, the law would come into force in August.

Meanwhile, mental health services in the country are warning of a substantial increase in the number of referrals since the arrival of K2. One service manager said this time last year no-one at the service was talking about K2. "We had just finished battling Kronic (another synthetic cannabinoid legal high)and starting to get our heads around it and then K2 appeared to replace it," he said.

He believed there had been a "definite" increase in the number of patients using the mental health service because of K2.

Although the service was for adults, he was aware many young people were being treated by youth services also grappling with the problem.

"K2 alters moods and there is an inability to focus. We see irritability, anger and a lot of paranoia in patients and at the severe end they experience psychosis, hallucinations and potential self-harm and violence towards others."

K2 has just been banned in New Zealand, but largwe stockpiles are reporterd and a feeling among health and enforcement professionals that K2 will quickly be replaced by something else.

Packed off

The government's refusal to commit to plans forcing tobacco companies to sell cigarettes in plain packaging is yet another blow to public health campaigners. Earlier in the year, the government pulled back from the pledge to introduce minimum alcohol pricing with the Cabinet itself deeply divided on the issue.

Now campaigners are claiming that both the tobacco lobby threat to jobs and the support for smoking from UKIP have kicked the packaging proposal into the long grass.

According to *The Observer* (5 May), Department of Health officials held meetings with the four key tobacco manufacturers. Of those, just the minutes of the meeting with Imperial Tobacco were released who warned government that the proposals would result in 'significant job losses' for the UK as packaging would be sourced from the Far East. The DH denied that lobbying had influenced the decision to pull the proposed legislation from the Queen's Speech, but this is clearly causing concerns for the government's own health advisers; Kevin Fenton, director of Health and Wellbeing at Public Health England said "our view is that plain packaging is one of a range of measures shown to be effective in reducing the amount of people taking up smoking."

Double vision

Researchers examining the submissions from the alcohol industry to the Scottish government's consultation on minimum alcohol pricing have accused the industry of providing no substantial evidence to support its case.

In a report funded by Alcohol Research UK, the academics from the London School of Hygiene and Tropical Medicine, quoted the alcohol lobby organisation The Portman Group, as saying that there was a "raft of contradictory evidence of the influence of price and promotions on harm" but then failed to produce anything substantial. In reply, the Portman Group didn't appear to directly address the points raised in the report, but simply reiterated its own views about the best way to tackle problem drinking.

MSPs passed The Alcohol (Minimum Pricing) (Scotland) Act 2012 last May, but the government had undertaken not to introduce the measure until a ruling on the legal challenge to the Bill brought by the Scottish Whisky Association. However, this month, the legal challenge was thrown out by the Court of Session.

Cannabis for crack

The mayor of Bogota has proposed a pilot scheme to explore substituting cannabis for coca paste (bazuco). The plan is to treat a group of problematic users over an eight month period and then evaluate the results.

There is some evidence to back the plan. A Brazilian study from 1999 demonstrated that providing cannabis to crack users reduced cravings and promoted positive behaviour changes towards overcoming their drug problem,

A drug treatment expert who is advising the mayor on the trial said that cannabis could play an important part in reducing stress and anxiety in crack addicts and sit alongside more traditional intervention such as self-help groups, therapeutic communities and psycho-social support.

A similar trial undertaken in Uruguay has already produced encouraging results. Speaking to the Transnational Institute's Tom Blickman, Dr Raquel Peyraube said, "three or four puffs of marijuana every four to six hour…helps them to regulate and remain abstinent from cocaine base paste".

Ecstasy tops drug pleasure league while dark side of drug use lurks, reports latest global drug poll.

Ecstasy is the most pleasurable drug to take while tobacco is the least, according to feedback from thousands of users who responded to the latest Global Drug Survey.

The survey's Net Pleasure Index was created after it asked 22,000 people from around the world to rank drugs in terms of pleasure and pain. All things considered, ecstasy attained the highest positive score, followed by LSD, magic mushrooms and cannabis.

Further down the list comes cocaine, amphetamine, mephedrone and ketamine. Two legal drugs, alcohol and tobacco, are seen by pleasure seekers as having the least positive highs, compared to the lows.

But the survey, conducted among more than 7,000 recreational drug users in the UK also revealed the dark side of drug use.

It found that one in five respondents had been taken advantage of sexually while vulnerable after alcohol or drug use. Women were three times more likely to report sexual assault as a result of drug use than men, with younger drug users, particularly teenagers, more at risk, than older people.

Although reflecting a highly targeted group of mainly middle class recreational drug users – the survey was carried in partnership with the *Guardian, Mixmag* and *GT magazine* – the numbers of people turning to the internet to buy their drugs appears to be on the rise. More than one in five (22 per cent) of respondents said they had bought drugs online in the last year.

The survey also revealed that one in seven respondents had taken a mystery white powder in the last year. Among recent users of cocaine, speed or MDMA, this figure doubled to 28 per cent. The results revealed alcohol was a big factor contributing to people's willingness to try a mystery drug – nearly 80 per cent were drunk when they took the unknown powder.

For more information: http://globaldrugsurvey.com/

Live and LEAHN

A new international network has been established to support human rights-based approaches to HIV. The Law Enforcement and HIV Network (LEAHN) aims to build a collaborative network of police and other law enforcement and security services supportive of a public health approach to HIV globally, especially among key affected populations such as people who inject drugs, sex workers and men who have sex with men.

It will do this by information and resource development and provision, by communication with police individually and through police institutions, collaboration with police training institutions and advocacy with those concerned with development and implementation of police policy. Critically, LEAHN has been established to provide a peer group for supportive police and an environment in which they can safely explore police-health and police-civil society interactions in response to HIV epidemics and underlying issues.

The International Police Advisory Group (IPAG) for LEAHN has been established to provide senior police advice and connections for LEAHN, to provide a point of connection between LEAHN and the wider world of policing and police reform and development, and to provide an authoritative voice in policing circles about the benefits of the public health partnership in response to HIV. It is hoped that IPAG will develop the capacity for leadership in this area, not simply for LEAHN, but for its whole constituency; and become an important partner for UN agencies and others engaged in developing and implementing policy and programs which involve police in response to HIV.

The membership is global in reach including several and current high ranking officials and officers from every continent. UK signatories includes Bill Hughes and John Grieve, the former heads of the Serious Organised Crime Agency and the Metropolitan Police Drug Squad respectively.

Geoffrey Pearson

Geoff Pearson was born in Manchester, and educated at Accrington Grammar School and Peterhouse College Cambridge and the LSE, and after working as a psychiatric social worker, Geoff before commencing his academic career. His first major publication *"The Deviant Imagination"* (1974), confronted and unpacked a wide range of theories, and located the historical foundations for many of our contemporary policies and attitudes, particularly those relating to youth deviance.

In 1976 Geoff published his most celebrated study *Hooligan: A History of Respectable Fears*, which provides a historically grounded antidote to the popular idea that deviant youth were a radical and dangerous departure from an eternally recurring golden age of stability peace and tranquillity. In *"The New Heroin Users"* (1987), he gave a voice to users and addicts, confounding the stereotypical imagery of this most demonised group, while positioning chronic drug use within the context of multiple deprivation and social exclusion.

Geoff moved to Goldsmiths College in 1989, and was a member of the Runcimann Inquiry into *Drugs and the Law,* and vice-chair of the Institute for the Study of Drug Dependency/ DrugScope, He worked on studies of drug use amongst young people in care, drug markets, and the policing of drugs, becoming a major figure in debates around drugs and drug policy.

Geoff retired in in 2008, and chaired the *independent Commission on Social Services in Wales* that produced a highly critical report in 2010. He championed early career social historians and ethnographers, and always insisted that the deprived and demonised had stories to tell. A dedicated husband, father, grandfather and great grandfather, a lifelong Manchester United fan and a loyal friend, Geoff Pearson was one of those rare senior academics who knew the value of listening. He leaves a huge gap.

Professor Dick Hobbs. Department of Sociology, Essex University

Steve Abrams

Steve completed his psychology degree at his home town University of Chicago in 1957 and moved to the UK in 1960 to undertake a doctorate at Oxford University part-funded by the Human Ecology Fund. This turned out to be a CIA front organisation, itself secretly funded by the notorious CIA mind-control project MK-ULTRA which included dosing people with LSD without their knowledge to see if it could be used as truth drug and as a way of disabling enemy forces.

Steve finished his studies in 1967, but never received the award because by then he was one of the UK's leading drug reform activists and therefore a major source of embarrassment to the university.

He formed the Society of Mental Awareness (SOMA) and wrote an essay which said (correctly) that cannabis smokers were dealt with more harshly than heroin users, because heroin was legally prescribed to addicts on the NHS. In January 1967, *The Sunday People* got hold of the story and focussed on Steve's claim that 500 Oxford students smoked dope. This story was the spark that lit any number of stories and surveys about campus drug use in the UK and eventually led to government investigations into drug use, chaired by Baroness Wootton.

Meanwhile Steve was earning himself the reputation as a 'dangerous man who must be stopped' – according to *The News of the World* in 1968 because he had discovered a loophole in the law which allowed the prescribing of cannabis tincture and SOMA itself began manufacturing pure THC for medical purposes.

But Steve is probably best known for organising the famous full page advert in *The Times*. Appearing on 24 July 1967 at the height of the media storm over the arrest of Mick Jagger and Keith Richard on drug charges, the advert began 'the law against marijuana is immoral in principle and unworkable in practice'. Paid for by Paul McCartney, the advert was signed by 65 leading names in British society including Graham Greene, MPs Tom Driberg and Brian Walden, David Dimbleby, RD Laing, Jonathan Miller and David Bailey.

By the richest of ironies, Steve's view that the law on cannabis had never been prosecuted was lauded by Peter Hitchens in his recent book which attacked the British establishment for deliberating allowing cannabis smoking to go unpunished so that left-wing intellectuals could be left to indulge in peace.

Steve pretty much disappeared from public view, spending much of his time writing and researching the history of UK cannabis policy while sadly struggling with emphysema which left him housebound and was the ultimate cause of his death last November.

See also the obituary for Steve written by Dave Luke in published in 2013 edition of Psychedelic Press UK.

Harry Shapiro

American expert for PHE

Public Health England has appointed former US deputy drug czar, Dr Thomas McLellan, as its drug recovery advisor. McLellan is CEO and co-founder of the Treatment Research Institute (TRI), a not-for-profit research and development organisation established in 1992 and dedicated to science-driven improvements in substance misuse policies and programmes.

Dr McLellan has more than 35 years of experience in addiction treatment research, publishing over 400 articles and chapters on addiction research. From 2000-2009 he was Editor-in-Chief of the *Journal of Substance Abuse Treatment*, and he has also served on several other editorial boards of scientific journals. Dr.McLellan is the recipient of several distinguished awards including the Life Achievement Awards of the American and British Societies of Addiction Medicine (2001 & 2003); the Robert Wood Johnson Foundation Innovator Award (2005); and awards for Distinguished Contribution to Addiction Medicine from the Swedish (2002) and Italian (2002) Medical Associations. In the 1980s, with his colleagues from the Center for the Studies of Addiction at the University of Pennsylvania, Dr McLellan introduced the Addiction Severity Index and, later, the Treatment Services Review. Both are among the most widely used assessment instruments in the world.

With the recent decision to abandon alcohol minimum pricing, no commitment on plain packaging for cigarettes and continuing political tensions at the centre over the direction of treatment policy, PHE may well feel their commitment to the evidence base would benefit from the added weight of opinion from an internationally-acknowledged scientist.

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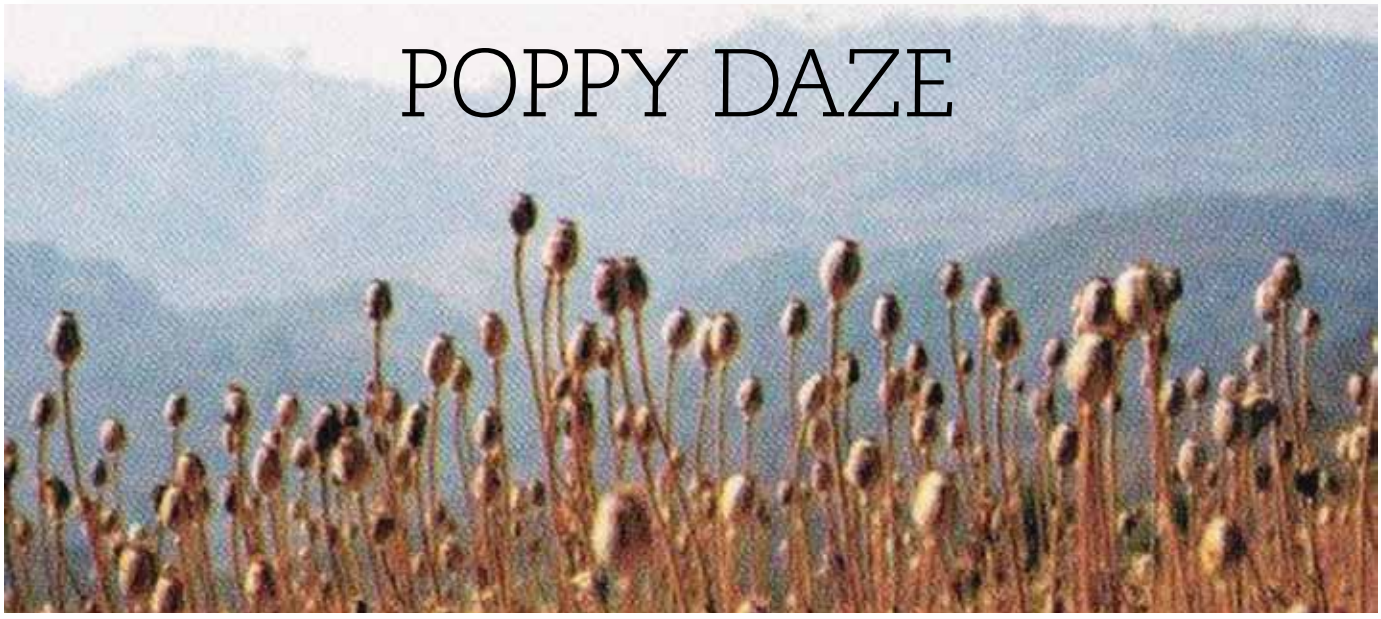

Media interpretation of the implications of the current bumper opium crop in Afghanistan is flawed. By **Harry Shapiro**

The latest UN report on opium growing in Afghanistan painted a bleak picture of a situation which appears to be worsening, 'poppy cultivation is not only expected to expand in areas where it already existed in 2012…but also in new areas or areas where poppy cultivation was stopped'.

The UN analysis is that lack of western agricultural aid is mainly to blame for driving the farmers into the arms of opium traders who supply seeds, fertilisers and also advance payments to encourage growing. However there is little or no evidence that isolated crop substitution (or eradication) programmes can be effective in the long-term without substantial infrastructure, law and governance improvements.

More immediately, there is an assumption that a rise in cultivation in Afghanistan will flood the UK with cheap heroin. This was the focus of media attention on the back of the report. But there have been poppy surges like this before and they seen to make no obvious difference to the availability of heroin on our streets.

There are various reasons for this. Firstly the supply chain for heroin to the UK is over 3500 miles long. Nobody knows how much heroin is in transit at any one time nor how long it is likely to take for the crop from one growing season to be fully processed and transported. Then although 90% of our heroin comes from that region, by no means does the UK absorb the whole supply. Large quantities are transported through the Central Asian republics to Russia. Moreover, Afghanistan, Pakistan and Iran have significant and increasing heroin problems of their own, fed by the regional crop. There is also a new factor in the equation; the ageing heroin population across western Europe generally which suggests a continuing fall in demand.

The other flawed assumption is that the jump in cultivation reflects badly on British troops. The reasoning is that following the fall of the Taliban in 2001, Tony Blair's high priority for drugs policy at home, led him to take on the brief for counter-narcotics work in the region. However, on the ground, the British and American troops took a very different approach to the opium problem. Led by the former US Ambassador to Colombia William 'Chemical Bill' Wood, US troops and contractors acting on their behalf wanted to lay waste to the opium crop. By contrast, the British forces knew that as difficult as it was to win the battle for hearts and minds, destroying the livelihood of thousands of Afghan farmers was really not the answer. Interviewed by *Druglink* in November 2011, UK ambassador at the time, Sir Sherard Cowper-Coles said that not only was eradication not part of the British game plan, but when British forces arrived in Helmand Province in 2006, we actually gave confiscated opium back to the farmers and did a leaflet drop stating that British troops were not the ones destroying the crops. The Americans were not impressed.

As it happened, the one event that did see a reduction in UK heroin was the poppy blight of 2010. This combined with reportedly increased activity by Turkish law enforcement to seize shipments, did cause a noticeable, if short-lived, heroin drought in the UK.

But as the former UK Ambassador told *Druglink*, "Nothing will change unless we have what I call a 'double decker' solution. The top deck is a meeting of all the region who have a major stake in dealing with Afghanistan's drug problem. Iran for example, has lost thousands of border guards in battles with drug traffickers…Unfortunately only the US could broker such a meeting and currently shows no enthusiasm for the idea". The bottom deck is all about how you tackle entrenched problems of security, the rule of law and economic development in a country battered by decades of war. And that wont be solved until long after all the troops have gone home.

PMA IMPLICATED IN DRUG DEATHS

At least five users in the north-west of England have died after ingesting PMA – sold as ecstasy pills.

By **Mike Power**

In April, Rachel Clayton, 34, and 30-year-old Emma Speed were found dead at a house on Crompton Road, Levenshulme. Toxicology results showed the pair had PMA in their systems. PMA was also found in the body of a 34-year-old man who was found dead in a caravan on Batemill Close, Macclesfield in February. Charlotte Woodiwiss, 20, of Chapel-le-Frith, and Dale Yates, 18, from Buxton, died in late December 2012. Toxicology reports showed that the pair, who did not know each other and who took different pills, confirmed the deaths were caused by toxic amounts of PMA.

Nineteen arrests have been made in relation to the latter two cases but no PMA-containing pills have been found, Derbyshire police said.

These deaths were part of a localised wave of fatalities in the north-west. Gareth Ashton, 28, from Wigan, and Jordan Chambers of Poolstock, near Oldham, died in late January, with PMA suspected and police issuing an alert, but not yet confirmed. In February, Travis Barber, 19 and from Manchester, also died after taking half a pink, heart-shaped pill, and though it was uncertain at the time of reporting if this caused his death, police in Greater Manchester issued a warning that PMA was circulating.

This spike in death numbers in such a small area is statistically significant.. Between 2006 and 2010 in the UK, MDMA featured, in conjunction with other drugs, on an average of 35 death certificates a year, according to the Office of National Statistics.

The average number of annual deaths in which MDMA was the only substance present over the same period is 18 – nationwide.

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Ecstasy pills commonly contain a mix of substances, with MDMA the desired chemical by most users, with its euphoric and sociable effects and relatively safe toxicology profile. Around 25 million pills are estimated to be used in the UK each year in a user base of around half a million.

MORE THAN ONE OR TWO PILLS AND IT GETS DANGEROUS, FAST

There are many synthetic routes used in the manufacture of MDMA, most utilising the banned precursors paramethylketone, safrole or isosafrole, with the chemistry carried out in the Netherlands and Belgium.

PMA is made from an entirely different starting material: anethole, a cheaper, legal chemical. Its presence in Ecstasy pills is not an accident of inexpert chemistry; rather, it is a deliberate passing-off of one chemical as another.

PMA has a steep dose-response curve, with 100mg of the drug affecting users more than twice as hard as 50mg. Its onset is slow and mild and can lead users to think they have been sold inferior tablets, prompting them to take more. At 50mg PMA causes mild euphoria. At slightly higher doses its effects increase rapidly, with heart rate, blood pressure and body temperature all soaring, with the risk of convulsions, coma and even death.

When mixed in pills with MDMA, it can become even more dangerous since PMA can potentiate the serotonin-producing effects of MDMA and can lead to serotonin syndrome and death by overheating.

Johnboy Davidson, administrator of pillreports.com, a website that issued several PMA warnings ahead of the British police's alerts, said: "PMA, when combined with low doses of MDMA, gives [dealers] a lot more bang for their buck. More than one or two pills and it gets dangerous, fast."

Newspaper reports have cut-and-pasted inaccurate information from the Wikipedia page on PMA, saying the drug is "known as" Mitsubishi Turbos, Pink Ecstasy, Dr Death, Pink McDonald's, Double Stacked, Chicken Yellow and Chicken Fever. In fact. PMA in the UK is never sold by any brand names and is instead an adulterant in ecstasy pills, sold in many different colours, sizes shapes and logos.

BLOOD SIMPLE

© ISTOCKPHOTO

There are too many barriers to treatment for marginalized people with hepatitis C. But a new report outlines some key measures to ensure London's burgeoning HCV population receive the best help possible.

By **Max Daly**

London is home to nearly a quarter of the UK's estimated 216,000 chronically infected hepatitis C (HCV) sufferers.

Despite the large numbers of people with the HCV in the capital, and the public health threat posed by the spread of this virus, rates of testing, diagnosis and treatment are relatively low.

This could be down to the fact that HCV disproportionately affects a marginalized population -current and former injecting drug users.

But as every year goes by, the number of people finding out they have advanced liver disease after becoming unknowingly infected through injecting drugs in the 1980s and 1990s, begins to mount.

In an attempt to tackle this emergency head on, a joint working group on substance misuse and hepatitis C commissioned a detailed 65-page report into the commissioning of hepatitis C treatment services for people who inject drugs. The report focuses on London, although its findings can be taken up by commissioners across the country.

The first step to dealing with HCV is identifying those who have it, as early diagnosis is key. Most HCV testing is carried out at drug treatment services, but this can be expanded to GP surgeries and pharmacies, targeting people who have injecting histories.

Blood testing, which requires two separate samples and appointment for antibody and polymerase chain reaction (PCR) tests, can be problematic and off-putting for people who inject drugs. If this process can be simplified, the report says, more people will access treatment.

But London is sadly lagging behind other parts of the country in this respect.

The National Institute for Health and Care Excellence (NICE) has recommended reducing the number of samples needed from two to one, something not currently offered by laboratories in London – despite being conducted by half of all regions in England. Alternative means of taking samples, such as dried blood spot (DBS) testing, can be conducted 'on the spot' by non-specialist staff.

In terms of good practice in blood testing, Manchester is way ahead of London. Technology has been developed there that enables both the antibody and PCR tests to be performed from a single dried blood spot test.

THE REPORT'S SOLUTION IS TO REDUCE THE NUMBER OF HOSPITAL APPOINTMENTS AND MAKE THE 'PATHWAY' TO TREATMENT MORE PATIENT ORIENTATED

The priority for commissioners, according to the report, should be to ensure that all drug treatment services offer routine blood-borne virus screening and vaccination (for hepatitis A and B), complemented by annual reviews to reassess risk.

Once someone has been diagnosed, more barriers to treatment begin to reveal themselves, and the largest one is hospitals.

Patients are referred to hepatology units at hospitals for assessment. Yet this incurs a high drop-out rate, because it requires people to attend multiple appointments, often in different places.

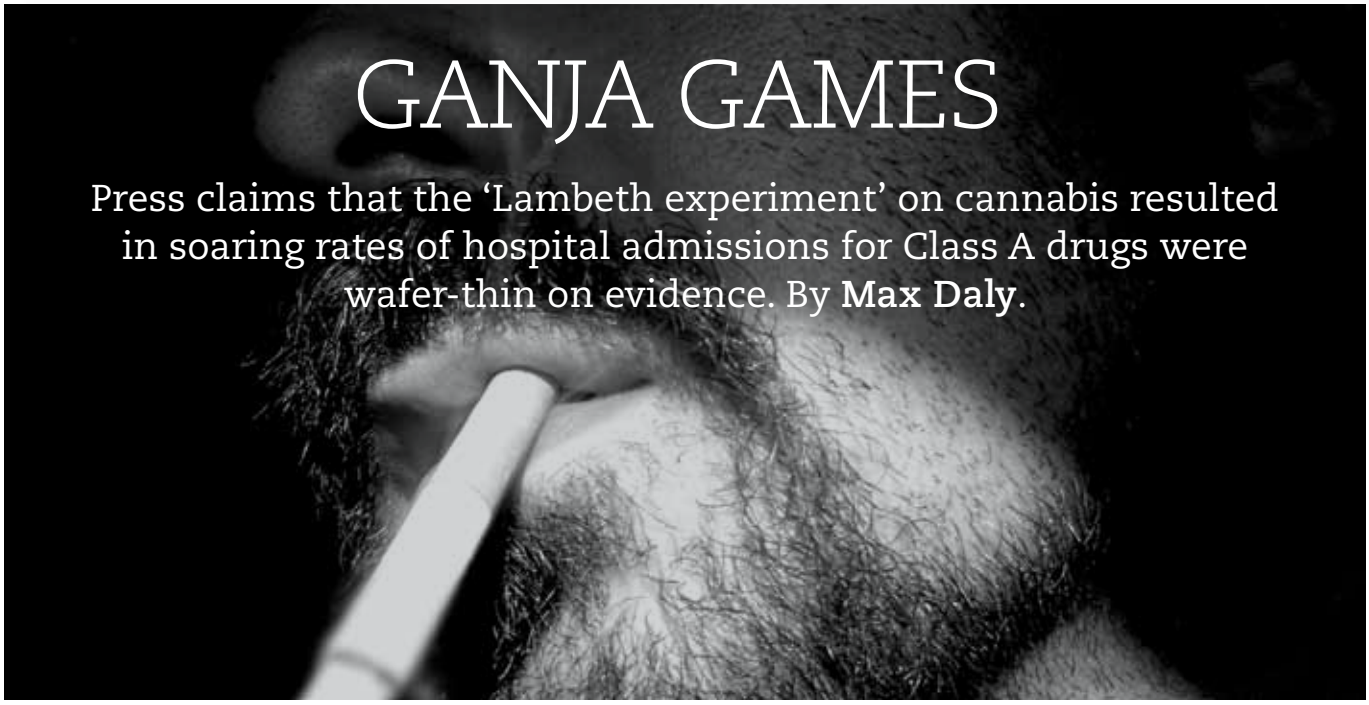
The report's solution is to reduce the number of hospital appointments and make the 'pathway' to treatment more patient orientated. The ideal solution, modeled at Lewisham and Tower Hamlets, is to have a hepatitis treatment clinic attached to drug treatment services.

Alongside treatment, a multi-faceted prevention programme, encompassing opiate substitution therapy, needle exchange programmes and awareness campaigns, should be implemented.

In order to assess effectiveness, data and progress should be monitored across all London boroughs. It is for local areas to determine how best to jointly commission these services between public health departments and clinical commissioning groups.

Finally, the report points out that commissioners should lobby pharmaceutical companies which are developing new treatments for HCV "to set sufficiently affordable prices to optimize access to treatment in this marginalized group".

Public Health Report on Commissioning of HCV services in London for People who Inject Drugs published by The London Working Group on Substance Misuse and Hepatitis C and NHS North West London.



GANJA GAMES

Press claims that the 'Lambeth experiment' on cannabis resulted in soaring rates of hospital admissions for Class A drugs were wafer-thin on evidence. By **Max Daly**.

In April, two national newspapers declared that research proved a softer approach to policing cannabis under Labour in the 2000s ramped up drug use, crime and hospital admissions.

The *Daily Mail* headlined its piece: 'The price of going soft on cannabis: Labour's experiment 'pushed up hard drug use and crime'. The same day, two *Daily Telegraph* headlines declared not only that 'Cannabis use soared by a quarter after Class C downgrade', but also that 'Softly softly cannabis scheme drove up hospital admissions for hard drugs'.

The "going soft" policies that the papers referred to were the 2001 'Lambeth Experiment', overseen by Commander Brian Paddick, to stop arresting people for simple cannabis possession (in order to focus on crack and heroin dealers) and the declassification of cannabis from a Class B to a Class C drug in 2004.

However, all the evidence to date on the impact of these policies had shown a very different picture from that presented by the newspapers, in fact quite the opposite. Criminologists were intrigued and not a little suspicious that only these papers carried the stories.

So what were these stories based on? Despite the fact the *Daily Mail* described them as "two major research studies", the sources for the stories were two unpublished research papers presented to the Royal Economic Society. Unfortunately, one is seriously flawed while the other remains unfinished and is confusing.

The first paper, *Policing cannabis and drug related hospital admissions: evidence from administrative records*, claims that the Lambeth Experiment raised hospital admission rates for hard drugs between 2001 and 2002. But as Alex Stevens, Criminologist Professor at the University of Kent points out, this is "a huge claim" which does not stand up to any scrutiny at all.

A PERFECT STORM OF SHAKY OR INCOMPLETE RESEARCH AND SENSATIONALIST REPORTING

For example, did hospitals in other inner city boroughs see a similar increase in Class A drug admissions? The research does not say. Nor could you glean from the research how a reduction in the classification for cannabis could relate to rising hospital admissions for cocaine.

The second paper, *Cannabis consumption, crime and victimization – evidence from the 2004 cannabis declassification in the UK*, says in its front page abstract that "declassification increased cannabis consumption by 25% for previous non-consumers relative to previous consumers". Like anyone else, the reporters, rushed as they probably were, should have checked out the muddled meaning of that sentence with the authors of the report – and also taken heed of the two national surveys that provide by far the most reliable information about trends in cannabis use.

The *British Crime Survey* and the *Survey of Smoking, Drinking and Drug Use Among Young People in England* found that cannabis use had fallen from 11 per cent of adults and 13 per cent of children before the declassification, to eight per cent and nine per cent respectively. "It is very hard to square these reductions with a claim that the changes in 2004 caused cannabis use to rise," said Professor Stevens.

In fact, one of the reports authors, Dr Nils Braakmann, sought to distance himself from the newspapers' take on his research, saying that that his research "does not demonstrate an absolute increase among people who previously did not consume cannabis."

Ewan Hoyle, of the Liberal Democrats for Drug Policy Reform, accurately summed up the stories in an article on politics.co.uk as "a perfect storm of shaky or incomplete research and sensationalist reporting".

The Work-Work balance

Since its introduction in mid-2011, the Department for Work and Pensions flagship Work Programme (WP) has come in for widespread criticism. **Paul Anders** looks at the WP in detail, and considers its relevance for the drug and alcohol sector.

A road most travelled

Active labour market policies can be roughly divided into three categories – job creation, job subsidy, and job preparation. In the UK, large scale active labour policies became more widespread from the 1970s onwards, delivered by bodies such as the Manpower Services Commission and later by a plethora of Training and Enterprise Councils which had a broad and somewhat confusing remit that included promoting local growth, encouraging investment and providing training and support to the unemployed.

However, other than in the relatively small and atypical Nordic economies, large scale and systematic use of active policy had to wait until 1996, with the United States' landmark Personal Responsibility and Work Opportunity Act, which provided for sanctions as well as incentives, focussed on duties as well as rights and provided a template followed by other countries. A number of factors contributed to this change in policy, including a sense that the sustained unemployment that had been a feature of Western economies since the transformational economic policies of the 1980s needed addressing and, arguably, a gradual hardening of public attitudes towards social security.

Shortly after taking office in 1997, the Labour government initiated the New Deal, which Tony Blair described as "a message of hope" for the "forgotten people": a high-profile, active policy funded largely by the £5bn raised from a windfall tax on privatised utilities. The New Deal in fact encompassed a range of initiatives targeted at different groups, including the long-term unemployed, single parents, young people, the disabled, and those aged 50+. Over time, the New Deal was joined by local Employment Zones, Pathways to Work, and progress2work, the last aiming to support people with histories of drug and alcohol use, homeless people and ex-offenders: the groups considered to be at the greatest disadvantage in the job market.

In 2009, the New Deal was rebranded (with reduced funding) as the Flexible New Deal, and joined by the Future Jobs Fund – a response to the substantial rise in youth unemployment emerging in the wake of the financial sector crisis, and a break from recent trends, in providing a direct subsidy to employers, largely from local authorities or the voluntary sector, to create new posts reserved for young people.

A new dawn

In 2010, the incoming coalition government announced that it was ending this increasingly complex network of provision and introducing the Work Programme; a simple and universal programme that would roll up most of the previous provision into one wrapper and would feature a strong payment by results (PbR) component. It would be contracted out, and delivered by networks of prime and sub-contractors willing and able to deliver sustained employment outcomes. In contrast to what was described as the ineffective box-ticking of previous provision, the WP would be a "black box": providers would be set free to innovate and the amounts of money on offer looked large. The figure of almost £14,000 per person into sustained work attracted the attention of the media and public, although few people noted at the time that the overall payment varied largely by benefit type alone, not need.

Big Society?

Talk of "Big Society", was everywhere in 2010. Although there was uncertainty as to what it meant, there was a vague sense that in part it meant that voluntary and community sector organisations would be given the opportunity to deliver public services. However, the specification for the WP effectively ruled out most charities at top-level or prime contract, moreover,

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the staged payment model – with payments in most cases not even starting until someone had been in a job for six months, meant that most voluntary sector organisations of any size would have had difficulty in accessing sufficient working capital, even if they were prepared to take the risk.

The result was a programme of 40 prime contracts delivered by 18 providers, primarily from the private sector, each having a supply chain comprised largely of smaller or specialist organisations, many from the voluntary sector – over 400, in total. Most prime contractors sought out specialist services from the drug and alcohol sector, giving treatment providers collectively a WP presence across almost all of England, Scotland and Wales.

So what's the problem?

It's worth considering the issues faced by the WP in two ways – problems faced by the WP as an initiative, and those affecting specialist subcontractors from the drug and alcohol sector.

At Programme level, the model was hampered by a number of constraints, both external and designed-in. Like the various New Deals, the WP is a supply side initiative: this type of intervention is likely to work best when there is strong demand for labour and large numbers of vacancies. While the post-2008 job market has been in some ways surprisingly robust, the over-riding problem in the market is a shortage of demand and a shortage of job vacancies. This is a simplification, but currently there are many more job seekers than jobs, and the main function of the WP is to allocate (or reallocate) jobs more efficiently – it can do little or nothing to create jobs.

Additionally, it was clear upon even quick analysis that behind the headline-grabbing £14,000 figure – which in any case only applied to a small proportion of WP customers – was an overall initiative designed to be cheap. Map maximum payments for client groups onto performance expectations, and the average per head payment drops dramatically, to not much more than £1000 per person, for up to two years of support. Deliver above minimum targets and that sum could rise, and rise substantially, but it could also fall, and those targets were set when there was optimism about the future state of the

economy and job market.

Turning to the design of the PbR model itself, organisations as diverse as the Social Market Foundation and Boston Consulting analysed data from the Flexible New Deal that pointed to a possible problem inherent to the model – not just that it wouldn't work because of external factors, but that it couldn't. Providers would be paid too much for low levels of success and too little for delivering good results, with the effect that a profit-maximising provider (or even a charity that only wanted to break even) would quickly reach an upper limit beyond which it would be financially impossible to progress.

Combine that with a less than buoyant job market with strong regional imbalances, and changes in the patterns of employment such as part time working and fixed-term contracts – all likely to adversely affect both WP caseloads and income, and it was clear that the WP faced a more difficult environment than anticipated.

Almost as soon as the WP started, specialist organisations began to express concerns. Many had had no success in joining supply chains despite running effective and good value employment services. Others had been successful in getting onto the Programme as spot-purchase providers – in effect, selling specialist interventions to other providers. Many of them saw few referrals, in some cases none. Conversely, providers who had agreed to deliver a full end to end service as specialist subcontractors, sometimes found themselves managing larger than expected caseloads, often clients with needs they had little experience of and limited ability to provide support around.

And what about the clients?

There are a number of contributory factors to the WP's limited impact to date for clients with histories of addiction. Jobcentre Plus has historically faced challenges in encouraging people to disclose drug or alcohol use, and consequently are unable to pass that information on to Programme providers in "warm handovers", or assign them to the right customer group. Programme providers in turn, may struggle to get people to disclose, perhaps unsurprisingly given reports made to DrugScope of disparaging comments from advisers about "junkies" and an absence of referrals to specialist provision.

Alan Cave, the DWP director originally responsible for the Programme said in 2011 that DWP had been surprised by the number of JSA claimants who had substantial barriers, health and otherwise, to employment. If officials genuinely were surprised by this, that is in itself surprising, and highlights the mistake made in using benefit type as a proxy for need. Interviewed by DrugScope, Kirsty McHugh, chief executive of the welfare to work trade body ERSA, stated that around 30-40% of people on JSA on the WP have self-declared health problems, and that needs and barriers among other claimant groups vary significantly.

WHILE IT ISN'T THE DISASTER SOMETIMES PAINTED – THE SUGGESTION THAT IT'S WORSE THAN NOTHING RELIES ON DWP'S OVER-OPTIMISTIC ASSUMPTIONS FROM 2010 ABOUT THE JOB MARKET

All of which raises the question of whether the WP is a suitable means of supporting those furthest from the job market at all. With vague minimum service standards and sometimes little hope of outcome payments, there is a risk that some people will simply be ignored: the incentive structure and binary outcomes don't encourage providers to support people unlikely to find work. McHugh points to the acknowledgement of distance travelled in other government programmes such as European Social Fund Families, and suggests it may be worth reconsidering active interventions that central government has largely abandoned, such as intermediate labour markets.

However, there are some positive developments. Supported by the NTA and DWP, Programme providers have made some progress in establishing links with treatment providers, albeit on a non-contractual basis. And in April 2013, DWP announced two new WP drug and alcohol pilots. One of these would, for the first time, tie payments more closely with need rather than benefit type. Rachel Radice, DWP's Head of Drug and Alcohol policy explained that these could be a proof of concept for a model that could be rolled out for other disadvantaged groups, and will also enable a thorough qualitative evaluation of the experience of clients with drug and alcohol histories that could, conceivably and over the longer-term, lead to different sorts of provision being developed or incentive structures applied.

And the future?

The drug and alcohol sector has been quick to acknowledge the value of work as a key component of recovery and provides effective services that fit within the overall WP price envelope – some cost more, but deliver more outcomes. This poses the question of why these services haven't been used to the extent expected.

Ministers have spoken about the inability of the voluntary sector to negotiate a good deal, but the reality is the market is distorted by having many sellers and very few, very powerful buyers. Whatever happens in the 2015 election, there will be some sort of active labour policy in place, and hopefully with more VCSE involvement – in a Work Foundation event in 2012, Mark Hoban MP, Minister for Employment spoke of his vision of a smaller, more specialist successor focussing specifically on people with complex barriers to employment.

The impact of PbR elsewhere must also be considered. The WP is possibly the largest PbR contract in Europe, and while it isn't the disaster sometimes painted – the suggestion that it's worse than nothing relies on DWP's over-optimistic assumptions from 2010 about the job market – this flagship policy hasn't been an unqualified success. Will the learning from the Programme be embedded in treatment and offender PbR initiatives? Statements indicating that Ministry of Justice plans involve adopting aspects of the WP do not reassure.

Postscript

Remember the Future Jobs Fund mentioned earlier? External evaluation of the Future Jobs Fund published in 2012 suggested that it was probably the most successful programme of its sort ever in the UK, achieving a net financial benefit to society and a sustained improvement in employment of over 25%, which for schemes of this sort is exceptional. Long before that evaluation however, and after being described as "one of the most ineffective job schemes there's been", it was promptly scrapped.

Paul Anders is DrugScope's Senior Policy Officer, and leads the Trust for London funded London Drug and Alcohol Network *Routes to Employment* project.

Game on: drug and alcohol services and the new local players

Connaught Rooms, Great Queen Street, London WC2B 5DA

6th November 2013 9.45am – 4.30pm

It has been a long time coming, but now it is here. As the National Treatment Agency rides off into the sunset, over the hill comes Public Health England and with it a whole new landscape in which drug and alcohol services need to operate. PHE will be much more 'hands off' than the NTA and for some that will be welcome. But it does mean that the voice for services inside Whitehall will be quieter – and we will all need to get smarter at making the case for services at the local level. So we have speakers that reflect the new dynamic as well as those reporting on developments in drug use which may well impact on services.

Confirmed speakers and workshop leaders include:

- Dr Andrew Howe, Association of Directors of Public Health
- Dr Owen Bowden-Jones, Royal College of Psychiatrists
- Sophie Howe, Deputy Police and Crime Commissioner, South Wales
- Dr Marcus Roberts, Director of Policy, DrugScope
- Dr John Ramsey, St George's Hospital Medical School
- Tom Woodcock, Commissioning Lead for Lancashire
- Debbie Holt, Independent consultant on commissioning
- Katy McLeod, Crew 2000 Scotland
- John Jolly – CEO Blenheim/CDP
- Steve Broome – Director of Research,. Royal Society of Arts
- Local Government Association (speaker TBC)

DrugScope/LDAN members £132 plus VAT. PRICE HELD FOR MEMBERS. Non-members £170 plus VAT

Booking form at:
www.drugscope.org.uk/events/drugscopeevents/gameon.htm
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WHITE RIOT

When Millwall fans started punching anyone in sight at an FA Cup game being shown live on TV, it reignited memories of the hooligan blighted days of yesteryear. **Max Daly** on how the rise of cocaine is fuelling a new breed of football thug.

The outbreak of crowd violence that marred the televised FA Cup semi-final game between Millwall and Wigan at Wembley in April surprised many observers. It was the worst bout of hooliganism seen at the national stadium since it reopened six years ago. Millwall fans fought police and Wigan fans. But strangely, most of the fighting involved Millwall supporters attacking each other, rather than rival supporters.

Over the next few days, police started to examine reports that many of the Millwall fans had been seen snorting cocaine before the trouble broke out. One angry Millwall supporter told *The Daily Mirror:* "There was no attempt to cover up what they were doing. They were openly snorting cocaine like other lads were downing lager."

Of the 14 fans arrested at the game, three were found in possession of a Class A drug, believed to be cocaine. The next week, The Sun found that half the cubicles tested at the Millwall's home ground, the New Den, tested positive for cocaine.

On the same weekend as the Wembley match, there were 29 arrests after vicious fighting broke out at the Tyne-Wear derby game between Newcastle and Sunderland, during which one fan punched a police horse. Also that day a group of 11 Watford supporters were arrested at Kings Cross station for public order offences, with one being found in possession of cocaine.

In February, ten Charlton Athletic hooligans were arrested after they smashed up cars and garden walls in south London following their team's loss at local rivals Crystal Palace. Two of them were caught in possession of cocaine.

Football violence is far less common today than it was 20 or 30 years ago, when hooliganism was highly organized and widespread. Banning orders and more sophisticated policing have severely curtailed fighting on the terraces and outside grounds.

But more common use of cocaine among the general population, has seen it become the illegal drug of choice for the modern day hooligan. And it is a drug that combines with the traditional intoxicant, alcohol, to act as a performance enhancing drug for thugs.

To fans intent on getting involved in some match day violence, cocaine can also provide feelings of alertness, exhilaration and physical strength thugs feel are important before going into 'battle'.

COKE ENHANCES THE FEELING, THE ARROGANCE AND THE BRAVADO. YOU FEEL YOU CAN TAKE ANYONE ON

Tony, a Nottingham Forest FC hooligan and English Defence League (EDL) supporter interviewed for my 2012 book, *Narcomania*, told me that taking cocaine was a regular part of getting ready for a match.

"You've got to have a swagger, and a few lines of coke will help you along. Coke enhances the feeling, the arrogance and the bravado. You feel you can take anyone on. On the coach, you will see lads snorting off the tables, bags or wraps of coke will be passed around with everyone taking a dab.

"Cocaine keeps your thought processes alive; too much alcohol deadens them. The last thing you want is not to be able to function properly. You need your wits about you. With the natural adrenaline of meeting your rivals, it's a powerful thing."

Cocaine, says Tony, is also a drug used by the football thugs who make up a large proportion of those attending EDL marches in Britain. "We always have a bit of coke before a rally. It sets you up nicely and gets you in the mood for a fight," he said.

Andy Holt, the Association of Chief Police Officers (Acpo) lead on football policing, told the BBC that cocaine use among fans presented the police with a new challenge: "There is certainly a link between substance misuse and violence in today's game, particularly when you start mixing cocaine and alcohol," he said. "People become very volatile, very hard to control and sometimes they are not rational.

"There are a whole range of initiatives to combat this, such as sniffer dogs to police the queues as they go into the ground. But it is not impossible for people to smuggle drugs into grounds, or to take them in public house toilets before they go in. These things happen and we've got to do all we can with both the licensees and the clubs to make it as difficult as possible to watch football under the influence of alcohol or drugs."

To some extent, fan's behavior has been influenced by the changing drug scene. During the rave era in the 1990s and 2000s football fans were more likely to take ecstasy. Research carried out by Mark Gilman, at the time a drug worker in the north west of England, found that for a period in the early 1990s, football hooligans were "more interested in raving than rowing".

Instead of engaging in the regular beer-soaked brawling at the derby

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games, rival Manchester United and City teams were starting to mingle on the terraces, having taken ecstasy and dancing together in the same clubs the night before. Talk of organising the next fight had turned to talk of where the next outdoor rave was.

But, as Gilman pointed out at the time, youth culture, and drug culture, are highly changeable beasts. When in the 2000s cocaine began to filter down to blue collar workers to become an increasingly acceptable part of modern working class culture, the days of loved-up football rivals passing round the pills ended.

But while football hooligans may use cocaine for social reasons and to prepare themselves mentally for a confrontation, does the drug actually breed violence?

Statistics gathered by the Greater Manchester Police of people arrested for violent assaults over seven months between 2007 and 2008 (see Druglink March-April 2009) found that half tested positive for drugs. Of these, almost two thirds (62%) tested positive for cocaine only. Is this just because lots of people just happen to use cocaine? Probably not.

The range of emotions that cocaine and alcohol can each produce in people – for example over-confidence, irritability, loss of inhibition, confusion and paranoia – lend themselves to an increase in violent encounters. Much depends on the individual, for some these drugs, particularly cocaine, can engender more of a 'flight' than 'fight' reaction to danger. However, cocaine's ability to keep people awake undeniably enables them to drink more alcohol.

According to *Bars, drugs and football thugs: alcohol, cocaine use and violence in the night time economy among English football firms,* a research paper by Tammy Ayers and James Treadwell at the University of Leicester, both cocaine and alcohol can be linked to violent behavior.

'Independently, both substances are disproportionately connected to violence. However, when used together the violence tends to be exacerbated and becomes more volatile: the heavier the use the more severe the violence is likely to be.

The two drugs create a third, cocaethylene, which triggers a further high but also is highly liver toxic. Studies have shown that cocaethylene also increases the propensity for violence. While there is concern about the potential for violence within heavy users of cocaine and alcohol, some drug services are also warning about the health affects on these people's own bodies.

Drug charity Chillout Sound Support carried out research into the links between football hooliganism and cocaine after noticing a rising number of service users being treated for cocaine and alcohol were members of local football firms. The charity prepared a report for Nottinghamshire City Primary Care Trust in 2009. It found that cocaine use, especially alongside alcohol, had become "normalized" among football fans. It said: "Relevant health messages needed to reach these clients in a way that is credible to them, otherwise serious health issues already identified will get worse."

The supply side of the cocaine trade has close links with football's more violent elements. While many football thugs are otherwise perfectly law-abiding family men and professionals, others are involved at various levels in organized crime.

Former Barclays bank project manager Malcolm Carle, 57, was jailed for six years in March for laundering drugs money for one of Britain's biggest cocaine gangs. As chairman of the North West Chelsea Supporters Club, Carle was regularly quoted in in the press, but he also hid a conviction for football violence.

PC Pete Dearden, Arsenal's football intelligence officer told The Observer in 2010: "Cocaine… gives them that strength of character to go into situations where otherwise they might have been frightened. It makes them braver. "The best way for me to curtail the activities of my risk group [in Islington, Arsenal's borough] is to cut off their supply of cocaine – with good intelligence, arresting the person supplying them."

Max Daly is author of *Narcomania: A Journey Through Britain's Drug World* published by Random House

Professor John Strang

A series of three recent papers in *The Lancet* summarised the findings of a six year project published as 'Drug Policy and the Public Good' published in 2010. John Strang was part of that project and here we discuss the general process of gathering and reviewing evidence in an always controversial subject area.
Interview by **Harry Shapiro**

Can you give some background to the Drug Policy and the Public Good (DPPG) project?

It built upon the work of an alcohol project which began in the mid 70s. The international scientific community were beginning to understand things about alcohol, alcohol policy and health and it was thought that these should be written down in a way that the ordinary, intelligent reader could understand. The book *Alcohol and the Public Good* was published in 1994. It was very influential and was attacked by the alcohol industry: they didn't like the conclusions and they deliberately went out of their way to discredit it by offering to pay researchers to write negative reviews (see also News page 2). It was updated in the book *Alcohol: no ordinary commodity*. The books laid out, in plain English, the 'Known Knowns' of the alcohol policy field. From that emerged the idea of *Drug Policy and the Public Good*.

What was the underlying principle behind it?

The objective was to bring scientific rigour to bear – what conclusions can we come to that are clear and true – whether the news is good or bad? And let's tell the reader where we haven't much to contribute at all. It summarises the strength of the collective body of evidence.

So in the prevention arena, ten years ago we would have had to say that we don't know whether anything makes much difference, but nobody is quite sure. We can now say that there is a strong evidence base for only minimal impact. People might go, 'well that's no different'. But it's massively different – previously we didn't have evidence of impact – now we have good evidence of minimal impact. The same applies to much of the activity around law enforcement . And with other areas, such as residential rehabilitation, even though the intervention maybe very popular and widespread and lots of people maybe passionate about it, we actually find only a modest body of high quality evidence of effectiveness.

Presumably there were people even within the group who were unhappy with the messages?

Absolutely. All of us had attitudinal baggage and we were all aware of that. So there were people who had worked with Democrats, with Republicans; people who had worked to introduce law enforcement in different countries, drug courts or who had run prevention programmes – and part of the rites of passage of being part in the group was to hang those pre-formed conclusions at the door – and if I drift towards being a campaigner, for example, you are mandated to stop me. Those were the rules.

Just thinking about how policy change happens though, isn't it true that politicians are really only motivated to act in a crisis rather than take a considered, objective view of the evidence? I'm thinking for example harm reduction in the UK as a response to the threat of HIV/AIDS to the wider community or a similar response to Needle Park in Zurich?

Yes, you're right, the time course doesn't always permit careful consideration of the evidence. So when the first needle exchanges opened in 1986, I was the newly appointed advisor to the Chief Medical Officer and the discussion was – do we shut them down or roll them

out? And the answer was a classic civil service compromise of using the two that had opened as a monitored research project, while they slowly expanded – and that actually became Gerry Stimson's research enterprise.

But policy change can happen in the light of evidence. Supervised heroin clinics in Denmark are a good example. They examined the recently-published results from well-designed trials in other countries and considered whether they needed to do any research – and decided that the research evidence base was sufficient to go ahead.

So what constitutes robust scientific evidence in our sector?

Scientific rigour is often mistakenly framed in terms of rigidity – people mistakenly think that you must always have randomised controlled trials (RCT) or double blind studies. That's completely wrong. What we were trying to encourage was buying into the scientific process, not any particular way of doing it. Obviously you can't do RCT studies for everything, but that doesn't mean you abandon scientific rigour in the search for a causal relationship.

A situation arises and you say – what is the best we can do in the compromised environment? Can we devise a study so that, in three years' time, we can look back and check to see if it was the right judgement call? So an example would be in the mid-1990s a number of us came to realise that unsupervised prescribing of methadone was probably contributing to a rise in methadone deaths. We had many more methadone deaths than other countries per capita and we were distinctive in that we didn't pay much attention to supervision – so maybe there was a correlation. A decision was made to introduce supervision in Scotland and then, a few years later, in England. And about ten years later we worked out that we could test if that was a right judgement. It wasn't a randomised trial, but it applied the rigour of science. Deaths per million dispensed doses dropped massively and we worked out that around 2500 lives were saved. You couldn't have done an RCT on that but it was good-quality science nevertheless

You have recently started a large prison-release take-home naloxone trial. But don't we know already that naloxone saves lives?

Yes, we know that naloxone works (spectacularly). But we don't know for certain, not 100%, that it saves lives overall. So in the public debate, some people will be saying, well that just encourages people to inject drugs because they know they have an antidote. For example, we don't know that giving somebody an advance pack will save lives. They might not have it on them when they need it or whoever is with them might be frightened to give it or it could even have an unintended negative consequence, by generating a sense of safety around injecting heroin or using more heroin. I don't think that will happen, but we need to test it out.

This one will be an RCT. In the trial 50% of people will be given a DVD about how to manage overdose plus an emergency dose of naloxone and the others will just be given the information. And in our view and the view of the ethical committee, it is ethical because at the moment, giving out naloxone is not current practice, so you are not withholding that from anybody. We are bringing an experimental intervention which we think will reduce deaths. If you can genuinely demonstrate lives saved, then that answers any criticisms that it doesn't work. Whether it subsequently gets widely implemented, is another issue that is then the next step in the translational process

So let's talk about the impact of the research process.

The best example in the UK would be NICE. The mind set is similar to that which existed within the DPPG group. NICE will say 'there are some key issues in the treatment field where we think there is evidence there to be gathered and we are going to do that in an authoritative scientific synthesis'. NICE has a top grading of reviews called a Technology Appraisal (TA); TA116 was to do with methadone/buprenorphine maintenance and because it is a TA, and if NICE say it is both clinically and cost effective, it is essentially mandatory for the NHS to provide it. The next level down is a CG or clinical guideline which is not quite compulsory but there must be reasons why you don't follow it.

The NICE process also says what you shouldn't do (or at least raises questions about the evidence base and challenges whether it should be done). We looked at CBT specifically for the treatment of dependence and as far as we could see there wasn't any evidence that CBT was of any use in the treatment of the dependence itself although it had clearly been shown to be of use in the treatment of co-morbidities like depression/anxiety. At best, the impact on dependence and associated behaviour was marginal – and we contrasted it with contingency management with which there was evidence of an amount of benefit (an "effect size") that was much larger. Now that upset a lot of people, but it is what the evidence found.

Going back to the DPPG; your conclusion that neither enforcement nor prevention had much impact was really questioning two thirds of most government drug strategies (the other being treatment). What has been the impact there?

It wasn't our job to make the final decisions about what drug policy should be. Some of us found that difficult because with other hats we might be on committees or government advisory groups and some of the people sat around the table had sat in government departments. Our job was to identify clear conclusions that should inform the public debate – not to tell the public what to do.

Through the book we want to ensure that the reader understands that however much you allocate to certain activities (like enforcement or prevention) don't expect to get a return on it. And there are big differences in the "effect size" of different strategies (in the different chapters) as well as between different methods (within each chapter). These are simple messages but also profound; simple in that the conclusions where they exist are strong, but they are particularly profound because they are in conflict with what we do.

THE EVIDENCE DEBATE

The Cochrane Collaboration, now twenty years old, conducts systematic reviews of randomised controlled trials (RCTs) of health-care interventions. But how relevant is the RCT to the addictions field? RCT is on trial here with **Tim Leighton** and **Ed Day**.

Tim Leighton, Director of the Centre for Addiction Treatment Studies, Action on Addiction

There is no doubt that for many kinds of intervention the meta-analysis of high quality randomised controlled trials (RCTs) is a route to more certain knowledge about their efficacy than any other review method.

However there is a rising chorus of discontent about the evidence in the drug and alcohol fields, particularly about psycho-social interventions such as "talking therapies" and complex social programmes such as therapeutic communities and mutual help organisations. This discontent is very far from anti-scientific in character: it is not coming from people who don't like the conclusions of the reviews because they challenge their beliefs or self-interest. Rather the voices are from among the most experienced and respected scientists in the field, each has related but different reasons for arguing that this evidence hierarchy has serious limitations.

The main arguments involve the research design itself and its relationship to real-world settings, the assumption that psychosocial interventions are technological, involving specific, theory-based active ingredients that can be packaged and tested, the question as to how causality can be established scientifically, the quality and quantity of the trials in specific areas, and whether or not the emphasis on RCTs is a problem for innovative and evolving treatments. Many of these arguments have been presented clearly and convincingly in the literature, but one aspect of the problem has yet to be properly articulated.

This is the very narrow, de-socialised view of science which maintains that truth about causality can only be established with controlled experiments. The main problem is that psychosocial interventions and programmes *do not have causal powers in themselves*. The causes of change in participants and recipients of such interventions are processes of changing reasoning (including emotional reasoning) and making use of resources offered. These causal powers are known to realist social scientists as 'mechanisms' and these are activated or inhibited according to a variety of contexts. This simple truth explains the baffling and contradictory results of apparently similar trials and the notorious failure, well-known to criminologists and health promotion researchers for example, of experimentally verified programmes and interventions to generalise to other social and cultural contexts. Different social contexts and positions provide different reasons to people to act.

What a significant positive result from an RCT of a psycho-social intervention actually tells us is that for this particular sample in this particular context the intervention studied was more effective than something else in activating change mechanisms. And this would be great if further trials revealed a consistent picture, but they very seldom do, so the solution is seen to lie in pooling and selecting for quality in the hope that a forest plot will reveal a significant trend. But what if the contexts and populations are different in the various studies? And could it not be that a study

in which CBT say, is found to be superior to Motivational Interviewing (MI), and another in which the reverse is found, both have something important to tell us about how interventions succeed or otherwise? Simply putting these and other studies into the mincer of meta-analysis squeezes out the significance of ground level variation in outcomes which is likely to be crucial in the application and contextual adjustment of interventions required to improve their effectiveness. As Ray Pawson has pointed out, the outputs of meta-analyses are means of means of means of means!

The Cochrane Review by Smedslund et al. (2011) on MI concludes that practitioners may be confident that doing MI is probably better than doing nothing, but that the evidence is not strong enough to conclude that MI is any more effective than a range of other things. As well as the usual recommendation for more trials, this review goes on to say: "This is a field where there is no lack of randomised controlled trials. Perhaps it is time to move from only studying whether MI works to also studying how it works, that is to study the mechanisms behind MI." The answer to finding out what is likely to work might not be more or better designed RCTs even when such studies are practical or viable. There is a large literature on mechanisms which has been accumulating since the 1970s. This literature has in my view been pushed aside by the dominant and perhaps simple minded idea that evidence from reviews of RCTs is the gold standard and the sole source of the truth about effectiveness. The value and utility of a good RCT is not in doubt, but the limitations of this method are hiding in plain sight, and it is time for the field to explore and understand these.

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If we want to know if an intervention is effective at achieving a specific outcome, we could simply deliver the intervention and observe the outcomes. However, even if it is successful, how would we know whether it was the intervention that caused the result or some other factor? Furthermore, we know that people that put themselves forward for a particular intervention are systematically different to those that do not. They may be more motivated to make a change for example, or have higher levels of social support encouraging them to attend. This is likely to mean that any positive effects of the intervention will be exaggerated. Both factors are examples of 'bias', or systematic errors or deviations from the truth in results or inferences. Bias can lead to both under- and over-estimations of the true effect of the intervention.

The solution is to use a randomised controlled trial (RCT). This type of research experiment is an attempt to ensure that the people receiving both interventions are as closely matched as possible. In its simplest form, all people that are eligible are randomly divided into two groups, one of which gets the normal current intervention and the other gets the new intervention. By *randomly* assigning people to groups we can eliminate the possibility that external factors affect the results and demonstrate that any differences in the pre-specified outcome between the two groups are a result of differences in the interventions.

RCTs are now the universal means of assessing which of two medical treatments works best. RCTs are used in areas as diverse as business strategy, international development work, public policy, and even the criminal justice system. However, Cochrane's major contribution was the recognition that such valid evidence was not usually accessible to decision-makers. The sheer quantity of research available from a rapidly increasing range of sources meant that it was difficult for anyone to keep up, and reviews of the literature were crucial. However, these also need to follow scientific principles in their preparation, as otherwise the views of experts (presented in textbooks) often ignore evidence for effective treatments and continue to recommend ineffective ones.

Reviews conducted under the banner of the Cochrane Collaboration respond to this challenge by identifying, appraising and synthesising research-based evidence and presenting it in an accessible format. Transparent and consistent procedures are used to find, evaluate and synthesize the results of relevant research. Procedures are explicitly defined in advance, in order to minimize bias and to ensure that the exercise can be replicated by anyone else that wishes to do so. Furthermore, RCTs may be expensive and difficult to organise at a practical level, and so may be 'underpowered', i.e. lacking sufficient numbers of participants to detect small but potentially important differences in outcomes. A systematic review can overcome this by using statistical methods (meta-analyses) to combine the results of a number of smaller studies to effectively make one larger one.

The work of the Cochrane Collaboration is not a panacea for all ills, and the RCT may be less useful in conditions where the intervention and the outcome cannot be clearly defined and measured. However, I would argue that the 20th birthday is a cause for celebration for two main reasons. Firstly, the inclusion of drug and alcohol problems as a topic area is important to raise the profile of the problem and to challenge the stigma often associated with addiction. The Drugs and Alcohol Group was registered with the Collaboration in January 1998. As of March 2013, 66 reviews had been completed, covering treatments from acamprosate to Alcoholics Anonymous.

Secondly, the egalitarian nature of the Collaboration and its procedures should reassure clinicians and clients alike. When RCTs were first introduced in medicine they were strongly resisted by some clinicians, many of whom believed that their personal expert judgement was sufficient to decide whether a particular treatment was effective. Likewise in the case of addiction there is a danger that experts by experience may 'prescribe' the pathway to recovery that worked for them, regardless of whether it works for another individual. Both groups may be right, but such confident predictions about treatment made by experts have also proved to be wrong in the past e.g. the failure of the 'Scared Straight' programme for deterring juvenile offenders. A Cochrane systematic review strives to present the whole picture, and do so in a way that invites critique and improvement. This puts vested interests to one side, and can only benefit the consumer.

People Power

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Mark Gilman argues that being part of a social network should not be regarded an optional extra for the recovering addict. It could be a matter of life and death.

Over recent years we have seen three phases in the modernisation of treatment for substance misuse problems. The first phase saw waiting times dramatically reduced and the numbers of people entering treatment increasing to over 200,000. The second phase was to retain as many of these people in treatment long enough for the treatment to have an effect. The third and final phase is recovery. In essence, this is the process by which people successfully complete and leave bio-medical and psychotherapeutic treatments and engage in social networks. Recovery is a social activity. This is seen in the slogans associated with recovery; *"I can't but we can", "You alone can do it but you can't do it alone"*.

From this perspective the quality of the recovering person's social relationships is a matter of life or death. Researchers in Glasgow are wrestling with the fact that men in particular die much earlier than their socio-demographic equals in Manchester and Liverpool. Bruce Alexander first introduced us to the 'Rat Park'. This research showed that rats living in isolation without contact with other rats would self-administer drugs of addiction to the point of death. Alexander has gone on to describe the 'Globalisation of Addiction' among humans as an overwhelming attachment to substances as a way of coping with social isolation and a general lack of meaning.

Public health colleagues recognise the importance of social relationships in the prevention of premature mortality. In their 2010 paper *Social relationships and mortality risk: a meta-analytic review.* Holt-Lunstad and colleagues noted, "Social relationship– based interventions represent a major opportunity to enhance not only the quality of life but also survival"

Duncan Selbie, CEO of Public Health England (PHE) has said that PHE will focus on the three most important things that will promote good health; jobs, homes and friends. For those people who are overwhelmingly involved with drugs and alcohol, the good news is that we can find them friends. A recovery community is, in essence, a social network of people coming together to create social relationships that support and sustain recovery. Recovering addicts and alcoholics will be joined in recovery communities by people recovering from mental health problems and the friends and families of all those effected. A recovery community is a 'big tent'.

Looking at the world of substance misuse treatment from the perspective of Public Mental Health and Wellbeing is a sobering experience. Suddenly our long held, evidence based and self-justifying mantras seem to ring a little hollow. Injecting heroin is one of the most destructive forms of addiction. Unprecedented levels of investment have been directed to treating injecting heroin addicts and from a clinical healthcare point of view services this investment has been justified. Addicts are kept alive, out of prison and free of HIV.

However, many of those in treatment are still dependent on prescribed medications, alcohol and tobacco and are dying prematurely as a result of chronic lifestyle problems within a context of social isolation. It is difficult to see how

this massive investment has made any significant contribution to improving mental health and wellbeing and the struggle for social justice. Wealth is no protection against addiction. But, addicts with money can buy very different kinds of clinical healthcare services. Services for wealthy addicts will invariably be abstinence based and three dimensional: bio-medical; psychotherapeutic and social network integration. Addicts in disadvantaged communities will typically be offered a one dimensional bio-medical intervention such as Opioid Substitution Treatment (OST). The Public Mental Health and Wellbeing agenda seeks to address these inequalities in provision and improve the situation for the poorest addicts the fastest to improve resilience and address this inequality by the adoption of 'assets based approaches'. One of the biggest assets in England is the anonymous 12 step fellowships and the more secular and scientific alternative SMART Recovery.

Successful recovery from addiction to alcohol and other drugs is about moving through the narrow corridor of clinical healthcare services into the wide world of positive social relationships. Recovery is constructed with others in communities of recovery or recovery communities.

Written in the 1930s, the book of Alcoholics Anonymous (aka *The Big Book*) describes the recovery process like the aftermath of people from all walks of life being rescued from a shipwreck where they are quite literally all in the same boat;

Unlike the feelings of the ship's passengers, however, our joy in escape from disaster [addiction] does not subside as we go our individual ways. The feeling of having shared in a common peril [addiction] is one element in the powerful cement which binds us. But that in itself would never have held us together as we are now joined. The tremendous fact for every one of us is that we have discovered a common solution."

More recently the work of political scientist Robert Putnam in his books *Bowling Alone* and *Better Together* draws our attention to the limitations of 'bonded social capital' and the possibilities offered by 'bridging social capital'. What's the difference? The very worst place to be for any addicts or alcoholic is on their own thinking. Their very best thinking got them to the point where they needed treatment. Better to be in the local service's user group. But many service user groups represent a form of 'bonded social capital' a limited social network often comprised of a homogeneous group of very similar people. 'Bridging social capital' refers to social networks between heterogeneous groups. For example, as a member of a 12 step fellowship such as AA or NA or CA you can get off a plane anywhere in the world and bridge into a social network made up of a broad cross section of society.

SUCCESSFUL RECOVERY FROM ADDICTION IS ABOUT MOVING THROUGH THE NARROW CORRIDOR OF CLINICAL HEALTHCARE SERVICES INTO THE WIDE WORLD OF POSITIVE SOCIAL RELATIONSHIPS

So meetings of anonymous 12 step fellowships are, at their best, examples of 'bridging social capital' in action. Places where working class and middle class addicts meet on common ground with the common purpose of helping each other in mutual aid.

It is in these meetings that socially isolated and disadvantaged addicts and alcoholics often find jobs, homes and friends. Recovery communities can be geographical entities and/or virtual, online communities of interest using internet discussion groups, blogs and social media. Advising on the construction of geographical recovery communities offering a 'common solution' in each of the 152 local authorities is one of the tasks facing Public Health England. These recovery communities will be built using an Asset Based Community Development (ABCD) approach. AA, NA, CA and SMART Recovery are the most obvious assets that will form the nucleus of these recovery communities.

Recovery communities are best supported by recovery champions. There should be at least three kinds of recovery champion. The strategic recovery champion might be the Director of Public Health (DPH). Therapeutic recovery champions are people working inside treatment services whose job is to get people out of medical treatment and into social recovery communities. The NTA have produced a guide to show therapeutic recovery champions how to assertively link people to mutual aid. If, as is practically likely, the therapeutic recovery champions efforts are thwarted by more senior people in the treatment services, the DPH should be played in to remind treatment providers how essential recovery communities are. Recovery communities are independent but their creation must have strategic support from those involved in delivering public health outcomes from within the local authority. Recovery communities are not a threat to treatment services but they are, and should always be, independent. Commissioners of new systems need to ensure that recovery communities are sufficiently resourced. Moreover, these resources need to be tied to the most flexible of governance arrangements. If possible a dedicated recovery community centre could be provided. Probably the best UK example of this can be found in Halifax, Calderdale at the Basement Project http://www.thebasementproject.org.uk/ .

Public health's recognition of the importance of social relationships casts mutual aid groups such as AA in a new light. Assertive linkage to mutual aid and other positive social networks is every bit as important as the bio-medical and psychotherapeutic treatments. This is now recognised by commissioners and providers of substance misuse treatment services. As these recovery communities grow, recovery will become ever more visible and contagious. As this happens we will begin to see more instances where people with a substance problem choose to go to mutual aid meetings as a first resort and then subsequently seek out the necessary bio-medical and psychotherapeutic treatments. Support from experts by experience via mutual aid groups is available 24 hours a day, 365 days a year and is completely free of charge.

In summary, recovery communities exist to address the five ways to well-being to all who need them. Firstly, they provide social connections. Secondly, they provide access to physical activities of all kinds from walking groups to fishing clubs. Thirdly, they provide opportunities for everyone to become a volunteer and become one of the third kinds of recovery champion – a community recovery champion. Fourthly, a recovery community will help everyone to find ways of finding their passions in life whether its poetry or pottery. Fifthly, a recovery community will promote a daily awareness of the joy in being alive by taking notice and being mindful of the simple things in life.

Mark Gilman is Strategic Recovery Champion for Public Health England

Alive and kicking in doors

Geoff Monaghan challenges the view that drug law enforcement is dead in the water.

I was interested to read Matthew Bacon's thought-provoking article *Endangered species* (*Druglink* January/February 2013) concerning the "decline in the number of drug squads and the deprioritisation of drug law enforcement" in Britain. The central premise of his article is that this deprioritisation is the product of a more "realistic management approach" towards policing illicit drug markets. On the face of it, the fact that police services are disbanding their drug squads appears to support his assertion. However, a cursory trawl of local newspapers and police websites suggests otherwise; see for example below, the extracts from a newspaper in north London and the Greater Manchester Police posting. In any case, it doesn't necessarily follow that the disbandment of drug squads means a reduction in drug enforcement activities. The Metropolitan Police Service (MPS) for example, continued to have a raft of drug performance targets and dozens of specialist officers investigating drug offences long after its Central Drug Squad was disbanded in April 1991.

Notably, Bacon doesn't provide any statistics to support the notion of deprioritisation such as ongoing significant reductions in stop and searches, execution of search warrants, test purchases, seizures and arrests but according to the latest Home Office report covering searches of persons or vehicles for drugs under the Police and Criminal Evidence (PACE) Act 1984 and other legislation, these searches increased by 5% in 2010/11 compared to the previous year. Leaving aside the question as to whether Bacon's point on deprioritisation is well-grounded, some of his conclusions deserve further consideration.

To bolster his point that a more realistic management approach to tackling drugs is in the offing, Bacon relies on comments made by detectives he interviewed during his research. First, we have the following comment made by a 'Metropolis' detective inspector: "We could choose to ignore drugs if we wanted to, because it's victimless and isn't performance managed anymore…". Really? Does this officer believe that a 'nil' return for drug searches, seizures and arrests submitted by his/her police service wouldn't raise a few eyebrows (and I daresay, hackles) at the Home Office and Her Majesty's Inspectorate of Constabulary? Or that local MPs and the Police and Crime Commissioner (PCC) wouldn't be pressing the DI's chief officer for answers to some pointed questions? And I'm sure the courts would soon become involved in the event that a chief officer decided to issue instructions to the effect that offences under the Misuse of Drugs Act 1971 were no longer to be enforced in his/her police area.

WE MAY WELL SEE AN INCREASE, RATHER THAN REDUCTION, IN DRUG OPERATIONS, SEIZURES AND ARRESTS

While conceding that police officers in Britain have broad powers of discretion, they are still answerable to the law. In summary, the police can determine the circumstances under which statutes will be enforced, but not whether they will be enforced. The DI's point that drug offences are no longer subject to performance management is, at the very least, misleading when viewed alongside the Government's ambitions for restricting drug supply as part of its Drugs Strategy 2010 and some of the draft PCC Policing and Crime Plans I've seen. His additional point that "…you only have a drug problem if you look for it" just isn't true and contradicts the historical records. The creation of the MPS 'drug squad' in 1954 was justified on the back of an increase in the trafficking of cannabis and other drugs, likewise other drugs squads such as the Liverpool & Bootle Constabularly Drugs Squad which was set up in 1970.

Then we have the comment made by a 'Smallville' detective: "One thing you quickly come to realise in this job is that no matter how many dealers you put away there's always someone out there selling." I've heard variations of this comment for over thirty-five years and my response has always been the same: "So what?" Consider this variation on the detective's comment: "One thing you quickly come to realise in this job is that no matter how many thieves/robbers/burglars you put away there's always someone out there thieving/robbing/burglarising." Again, so what? Replace the word 'dealer' with 'sex offender', 'fraudster' or 'wife beater' and the conclusion and my response is the same. How many police officers believe theft, rape, alcohol and drug misuse etc. will be eradicated during their tenure? Finally, we have this from a 'Metropolis' detective: "The fact of the matter is millions of people commit drug offences every year – what are we supposed to do about that?! Apart from the ones that cause people harm, I'd say no one expects us to do anything." Quite apart from the expectations of central and local government agencies and officials,

this officer appears to have forgotten his/her statutory and professional obligations. Chief officers expect, indeed demand, that their officers fulfill their obligations when it comes to policing drugs, and do their best to make sure their officers have the resources and skills needed to meet their expectations. At the same time, they recognise the fact that police resources are limited and so develop realistic objectives and performance targets.

Why do police officers make comments of this kind? To my mind, they add little, if anything, to the debate on drug control policy and frankly I don't understand why researchers seem so keen to use them except to underscore the fact that the people making them haven't really given their point much thought. Moreover, I don't agree with Bacon that they convey the idea of "the pragmatic dimensions of police culture and the need for managerial efficiency." Rather, I think they serve to illustrate the fact that some officers simply don't understand their role when it comes to supporting national drug policies and local objectives. A somewhat surprising – and disappointing – finding given that these have been set out in detail in Government and police service policy documents stretching back to the mid 1990s. Thankfully, comments of the kind discussed don't seem to have much impact on policing policies or practices.

Bacon's point that the disbandment of drug squads as part of the recent public service cuts will result in 'minimalist' drug enforcement appears to be out of step with what's happening on a daily basis. A decade or so ago, many senior officers were loath to authorise proactive investigations concerning cannabis because the focus was on Class A drugs, particularly heroin and cocaine. Things have changed. Vietnamese criminal networks involved in cannabis production are also likely to be involved in child exploitation, money laundering, violent crime, human trafficking and immigration offences, so it makes sense to follow up intelligence reports regarding cannabis cultivation by Vietnamese people as a means for uncovering other serious offences, some of which are or will be performance measured.

Similarly, investigating street gangs committing robberies and firearm offences will almost certainly uncover drug offences. Arresting thieves and burglars often leads to incidental seizures of drugs; in turn these seizures swell arrest numbers for possession and trafficking offences. On the back of these connections, we may well see an increase, rather than reduction, in drug operations, seizures and arrests.

Bacon also suggests that 'deprioritisation' will result in greater attention being given to the "most socially harmful problems" associated with drug trafficking. In fact, the targeting of heroin and cocaine trafficking, drug related violence and prolific offenders have dominated police strategies and related performance indicators for more than a decade.

The challenge of improving their performance on the back of unprecedented budget cuts is one that faces all police services in Britain. However, I believe that the disbandment of drug squads can be compensated for by drawing on the skills, knowledge and abilities of uniformed officers, detectives and specialist squads such as gang and burglary units. It's also apparent from Bacon's research that some police services need to do more to encourage creative thinking amongst their ranks.

Metropolitan Police Service

Haringey gang members who supplied crack cocaine, heroin and cannabis have been jailed for more than 40 years after a successful police operation. The 31 men – who came from different gangs across the borough – were arrested in February and March [2012]. The arrests followed a large anti-drug operation by Trident Central Gangs Unit and Haringey officers, which targeted prolific offenders and involved more than 250 officers from across the Metropolitan Police. The members of The North London Somalian [sic] Gang, Albanian Young Guns, The Wood Green Mob and Ida Road Gang were all implicated in the illegal supply of Class A or Class B drugs – including crack cocaine, heroin and cannabis – as part of the evidence-gathering tactic of Operation Fadden.

Source: *Tottenham & Wood Green Journal* Wednesday, July 11, 2012. Accessed on 3 March 2013

Greater Manchester Police

Shortly after 6am today, Wednesday 27 February 2013, police raided seven homes at addresses in Radcliffe, Bury and Ramsbottom. It follows arrests made earlier this month in an ongoing fight against organised crime and the supply of Class A drugs in Bury. Dozens of officers were involved in the raids, including specialist officers from GMP's tactical aid and dogs units, as well as divisional officers. The warrants were carried out following months of intelligence gathering and follow on from numerous operations in Bury over the last 12 months which have resulted in over 60 people arrested and charged with over 160 drugs offences. Thirteen of those arrested received prison sentences amounting to 30 years, nine are awaiting sentencing and 29 await trial. Police have seized 30 kilos of heroin, 30 kilos of amphetamine and ¾ of a kilo of cocaine, as well as £120,000.

Source: GMP website. Accessed on 27 February 2013

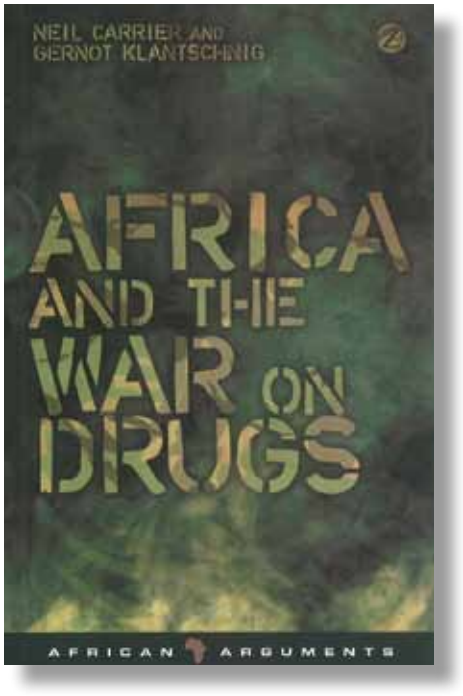
■ **Geoff Monaghan** is a former detective sergeant in the MPS, who served on the Central Drugs Squad and the Specialist Intelligence Section at New Scotland Yard and is now a Research Fellow with the Semeion Research Center for the Science of Communication in Rome.

The not so 'dark continent'

Shedding some light on what some perceive as the next battle ground for the 'drugs war'
By **Dr Krijn Peters**

Reviews

AFRICA AND THE WAR ON DRUGS
Neil Carrier and Gernot Klantschnig
Zed Books, London (in association with International African Institute) 2012



In 2007 the United Nations Office on Drugs and Crime (UNODC) released a report in which it warned against West Africa's growing role as an intermediary in the cocaine trade between Latin America and Europe. According to the report one quarter of all cocaine now sold in Europe passes through West African states.

While clearly there has been a surge in cocaine trafficking via West Africa to Europe since the mid 2000s, drug trafficking and drug consumption is nothing new to this part of the continent, or Africa in general. This is an observation that clearly comes across from Neil Carrier and Gernot Klantschnig's book. As such it offers a healthy antidote to the more alarmist messages of the UNODC, the US' on-going 'war on drugs' rhetoric and law enforcement policies and actions which it now has taken to the African continent, and the fears of an Al-Qaeda in the Islamic Maghreb (AQIM) financed by drug trafficking, as suggested by the media.

Step by step the authors deconstruct and disregard popular beliefs and perceptions that there is no history of substance use in Africa; that drug barons and organised crime networks have found solid ground in – and are taking over – the so-called failed and fragile states; or that drug production brings wealth and riches to a small group of greedy and unscrupulous drug kingpins, but misery and under-development to the wider community.

Through case studies of cannabis production in Lesotho and khat production in Kenya, the authors show the opposite: in a context where no state support can be expected, production of these drugs offers a reasonable livelihood to what otherwise would be farmers and petty traders living on the margin,

Referring to the work of Julian Bloomer on cannabis production in Lesotho,, the authors state that – rather ironically – the cannabis farmers there are opposed to better infrastructure since it will give easier access to police and government officials. Cannabis production is a major income source for many – accounting often for more than half of the farmers' arable crop revenue – and has become particularly important after labour migration to South Africa to work in the mines has declined due to (western-imposed) Structural Adjustment Programmes. Nevertheless, drug eradication and repressive law enforcement measures are likely to increase on the continent, so the authors argue, since these are the policies that can count on the (financial and technical) support of Western donors. Despite the fact that it is evident to nearly everyone that the "war on drugs" has been lost in Latin and Central America and that its main casualty has been the protection and safeguarding of basic human rights, harm-reduction strategies or let alone, the decriminalisation of drugs are not even at the African horizon.

'Africa and the war on drugs' offers an interesting read for those who want to know more about the continent's past, present and future relation with illegal substances. It is well written, well organised and structured and provides the reader with a wealth of information and a wide range of different issues. Discussing the full range of drugs – from soft drug such as cannabis or Khat to hard(er) drugs like crack-cocaine, heroin or methamphetamine – runs the risk of a blurring observations and findings. While use of Khat and cannabis generally brings limited health risks and the production offers an additional income opportunity to hundred of thousands of African farmers, these cannot be compared with the health risks of the more dangerous drugs (particular in a context where needle-exchange programmes are nearly non-existent and the number of HIV-Aids infections have taken pandemic proportions) or crystal meth laboratories run by organised crime networks. The authors do not fall into this trap and offer a much needed contribution to the yet rather limited literature on Africa and drugs.

Body of Evidence

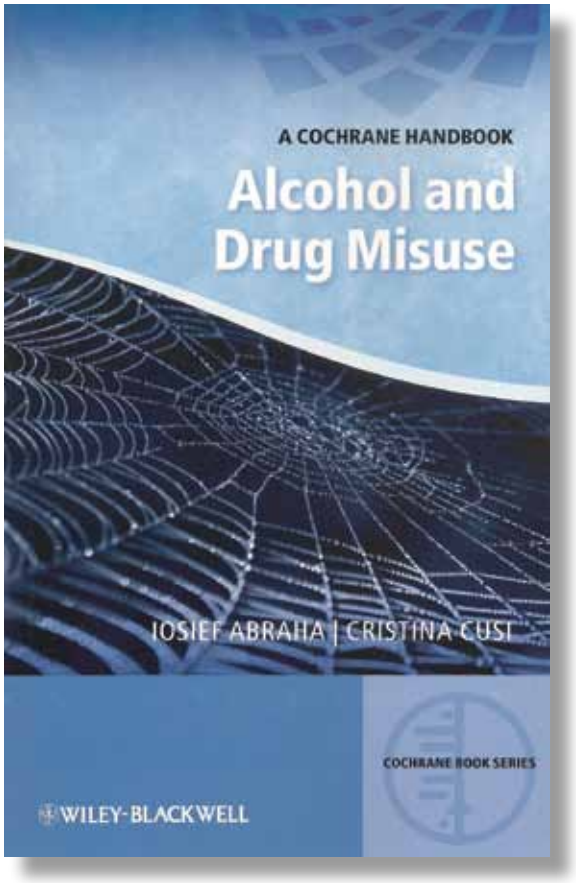
This year marks the 20th anniversary of the Cochrane Collaboration. How well has it served our sector? By **Luke Mitcheson**

Reviews

This book provides an overview of the 59 Cochrane Reviews conducted in the field of alcohol and drug misuse. It spans education and primary prevention initiatives as well as pharmacological and psychosocial treatments. As a Cochrane Review can only summarise existing research the focus is mainly on opioids, alcohol and cocaine. Each review is described separately in a three-page chapter, organised in an accessible format to the reader. The chapters start with a plain English statement of the review question, what is known of the topic and a summary of the answer. Some detail of the review follows; the objectives, description of the study population, search strategy and results. The chapter concludes with a summary of what the review adds to the knowledge, a statement of the main study limitations and implications for future research. Where relevant a forest plot is included showing the overall effect size of the meta-analysis.

The brevity and nicely laid out structure lend this book to be used as a very quick reference to the state of scientific evidence in each review area. But is this actually useful? The answer to this probably depends on the question you want answering and how you intend to use your newly found knowledge. As a psychologist working in the field I was drawn at first to areas directly relevant to my practice but was quickly frustrated with the lack of detail. As I expanded my knowledge search to areas I am less familiar with, such as education based interventions, I was pleased with the brevity and to see my pre-existing knowledge (or prejudices) confirmed. The book has been both a catalyst to seek further information in my area of expertise whilst also giving me some basic "bluffer guide" status in others beyond my narrow professional interests. Given that all the reviews in the book are available in full and for free on the web in the Cochrane Library one could argue the book is an excellent portal to this knowledge base. The more frugal-minded of you might want to go straight to the library and skip the book buying stage: www.thecochranelibrary.com

There are arguments to be had about the production of knowledge, the special status of the scientific method enshrined by Cochrane and whether this is the best way to answer all the questions we need to be answered in our field but these are beyond the scope of this review. This book reflects the state of the science rather than the art of drug treatment.



ALCOHOL AND DRUG MISUSE – A COCHRANE HANDBOOK
Losief Abraha and Cristina Cusi
Wiley-Blackwell 2012

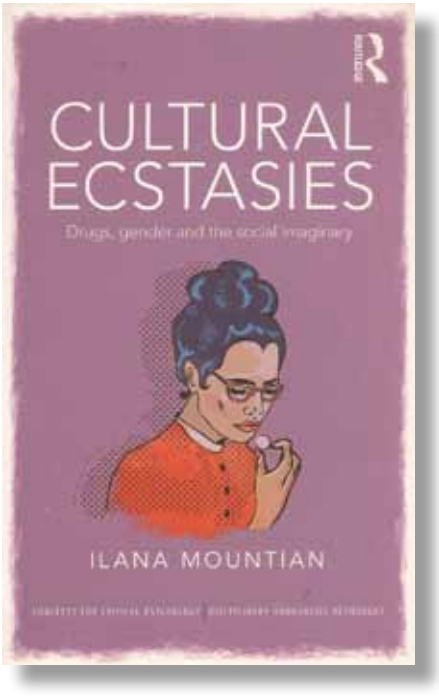
Luke Mitcheson is a Clinical Psychologist working in the community addictions services across the London Borough of Lambeth. He works for the South London and Maudsley NHS Foundation Trust.

Cultural ecstasies: drugs, gender and the social imaginary

By **Kay Nooney**

Reviews

CULTURAL ECSTASIES: DRUGS, GENDER AND THE SOCIAL IMAGINARY
Ilana Mountian.
Routledge 2012



The aims of the book are described as: 'first to provide a theoretical framework for critical analysis and second to highlight into mainstream discourses on drugs, addiction and drug users. For this aim, examples drawing on the history of drugs, drug treatment and drug policies will be used.' The definition of drugs employed in the book is inclusive of legal and illegal substances – tobacco, alcohol, anti-depressants, tranquillisers, amphetamines, marijuana, heroin, cocaine etc. The importance of a broader interpretation of the term drugs is that it leads to the corresponding inclusion of a content range from addiction and criminality to fashion and habit in the consideration of both individual behaviour and societal mores. This is an ambitious scope which seeks to encompass this breadth and diversity and reduce it to a form of theoretical understanding.

Chapter two sets the theoretical ground work, with the concept of social imaginary described as images, fantasies, illusions. The theoretical framework of 'social imaginary' is said to be drawn from Lacan's psychoanalysis and some aspects of Castoriadis' formulation of social imagery. The author provides an introduction to the focus of Lacan with its three dimensions – the symbolic, the imaginary and the real – said to be intermingling, not functioning separately, and also to be linguistically connected. The concept of 'other' is seen in the development of the individual. This is said to be a key conceptual point: 'when the child enters the symbolic, gender relations are also mapped out and the fantasies produced by the gaze at the imaginary level'.

A shorter account of Castoriadis contains the notion of the web of meaning: 'the magma of social imaginary significations. The institution of society embodies, carries and animates this web'. The author also includes a definition of Discourse Analysis. The concepts described in this chapter, if unfamiliar, are abstruse. Furthermore it is difficult to assimilate and understand their relation to the later chapters on addiction and drug policy and the historical discourse of drugs and drug user behaviour.

The author also draws on a sociological perspective, especially that provided by Foucault and his analysis of power and knowledge. The sociological framework seems more recognisable in the chapter discourses – indeed the author states that 'a key claim of the book is that discourses on drugs reveal specific societal moral values and ethical standpoints.' There is a useful summary of gender studies.

The remaining chapters cover historical discourses, addiction, social imaginary, gender and drug policies. 'Historical Discourses' contains a good summary of the development of drug use and changing attitudes of concepts of the drug user. Particular reference is made to the way in which medical, sociological and psychological research focus on the pathology of drug use, and does not necessarily acknowledge prevalent political and moral standpoints.

The chapter 'Drug Use and Social Imaginary' seems to suffer from the over-inclusiveness of the term 'drug' and it is difficult to find a focus or coherent theme. The chapter on drug policy is very brief, making it difficult to do justice to the topic. Similarly, the chapter 'Addiction' is disappointing from a psychological perspective but does serve to show that addiction as a topic can be considered without the aspect of individual pathology.

The chapter on gender and smoking is perhaps the best exposition of the theoretical frame-work, where the author shows how the image and societal roles of women both influence and are illustrated in the public and private use of the drug nicotine in the form of tobacco.

This book has a very erudite unusual theoretical framework but both the topic of 'drugs' and the scope of the book have been allowed a broad definition. This has made it difficult for the author to provide a coherent whole to the demonstration of the theoretical in practice. One consequence of this uncertainty is where and to whom the book is directed or intended. It seems to require an extensive previous knowledge of the work of the theorists whilst being of doubtful value to practitioners in the drug and alcohol fields.

■ **Kay Nooney** is a former forensic psychologist for HM Prison Service.

Review Briefs

Reviews

Critical perspectives on addiction

ed. Julie Netherland

EMERALD PUBLISHING: 2012

The publisher's description refers to the ways in which understandings and definitions of 'addiction' and associated treatments are changing, and the application of the term is extending to e.g. prescription drug use, eating, gambling and shopping behaviours."Featuring the work of several new, up-and-coming scholars working to deepen theoretical perspectives on addiction and its relationship to social control and deviance, this volume fills a gap in addiction studies by offering critical perspectives that interrogate and challenge traditional and/or mainstream understandings of addiction."

Amy my daughter

Mitch Winehouse

HARPER COLLINS: 2012

Her father's telling of the story of Amy Winehouse's life and death and the background to his setting up of the Amy Winehouse Foundation.

Harm reduction in substance use

ed. Richard Pates & Diane Riley

WILEY-BLACKWELL: 2012

The publishers describe this title as offering "a comprehensive exploration of the policy, practice and evidence base of harm reduction. Starting with a history of harm reduction, the book addresses key ethical and legal issues central to the debates and developments in the field. It discusses the full range of psychoactive substances, behaviours and communities with chapters on injecting, dance drugs, stimulant use, tobacco harm reduction, alcohol use and sex work.

Cognitive therapy for addiction: Motivation and change

Frank Ryan

WILEY-BLACKWELL: 2013

The publishers describe this title as outlining 'an innovative new approach to addiction treatment' linking cognitive behavioural therapy with cognitive neuroscience, using recent findings on the role of willpower in recovery from addiction.

Living with drugs

Michael Gossop

ASHGATE: 2013

Seventh edition of essential text by the well-respected writer and researcher.

Drugs crime and public health

Alex Stevens

ROUTLEDGE: 2010

Adopts a comparative approach to illicit drug policy centred on the UK but looking at other countries, including the US. Looks at the social contexts and the drugs, crime and health inequalities factors around illicit drug sue and policy making. Suggests future theoretical solutions after examining existing empirical evidence. This title will be reviewed in a forthcoming issue of *DrugLink*

NEW YORK NOTES

■ Maia Szalavitz

The loneliness of the addict activist

It's hard to convey the sense of crisis felt by people using intravenous drugs and facing AIDS in the early '90s: in New York, at least half of needle users were already infected – at least 100,000 people – and there was no treatment, let alone cure or vaccine. For me, there was a deep frustration that most people in recovery seemed unwilling or unable to do anything about it.

While gay men had ACT UP street activism and Gay Men's Health Crisis (GMHC) services, there were no similar groups for addicts in the US. In fact, the very idea seemed outlandish: Active addicts were thought to be too chaotic to even bother to save their own lives, let alone take political action.

Some treatment programs even refused to accept people infected with HIV. Organizations that should have been supporting us stood in the way of what would save our lives: opposing needle exchange and favoring harsh drug laws.

In those years, I was attending 12-step programs daily – and finding it extremely distressing that few recovering people seemed to think action against AIDS was essential. I recognized that the traditions wisely precluded political activism in the name of the program, but surely that didn't mean recovering people shouldn't otherwise try to fight for their own interests?

And so, in 1993, I wrote an op-ed for the Washington Post, using my own byline to show that it was possible to be "out" about recovery. It began like this:

"People don't think of addicts like me when they imagine intravenous drug users. I'm a white woman who works as a producer for a national PBS talk show. Five years ago I was shooting cocaine and heroin up to 40 times a day.

"When Americans picture a heavy drug user, they see an ignorant, immoral, undisciplined criminal…But because addicts are in the closet, no one banishes that image. And this lets addiction and AIDS continue to kill us. If we want to fight those diseases, recovering addicts had better come out and organize".

In America, one bright spot of early addict activism was the work of Howard Josepher, a former heroin addict. He had been among the first graduates of Phoenix House. In 1988, he founded ARRIVE, a program to teach ex-offenders about HIV and AIDS, which soon became much more than that.

Josepher realized that Phoenix House's tough, confrontational approach wasn't going to be useful here. Something more welcoming was needed. Since ex-offenders weren't required to attend, honey was going to be far more useful than vinegar.

The lure would be that those who graduated the program could get jobs as outreach workers or at ARRIVE itself – and that they'd have a place where they were welcomed and respected. Crucially, people didn't need to stop using to participate. Users just out of prison who were not interested in staying drug-free proved willing to attend.

Today, more than 9,500 people have graduated, many going on to become leaders in New York's AIDS and addiction programs. Josepher's organization, Exponents Inc. is still going strong.

When ARRIVE began, the idea of having active and recovering users in the same program was practically blasphemous. But soon, ARRIVE found that the mix was actually therapeutic: often, the active users would cut down or quit because they were inspired by those who were abstinent. And even if they didn't, a study showed that they reduced their HIV-risk behaviors.

But Josepher wasn't content to simply provide jobs and training. He saw that political action was needed. And so ARRIVE soon began turning up at AIDS demonstrations or doing their own street actions, bringing dozens of users and ex-users to call for change.

Several other activist groups rose and fell quickly for different reasons. There were huge challenges. Active and recovering users feared each other; alcoholics didn't like addicts. There was the problem of relapse and addiction itself. To make matters worse, those who were beyond early recovery often wanted to put the past in the past – or thought that 12-step anonymity meant no activism related to addiction. Finally, there are the deep divisions of race and class faced by all activism and all the agenda issues including law reform.

These conflicts mean that there are still very few "out" users and former users organized politically around addiction. These issues remain tough, but ACT UP proved that a small group of committed people can absolutely change the world.

Edited from an article that first appeared in The Fix

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