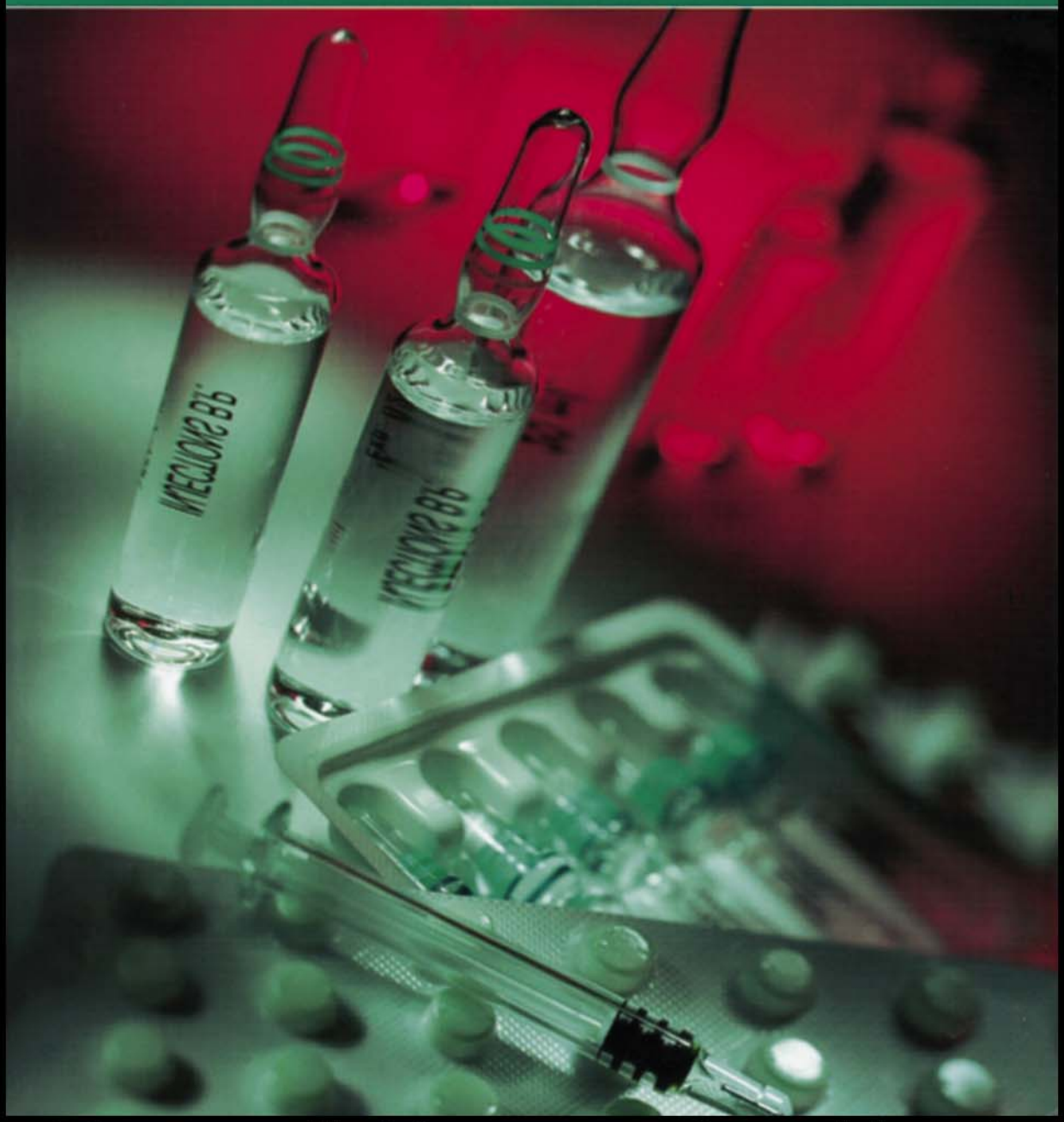
Edited by Janie Sheridan and John Strang

# DRUG MISUSE AND COMMUNITY PHARMACY



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# Drug Misuse and Community Pharmacy

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# An introduction to the book: context, aims and definitions

*Janie Sheridan and John Strang*

Two decades ago there probably would have been no need for a book which described the role and involvement of community pharmacy in services for drug misusers. Some community pharmacists would have been in contact with drug misusers through the dispensing of a small number of methadone prescriptions, or through furtive requests for injecting equipment, but there was no defined role for working with drug misusers. However, with the increasing numbers of individuals injecting drugs and the advent of HIV, community pharmacists, along with other health and social welfare professionals have found themselves in an ever-expanding demand for their services.

Now, in the twenty-first century, drug misuse poses a major challenge for health professionals and many of the health problems associated with drug misuse can be managed effectively in primary care, utilising the well-established network of primary care professionals. Community pharmacists are ideally placed to become involved in treatment and prevention strategies which may involve collaborative working between a number of professionals ranging from specialist medical and nursing care, through primary care, to support from social services. However, there are several generations of practising community pharmacists who have had little or no undergraduate or postgraduate training in the management of drug misuse. The quality practice of tomorrow will hinge on there being trained and competent practitioners working in a variety of community pharmacy settings and this book aims to provide the reader with a grounding in the historical, research and practical aspects of community pharmacy and drug misuse.

Like many other socio-medical problems, drug misuse can usefully be considered as a chronic relapsing condition. An additional dimension to this is that the patient's behaviour may have negative consequences not only for themselves and their families, but also for the community as a whole. Furthermore, they often find themselves stigmatised by some health professionals as well as by society in general. However, a non-judgemental and non-stigmatising attitude towards this area of healthcare is an essential starting point for quality care. In the 1999 Government clinical guidelines on managing drug misuse, GPs were reminded of their responsibilities with regard to caring for drug misusers through the General Medical Council

statement: "It is . . . unethical for a doctor to withhold treatment for any patient on the basis of a moral judgement that the patient's activities or lifestyles might have contributed to the condition for which treatment is being sought. Unethical behaviour of this kind may raise questions of serious medical misconduct" (Departments of Health, 1999). This could just as well have been written for community pharmacists.

Not all drug misuse results in dependence, nor does it necessarily result in problems for the user. However, it is important to remember that serious consequences can arise from the misuse of any substance (illicit or prescribed). And it is not just injecting which carries risks; these substances do not need to be injected to result in problems such as dependence, poor health, loss of income and the break-up of a relationship. The most serious consequences are likely to result from the use of illicit substances in a manner which is entirely inappropriate (in particular intravenous injecting), but which provides the dependent drug user with the most rapid and cost-effective use of the substance. In the UK, the illicit drug which creates the majority of work for health professionals is heroin, and therefore the reader will find that much of the book focuses on the management of opioid dependence.

This book has a particularly UK focus, with some chapters providing detailed information on UK drug services and UK law as they relate to the provision of these services. Nevertheless, an international readership is likely to find in all the chapters ideas and concepts that translate to their own experience. The book is aimed at all students of pharmacy and pre-registration pharmacists, any community pharmacist working with drug misusers or any pharmacists considering becoming involved, and anyone concerned with developing and managing primary health care services for drug misusers, in particular opiate dependent patients. This book is not a medical textbook on drug misuse, nor is it a textbook of pharmacology. Excellent books already exist which cover these subjects. This book has been written by experienced professionals in the field, and, where possible, uses an evidence-based approach whilst remaining focussed on the practicalities of service provision.

Whilst focussing on drug misuse, in particular the misuse of illicit drugs, two other areas of misuse and dependence also represent huge challenges to health and society – the use of alcohol and tobacco. The impact of brief interventions in primary care in these areas has been shown to be positive. Whilst tobacco and alcohol use are beyond the scope of this book, it is essential to bear in mind that community pharmacists can become involved in prevention and treatment services in this context. Furthermore, those who misuse illicit drugs may also be misusing these substances, further compromising their health.

The reader will note that chapter authors use different terminology to describe issues and individuals. We have left it to the discretion of the individual authors to choose the term they prefer. However, the terms drug misuser, drug user and problem drug user can, in many instances, be used interchangeably, whilst the terms client and patient are used to refer to a person who seeks treatment or a service such as needle exchange. And finally, the terms drug misuse, problem drug use and substance misuse are all used in the book to describe the inappropriate, non-medical use of a drug, sometimes prescribed or obtained through over-the-counter purchase, but more commonly obtained illicitly.

So what is the book about? We have sought answers to a number of questions that have a direct bearing on the development and future of community pharmacy involvement in services for substance misusers.

Our first question was "what is the history of drug misuse in the UK and the history of community pharmacy involvement"? In Chapters 2 and 3, experts in the history of drug misuse and the role of community pharmacy review the historical context in which to consider contemporary development. In Chapter 2, John Witton and colleagues provide us with a review of the UK drug scene from the early part of the twentieth century up to date, detailing some of the major legal and political decisions which have shaped the treatment of drug misuse in the UK today. In Chapter 3, Stuart Anderson and Virginia Berridge treat us to a walk through the history of community pharmacy and its relationship with drug misuse, from the early days when pharmacists could sell opium in their pharmacies – through to the tightly regulated and more integrated services of today.

Next, we ask "what can we learn from research carried out in this field"? The four chapters in this section describe the research and practice of community pharmacists in the UK and the rest of the world. These chapters provide the reader with a review of some of the available evidence about pharmacy's role and effectiveness in service provision and how the evidence informs practice development. In Chapter 7, a brief "voyage" around the world flags up some of the similarities and differences in the way in which countries utilise the services of community pharmacists in the management of drug misuse.

From there we move on to the practical business of service provision and ask "what can be achieved and what are the implications for practising pharmacists"? This is by far the largest section of the book, and provides the reader with a review of some of the approaches adopted by pharmacy – for example, needle exchange and supervised consumption of methadone. Other chapters provide ideas on the potential scope of a pharmacist's involvement in the welfare of drug misusers. The remaining chapters focus on some of the practical and ethical dilemmas faced by pharmacists in the provision of such services, mainly in a UK context, but with relevance to overseas readers.

Finally, we ask "how can community pharmacy contribute further to drug misuse services"? For our concluding section, we have commissioned chapters which focus on the development of community pharmacy through training and multiprofessional working, and finally we attempt to look into the crystal ball and discern the future of this essential cog in the vast machinery which seeks to prevent, treat and alleviate some of the suffering associated with substance misuse.

## REFERENCE

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# Opiate addiction and the "British System": looking back on the twentieth century and trying to see its shape in the future

*John Witton, Francis Keaney and John Strang*

"Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium".

(Thomas Sydenham, 1680)

**INTRODUCTION**

Looking back from our vantage point in the twenty-first century on the development of the treatment of drug users in the UK, there are a number of striking aspects of the British approach which are distinctive and have fascinated and perplexed commentators at home and abroad. Figures for 1999 indicate that about 30,000 drug misusers presented to treatment services in a six month period. If we go back forty years, Home Office statistics for 1956 reported 333 addicts in the country (currently the total population of patients of a local drug service). As a recent report observed, it is not just the character of the drug problem that changes like the tide ebbing and flowing; it is also that the sea level has risen dramatically. Yet despite this massive increase in drug misuse over the last forty years there have been features of British drug treatment that have endured. It is the features of this core response which have been dubbed the "British Experience" or "British System".

For many, the British approach to treating drug problems has been marked by the singular lack of a system or, until recently, the lack of a central co-ordinated policy. However, what has struck outside observers as being particularly unique to the British approach is the method of prescribing for drug misusers. Any medical practitioner can prescribe the opiate-substitute methadone or virtually any other drug (apart from the three specific drugs – cocaine, heroin and dipipanone). Only doctors with special licences can prescribe cocaine, heroin or dipipanone. In practice, such licences are granted only to doctors who work in NHS drug clinics and this type of prescribing is very modest. All these drugs can be prescribed either orally or intravenously where appropriate. Whilst guidelines on prescribing practices have attempted to establish recommended practice, there is a wide variation in the amounts of methadone that

have been prescribed, anything from 5 mg to an extreme of 1000 mg daily. There is also variation in the preparations of methadone that are available – oral mixture, tablets and injectable ampoules – in a way not seen in other countries. Most of the prescribers had received little or no training in substance misuse and often there is a marked contrast between prescribing habits of NHS practitioners and prescribers in the private sector. Journalists and commentators from abroad often compare this approach with what is happening outside the UK. In particular, British prescribing practice is in stark contrast to the United States where drug treatment is highly regulated and where there are limits on dosage of methadone, take-home privileges and programme content. Furthermore, with few exceptions outside the UK, there is no intravenous prescribing and physicians cannot prescribe heroin or cocaine.

Another striking feature of the British approach, when compared to other countries, is that it allows doctors, in their role as prescribers, a much more flexible approach to the needs of the individual patient. It was only after seventy years of treating drug problems that the first prescribing guidelines *The Guidelines of Good Clinical Practice* were published in 1984 by the Department of Health (Medical Working Group on Drug Dependence, 1984). These guidelines have subsequently undergone a number of revisions and updates in the succeeding years and the most recent updated guidelines, called *Drug Misuse and Dependence – Guidelines on Clinical Management* (commonly termed the "Orange Guidelines" for the colour of the publication's cover), were published in April 1999 (UK Department of Health, 1999). This is a much more comprehensive document that targets general practitioners and emphasises the importance of good assessment, urine testing before prescribing, shared-care, supervised ingestion (where available) and training. It should be noted that these guidelines have no defined legal position, except when they describe legal obligations in relation to the prescribing of controlled drugs (CDs), for example. They are not themselves regulations and the prescribing doctor remains largely unfettered.

So how could the absence of a central regulating system have been accepted for so long? This chapter provides a brief account of the circumstances that gave birth to the British approach and how this British system has evolved through periods of stability and points of crisis unimagined by its devisers. Following this account, attention will be turned to the analysis of current practice in the UK which has formed a notable part of the response to the combined problems of drugs and HIV. The latter part of this chapter focuses on new challenges including the hepatitis C problem and the current state of drug treatment. It then concludes with an appraisal of the options before us three years after the issue of the "Orange Guidelines", with regard to steering the British System in today's increasing international context.

## THE EMERGENCE OF THE BRITISH SYSTEM

The roots of the medical approach to the problems of opiate addiction in Britain lie in the nineteenth century and Anderson and Berridge have signposted the key events and debates in Chapter 3. In 1926 the Rolleston Committee established the template for the treatment of drug problems for the next forty years and its significance for this chapter is the latitude it accorded to doctors for prescribing to drug dependent patients (UK Ministry of Health, 1926). The report established the right of medical practitioners to prescribe regular supplies of opiates to certain patients which the

Committee regarded as "treatment" rather than "gratification of addiction". This move firmly defined addiction as a medical condition and as a problem for medical treatment. In such situations, prescribing might occur in the following circumstances:

"i) where patients were under treatment by the gradual withdrawal method with a view to cure;
ii) where it has been demonstrated after a prolonged attempt to cure, that the use of the drug could not be safely discontinued entirely on account of the severity of the withdrawal symptoms produced; and
iii) where it has been similarly demonstrated that the patient, while capable of leading a useful and normal life when a certain minimum dose was regularly administered, became incapable of this when the drug was entirely discontinued" (UK Ministry of Health, 1926).

Thus the UK followed a path altogether different from that adopted by the US. In the US, the passage of the Harrison Act in 1914 and subsequent legislation identified drug addiction as a deviant and criminal activity. In contrast in Britain, whilst the possession of dangerous drugs without a prescription was still the subject of the criminal law, opiate addiction became the legitimate domain of medical practice (and hence prescribing) where maintenance doses were allowed (even though this terminology might not have been used). This balance of a medical approach within a penal framework formed the basis of what was to become known as the British System for dealing with drug addiction.

As noted by Anderson and Berridge, calm seems to have prevailed on the British drug scene for the next forty years, and the American commentators at the time and subsequent commentators have eulogised about the effectiveness of the British System of these years – certainly in comparison to the continued and growing problems in the US. Schur identifies a total of 14 key characteristics of this British System including a small number of addicts around which it revolved, the absence of any illicit traffic in drugs, the absence of any addict crime or special subculture, the absence of any young drug users, and a high proportion of addicts from the medical profession and other socially stable circumstances (Schur, 1966). However, other commentators have questioned whether this quiet state of affairs was a result of the success of the system. As Bewley commented, in fact "there was no system, but as there was very little in the way of misuse of drugs this did not matter" (Bewley, 1975).

**The Brain Committee and the drug crisis of the 1960s**

Up until the 1950s, it was thought that the majority of addicts were of therapeutic origin, and were middle-aged or elderly people who were prescribed opiates in the course of the treatment of illness with a second category being "professional addicts" – doctors, dentists and pharmacists who became addicted partly through their professional access to dangerous drugs. In the early 1950s, the first signs of an American-type opiate problem occurred in London, following a theft of hospital drugs (Spear, 1994). Reports about the activities of young heroin users began to appear in the British newspapers such as had not seen before in the UK. Claims were made that drug sub-cultures were forming, mainly in London. These events prompted the two Brain Committee reports.

The key question the second Brain Committee addressed was whether these changes in the patterns and extent of drug use required a new approach. In their evidence, the second Brain Committee learned that the increased use of opiates related in particular to heroin for which the annual total number of addicts known to the Home Office had risen from 68 to 342 in the preceding five years, and was accompanied by a similar increase in the number of known cocaine addicts from 30 to 211 in the same period. Virtually all of these were combined heroin and cocaine addicts. These new addicts were predominantly young males living in the London area. The Committee soon established that there was no evidence of any black market imported heroin, and expressed their concern about the over-generous prescribing of such drugs, observing that "supplies on such a scale can easily provide a surplus that will attract new recruits to the rank of addict".

A rethinking of policy was urgently required as the pre-existing British System was clearly failing to limit the spread of youthful heroin addiction and actually appeared to be contributing to the spread of the problem by making supplies so easily available. Drug addiction was reformulated as a socially infectious condition for which it was appropriate to provide treatment. The second Brain Committee believed that control of the drug problem could be exercised only through control of the treatment. Three linked proposals formed the basis of the second Brain Report: restriction on the availability of heroin, the introduction of special drug treatment centres and the introduction of the notification system for addiction (as with infectious diseases).

**The arrival of the specialist clinics**

As a result of the Brain Committee's recommendations, special drug clinics were established in the spring of 1968, to coincide with the introduction of the new Dangerous Drugs Act (1967). Prescribing restrictions were introduced and only specially licensed doctors could prescribe heroin and cocaine to addicts. The aim was to exclude the naive or corrupt prescribing doctor, for, as Connell said at the time "all professional classes contain weaker brethren" (Connell, 1969). The brief for these new clinics had been outlined in the recommendations from the Ministry of Health which identified that, in addition to providing appropriate treatment to drug addicts, the aim was also to contain the spread of heroin addiction by continuing to supply this drug in minimum quantities where it was necessary, depending on the doctor, and where possible to persuade addicts to accept withdrawal treatment. As Stimson and Oppenheimer subsequently commented, new clinics were given the twin briefs of medical care and social control.

**The early years of the clinics**

By 1968 there were approximately 60 doctors licensed to prescribe heroin and cocaine, with 39 clinics providing treatment, 15 in London and 24 in other parts of England and Wales. Practitioners treating drug users were obliged to notify the Home Office of their cases for inclusion on the Addicts Index and 1,306 addicts were notified in 1968, the first year of operation of both the new clinics and the Addicts Index. Most of them were dependent on heroin and living in the London area. The clinics established in the London area saw 79% of the notified opiate addicts in England and Wales in 1968. Frequently the doctor working at the clinic would initially prescribe heroin and/or cocaine at doses similar to those previously prescribed by the private

doctor. Thereafter the average daily dose of prescribed heroin fell steadily over the next few years and there was a gradual establishment of injectable methadone and then subsequently oral methadone as a substitute for opiate drugs, which might be prescribed in combination with heroin. Cocaine was initially prescribed in an injectable form at the drug clinics, but this almost entirely ceased in late 1968 following a voluntary agreement between clinic doctors.

**The methylamphetamine epidemic**

During 1968, a new major problem emerged – the abuse of intravenous amphetamines. One particular private doctor had begun to prescribe methylamphetamine ampoules to drug addicts and widespread use of this drug in the London area followed. A short lived experiment into the possible value of prescribing injectable amphetamines to these patients in order to stabilise their lifestyles and eventually weaning them off, was largely a record of therapeutic failure. By the end of 1968 voluntary agreement had been reached between the Department of Health, the Drug Clinics and the manufacturers of the methylamphetamine ampoules, so that the drug was withdrawn from supply to retail pharmacies. Thereafter the drug was, in effect, available only through the drug clinics, which chose not to prescribe. This attempt to manipulate drug availability to stunt this emerging epidemic appeared to be successful.

**The clinics in the middle years**

After the initial impact of the introduction of the new drug clinics, there came the gradual realisation of the cumulative enormity of the problem being tackled. Although the clinics had some success in attracting addicts to their services even before the early years, evidence had emerged that pointed to the existence of a large population of drug addicts who remained out of contact with them. Many of these patients had been taken on with actual or presumed promises of life-long maintenance on injectable drugs. The optimistic original view had been that frequent contact between clinic staff and the patient would inspire the demoralised addict to undergo withdrawal. However, all too often, the change within the psychotherapeutic relationship was in the opposite direction, with the secure supply of pharmaceutical injectable drugs legitimately provided by the clinics, entrenching the addict in his/her drug taking ways as institutionalisation set in.

By the mid 1970s, London drug clinics appear to have undergone a collective existential crisis with regard to whether their prime responsibility was for care or for control. Rules were introduced to limit the distracting impact of some behaviours. Fixing rooms in which the addict and fellow users could inject their drugs gradually disappeared from the drug clinics and from the non-statutory agencies. A more active and confrontational style of working became more common in the practice of the clinics. No doubt this was partly born out of contact with the new drug therapeutic community such as Phoenix House, and partly out of a sense of stagnation resulting from the profound lack of personal progress, for many of the maintenance patients. There was an active discussion as to the relative merits of the three main drugs of prescribing, injectable heroin, injectable methadone and oral methadone. A study was conducted at one of the London drug clinics where 96 confirmed heroin addicts were randomly assigned to either injectable heroin or oral methadone maintenance and

were followed up for a one year period. The investigators concluded "prescribing injectable heroin could be seen as maintaining the status quo, with the majority continuing to inject heroin regularly to supplement their maintenance prescription from other sources"; whilst refusal to prescribe heroin and offering oral methadone "… resulted in a higher abstinence rate, but also a greater dependence on the illegal source of drugs for those who continued to inject" (Hartnoll *et al.*, 1980). The authors drew attention to these mixed conclusions which did not suggest the superiority of one approach over the other, but that the approach adopted depended on the aims of the service: whether to maximise the numbers who achieve abstinence or to "maintain greater surveillance over a higher number of drug users and ameliorate their total preoccupation with illicit drug use and criminal activity".

Stimson and Oppenheimer identified three arguments put forward by clinic staff as a need to change direction. Firstly, the legal prescription of opiates had not and never could entirely abolish a large-scale black market in opiates, let alone another drug. Secondly, control of drug use was not an appropriate role for treatment agencies and should be left to legislators and law enforcers. Thirdly, there were practical problems associated with maintaining addicts on injectable drugs when they eventually started running out of veins (Stimson and Oppenheimer, 1992). It is important to realise that there was no central absolute direction to the operation of drug clinics. As a leading consultant said "each physician in charge of a special drug dependence area is a law unto himself, as to how he treats and manages patients".

Consequently clinics began to introduce a policy that only oral methadone could be available for new patients, and by the end of the 1970s, most of the drug clinics had followed this pattern. Thus by the end of the decade a strange situation pertained involving a therapeutic apartheid between those patients who had attended early on (who often still retained maintenance supply of injectable drugs) and those who were taken on by the clinics at a later date (who were offered only oral methadone). The combined shift of prescribing policy and introduction of therapeutic contracts gave the clinic staff a new sense of purpose and direction, with their energies directed toward helping the drug user to be abstinent.

## THE BRITISH SYSTEM IN THE EIGHTIES: NEW EPIDEMICS AND NEW POLITICS

The eighties brought new pressures on the treatment system. Already struggling with the care or control contradictions of the previous decade the clinics now had to deal with a new epidemic of heroin use generated by the opening of new trade routes for black market heroin from Iran, Afghanistan, Pakistan and other parts of the "Golden Crescent". The number of addicts notified to the Home Office rose to over 12,000 in 1988, more than twice the number recorded three years before. The amount of heroin seized by customs had increased dramatically and the price of heroin had fallen by 20% between 1980 and 1983. The new wave of heroin addiction occurred particularly in the run-down inner city areas devastated by the restructuring of the British economy in the early 1980s (Pearson, 1987). Unemployed and with no future insight these new young heroin users favoured inhaling heroin, "chasing the dragon", in the mistaken belief that it was not addictive. This belief may have contributed to the increased popularity of the drug and consequently the ever growing number of new heroin users. However, preferred patterns and routes of use were still very localised with injecting still popular in

areas like Edinburgh in contrast to the new "chasers" in the northwest of England while heroin users in London favoured both injecting and smoking.

Widespread media coverage made this new wave of heroin use impossible to be ignored and drug use became an important and sustained policy issue for politicians for the first time since the sixties. The Conservative government of the day sought to encourage a coordinated response from across the range of governmental departments through the setting up of an interdepartmental working group of ministers and officials. Significantly the chair of this group was a Home Office minister and when the first government strategy document *Tackling Drug Misuse* was issued in 1986, three of the strategy's five main aspects were enforcement-related and with the health care elements looking like an imposed afterthought. This was probably an accurate reflection of the political view and hence represented a further decline in the primary nature of a medical response to drug problems.

**New directions for treatment and an expansion of services**

Against this backdrop in 1982 new ways of working within the British System were developed following the recommendations of the *Treatment and Rehabilitation* report from the Advisory Council on the Misuse of Drugs (ACMD). This report signalled a move away from an exclusive reliance on medically-led specialist treatment. The report had three main guiding principles. Following developments in the alcohol field the focus of treatment became the "problem drug user". Drug takers were now recognised as a heterogeneous group with a myriad of problems beyond the use of the drug itself, encompassing social and economic as well as medical problems. The generalist was brought back into the fold as a key to dealing with drug-related problems and drug use was no longer seen as the sole province of the specialist clinic psychiatrist. Finally the local nature of drug problems was recognised by the introduction of Community Drug Teams in towns, cities and counties across the country. These CDTs were based in each health authority and were to provide most of the services formerly provided by the DDUs. Whilst expected to be able to deal with most of the demand for treatment, they had recourse to Regional Drug Problem Teams for expert advice on how to deal with the more difficult cases. In a move to recognise the multidisciplinary impact of drug use, each district health authority would have a District Drugs Advisory Committee and each regional health authority a Regional Drugs Advisory Committee. These advisory committees would have representatives from the gamut of helping agencies including the CDTs, voluntary agencies, general practitioners, probation and social services. Although medical practitioners were still to take the leading role, the emphasis was now on multidisciplinary working.

**Guidelines for doctors**

In order to encourage the generalist to take a more active role in the treatment of drug use, the Department of Health convened a Medical Working Group on Drug Dependence which produced *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* which were issued to all doctors in 1984. The guidelines underwent further revision and expansion in succeeding years (1991, 1994 and 1999). Its main themes were to encourage the GP to help any drug using patients through more straightforward approaches like methadone withdrawal, but to look to the specialist drug misuse services for help where longer term prescribing of opioids seemed indicated.

These guidelines were seen by some as an encroachment on the independence of those seeking to treat heroin users and the private prescribing doctor re-emerged to take part in the wider treatment debate. These private doctors saw themselves as providing a service to those who were not ready for the abstinence goal set by the clinics, whilst the clinic specialists viewed the prescribing regimes of these doctors as counter-productive and inimical to the acceptable prescribing policies forged in the preceding decade. The debate continues, with a recent Home Office consultation document seeking to reinforce the standards set out in the most recent clinical guidelines by proposing to extend licensing to doctors who treat drug users with CDs other than oral methadone. As the Department of Health is allocating £3.4 million for the training of all levels of doctors on drug misuse, the role of the prescribing GP is likely to be a contested area for some time to come.

**The Central Funding Initiative**

These developments were underlined by central government in the form of finance specifically directed at funding drug services in the Central Funding Initiative of 1983. This funding led to a dramatic expansion of the drugs field – for both statutory and voluntary agencies. The national initiative aimed to displace the previous London-based specialist hospital system as the core of the drug treatment approach. Between 1983 and 1987, £17.5 million was made available for the development of new community based services, with over 42% of this money being administered by the voluntary sector. Many small voluntary agencies and residential centres providing care for drug users sprang up in the wake of this initiative but their longevity was uncertain due to the pump-priming nature of the grant-giving (MacGregor *et al*., 1991).

**Dealing with AIDS/HIV**

As the increase in service provision began to bed down, the mid-eighties saw the emergence of HIV and AIDS as the dominant public health concern. Injecting drug users, through their sharing of contaminated injecting equipment, were seen as a potential route for the HIV virus to rapidly diffuse into the wider community. The first governmental reaction came in the 1986 report from the Scottish Home and Health Department which introduced the concept of 'safer drug use' and proposed making sterile needles and syringes available to those who inject drugs. Improved treatment services and substitute prescribing were also seen as ways of reducing sharing levels and the spread of HIV infection. Through 1986 a small number of drug agencies began distributing syringes and later in the same year a pilot syringe exchange scheme was set up in England and Scotland. In response to this widespread concern the ACMD set up an AIDS and Drug Misuse Working Group. The subsequent report *AIDS and Drug Misuse Part I* provided the template and rationale for a reorientation of drug treatment practice to meet the new challenge of drugs/HIV. The report stated that "The spread of HIV is a greater threat to individual and public health than drug misuse. Accordingly, we believe that services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans" (Advisory Council on the Misuse of Drugs, 1988). Whilst reiterating that prescribing to drug users should still have an identified goal, the report advocated a hierarchy of treating goals whose appropriateness

depended on the user. The key aims were to attract seropositive drug misusers into treatment where they could be encouraged to stop using injecting equipment and move away from injecting towards oral use. Decreasing drug use and abstinence were further levels in the hierarchy and so harm minimisation was the core of the policy and received active support from the Government. This report and its sister report *AIDS and Drug Misuse Part II* continued the policy aim of embracing general practitioners and general psychiatrists and involving them more actively in the direct provision of services to address the more general health care needs of drug users, whilst the specialist clinics maintained responsibility for the more complicated needs of the more difficult drug users.

**Harm minimisation**

This was the period when harm minimisation became a legitimate objective as well as representing a banner under which an increasing number of clinicians and agencies re-focused their energies and work. Harm minimisation, acknowledged as the crucial approach to drug use was characterised by adopting measures that sought to reduce the harm caused by continued drug use and to seek a modification of the continued use of drugs. This approach recognised that many injecting drug users were unwilling or unable to stop injecting and that advice on how to clean needles and syringes would often be unheeded by users. Up to this time clean needles and syringes were difficult to obtain in many parts of the country and pharmacists were often unwilling to knowingly sell needles and syringes to drug users. A consequence of this situation became apparent in Edinburgh when within only a few years of the first case of HIV in the city, around half of the city's heroin users were found to be already infected with the virus. The introduction of needle exchange schemes were a reflection of this changed "harm minimisation" approach. Voluntary and health service agencies led the way in establishing centres where injecting drug users were able to obtain sterile injecting equipment.

**The re-emergence of maintenance**

In the light of the new public health reappraisal, maintenance prescribing once again moved centre stage – on this occasion in the form of oral methadone maintenance. Over the previous couple of decades, an impressive body of evidence in support of oral methadone maintenance had been established (especially from the US) which demonstrated its effectiveness at promoting, among other benefits, marked reductions in continued heroin use and continued injecting. In the new climate these particular benefits are obviously much sought after and the publication and wider presentation of reviews of this evidence (Ward *et al.*, 1992; Farrell *et al.*, 1994) contributed to the wider acceptance in the UK of oral methadone maintenance as a central plank of the combined drug/HIV treatment response.

**1990s: CRIME REDUCTION TO THE FORE**

By the early 1990s, it had become clear that the UK had not seen the major spread of HIV infection among injecting drug users that many had feared. However, the "drug problem" remained high on the wider political agenda and new policy developments continued. With the growth of recreational drug use in the late 1980s

and early 1990s and the increasing acceptability of drug use amongst adolescents and young adults the government published *Tackling Drugs Together: a strategy for England 1995–1998*. It sought to combine "accessible treatment" with "vigorous law enforcement . . . and a new emphasis on education and prevention". The aim of the strategy was to increase community safety from crime and to reduce the health risks and other damage related to drug use. A Department of Health Task Force was established to examine the effectiveness of treatment in order to help health purchasers decide what kind of treatment was needed and how it should be given. The Task Force had been set up in 1994 and surveyed current practice and cost-effectiveness of treatment services and examined current treatment policy. It commissioned new research to generate evidence including the National Treatment Outcomes Research Study. This study recruited a sample of 1000 drug users from four types of treatment modality, methadone maintenance, methadone reduction, residential rehabilitation programmes and specialist drug dependence units and intended to follow their progress over five years.

Among the widely-publicised findings from NTORS (National Treatment Outcome Research Study) was the observation that treatment was associated with major reductions in criminal behaviour (Gossop *et al.*, 1998a,b) – to such an extent that it was possible to calculate that each pound spent on treatment was associated with three pounds reduction in the costs to society (largely as a result of reduced levels of acquisitive crime and associated costs of the criminal justice system). This finding became public at a time when the drug–crime link was already becoming the dominant political concern about drug misuse (having overtaken HIV and health concerns as the main driving force), and hence resulted in a strange strategic alliance between law enforcement and the call for greater access to treatment.

A further strategy document followed in 1998, building on the themes of its predecessor and emphasising collaboration and partnership between different agencies. Amongst the aims of *Tackling Drugs to Build a Better Britain: the Government's Ten-Year Strategy for Tackling Drug Misuse* was to help people with drug problems to overcome them and live crime-free lives. The report was preceded by the appointment, for the first time in the UK, of an Anti-Drugs Coordinator (drug "czar") in January of that year. In the Coordinator's first annual report, performance indicators were provided, to support the strategy which included increasing the numbers in treatment to 66% by 2005 and to 100% by 2008. An extra £20.5 million for social services and £50 million for health authorities was expected to increase the treatment numbers by a third.

Treatment was thus re-conceptualised as an intervention which might lead to reduction of criminal behaviour. Drug using criminals were encouraged to enter treatment as a means of altering their behaviour. Policy initiatives and resources were introduced to link the criminal justice system and the treatment sector through DTTOs (Drug Treatment and Testing Orders). Under the Criminal Justice and Court Services Bill, drug testing of offenders could be introduced at every stage of the criminal process with an aim of identifying those offenders who should be getting treatment. The initial findings from NTORS were taken as proof that treatment "worked" in terms of reducing the criminality of drug users and was taken to provide a research rationale for the intermeshing of criminal justice and treatment aims.