

***Scottish Advisory Committee on Drug Misuse:
Psychostimulant Project Group Report***

Chapter 1: Introduction

Background

1. In 2007 there were reports, in line with other European Countries¹, of a significant increase in cocaine use in some parts of Scotland and some concern that services were unable to address the needs. This, coupled with the fact that the last Government report on the use of psychostimulants had been published in 2002², led the previous administration to ask the Scottish Advisory Committee on Drug Misuse (SACDM) to set up a short-life project group to examine the issue.

The project group and terms of reference

2. The first meeting of the Working Group took place in February 2007 (a list of members is set out in **Annex A**) and it was agreed that the remit of the Psychostimulant Project Group would be to:

- identify the extent and impact of psychostimulant use in Scotland; and
- review current service provision and to make recommendations on how to improve access, range and quality of services available to psychostimulant users.

3. The Group used the report of 2002 as a starting point.

What do we mean by psychostimulants?

4. Psychostimulants are substances that excite the central nervous system. They have the potential to produce feelings of alertness and wellbeing. They are habit forming and can cause dependence. Abrupt discontinuation can result in a characteristic withdrawal syndrome.

5. There are a number of naturally occurring psychostimulants, such as caffeine, nicotine, ephedrine and cocaine. There are also synthetic stimulants, which are predominantly amphetamines. They have been used as appetite suppressants and have been investigated for their potential to decrease fatigue and increase work output. Unlike opiates, there is no medical substitution for psychostimulants. Generally speaking problems with psychostimulants are addressed through psychosocial interventions often in

¹ European Monitoring Centre for Drugs and Drug Addiction (2007) *Treatment of problem cocaine use: a review of the literature*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

² Scottish Advisory Committee on Drug Misuse (2002) *Scottish Advisory Committee on Drug Misuse: Psychostimulant Working Group Report*. Edinburgh: Scottish Executive.

conjunction with complimentary therapies such as acupuncture and massage³.

6. The psychostimulants covered by this report are:

Amphetamines (speed, whiz) – a group of chemically related synthetic stimulant drugs generally produced illicitly or as tablets legally produced by pharmaceutical firms and subsequently diverted onto the illicit market.

Cocaine – cocaine hydrochloride and cocaine alkaloid which is known as ‘crack’ or ‘freebase’.

Methylamphetamine (meth, crystal meth, crystal, ice) – a powerful synthetic stimulant usually manufactured illicitly.

7. The Group recognised that substances such as gammahydroxybutrate (GHB), ketamine and other drugs, such as cannabis and alcohol, whilst not psychostimulants, were also used widely in conjunction with psychostimulants and are also prevalent in the recreational drug scene.

Structure of the report

8. Subsequent chapters of this report set out:

Chapter 2: Extent and impact of the psychostimulant use in Scotland

Chapter 3: Reducing harm from psychostimulants

Chapter 4: Reducing supply of psychostimulants

³ Scottish Executive Effective Interventions Unit (2002) *Psychostimulants: A Practical Guide* (2002). Edinburgh: Scottish Executive. Also see Crew 2000 (2007) *Annual Report 2007*. Edinburgh: Crew 2000.

Chapter 2: Extent and impact of the psychostimulant use in Scotland

Psychostimulant use in Scotland today

9. **There is no one single source of information** on psychostimulant use in Scotland. It is possible, however, to build a picture of psychostimulant use among the Scottish population by using information from a number of existing sources, including national surveys, drug seizures and treatment data.

10. **Based on survey data cocaine is now the next most commonly used drug in Scotland** after cannabis, with a marked increase in its reported use over the last 10 years: 4% of adults in Scotland reported having used cocaine in the past year in 2006, compared with only 1% in 1996⁴. The third most commonly reported drug is ecstasy, with 3% of adults reporting they had used it in the past year in 2006, compared with 2% in 1996⁵.

11. **Methylamphetamine is a synthetic drug** related to amphetamine, which produces greater effects on the central nervous system. **It appears to have a very low prevalence in Scotland** at present; there have been no seizures in the last three years except one very small recovery in the northern isles in 2007 which was handed to the Police anonymously. Very small numbers have presented for treatment. However, the experience from other countries such as North America and Australia demonstrate that it can have a devastating impact on individuals, families and communities.

12. There is a need to remain vigilant as patterns of drug use change. Given this, it is recommended that, where they do not already exist, systems should be put in place at both national and local levels to monitor psychostimulant use to capture data on trends in all drug use, including Methylamphetamine, GHB, Ketamine and other substances. This information should be shared between partners to allow speedy and flexible responses to emerging trends. If cocaine use continues to rise then services may need to be prepared to institute fundamental changes in the way that they operate.

13. Whilst it is recognised that all drugs can be used recreationally, it is wrong to call any substances 'recreational drugs', as all have the potential to cause harm, including dependency and addiction. Used to excess all these substances have the potential to cause serious mental and emotional problems, injury to the body and social problems, including family breakdown, financial and employment difficulties. The current estimation of problem drug users in Scotland (52,000 in 2003) does not include psychostimulants but we know that there has been an increase in the percentage of new clients

⁴ Brown, M. & Bolling, K. (2007) *Drugs Misuse in Scotland: Findings from the 2006 Scottish Crime and Victimisation Survey*. Edinburgh: Scottish Government.

⁵ Brown, M. & Bolling, K. (2007) *Drugs Misuse in Scotland: Findings from the 2006 Scottish Crime and Victimisation Survey*. Edinburgh: Scottish Government.

contacting treatment services whose main illicit drug is cocaine (from 1.3% in 2001-2 to 3.5% in 2005-6)⁶.

14. There was also a 0.2% increase in new clients reporting crack cocaine as their main illicit drug from 2003-4 to 2005-6⁷. The use of crack cocaine is geographically concentrated in certain parts of Scotland, including Glasgow and Edinburgh, as well as Aberdeen and Aberdeenshire where there is an established crack market within the opiate using population and which is closely linked to prostitution. Crack use, whilst also reported on the 'recreational' scene, appears to be linked to opiate use and problematic psychostimulant use.

15. The mandatory drug testing of arrestees pilots, which are currently underway in Aberdeen, Edinburgh and the east end of Glasgow involve testing for opiates and cocaine/crack cocaine of arrestees for certain trigger offences, principally theft related and Misuse of the Drugs Act 1971. The pilots will run for a 2 year period to June 2010 in the first instance and are likely to provide valuable data on usage in the pilot areas.

16. This picture of increasing cocaine use is supported further by a **46% increase in seizures of cocaine and crack cocaine** from 2004-5 to 2005-6, which while not conclusive in itself may be indicative of a growing problem and add to the other existing evidence⁸.

17. It is important to ask '**why**' **there appears to have been a marked increase in the use of cocaine over the last ten years**. It is suggested that the advent of the dance scene phenomenon in the late 1980s made the use of psychostimulants more acceptable among those people who were otherwise law-abiding⁹. Intelligence from the Scottish Crime and Drug Enforcement Agency suggests that recently the price of cocaine has dropped (from £100 per gram in 2002 to £40-£80 per gram in 2007) makes it more attractive to new users, as well as existing problem drug users. In addition, both Edinburgh and Glasgow have seen cocaine marketed as "tenner" bags, which suggests a deliberate effort on the part of dealers to appeal to heroin users.

18. There is also evidence that cocaine is seen as glamorous, a sociable drug that can be shared without risk. Attitudes towards cocaine are fairly relaxed compared to heroin which, for many people, has a stigma attached to its use¹⁰. Overall, this has resulted in a change in user profile from those with more disposable income to a wider section of the population. This means that psychostimulant users are not a homogenous group. In this respect, the

⁶ NHS Information Services Division (2006) *Drug Misuse Statistics 2006*. Edinburgh: Common Services Agency.

⁷ *ibid*

⁸ Scottish Executive (2007) *Drug Seizures by Scottish Police Forces, 2004/5 and 2005/6*. Edinburgh: Scottish Executive National Statistics Publication.

⁹ McCambridge, J., Mitcheson, L., Winstock, A. and Hunt, N. (2005) Five-year trends in patterns of drug use among people who use stimulants in dance contexts in the UK. *Addiction*, 100: 1140-1149.

¹⁰ Scottish Executive (2006) *Know the Score – Cocaine Wave 3 – 2005 Post Campaign Evaluation*. Edinburgh: Scottish Executive.

Group felt that the definitions provided in the 2002 SACDM report were still broadly correct but it recommended that 'youthful experimenters' is amended to 'experimenters'. The amended definitions are set out in the box below.

Experimenters - who are likely to use stimulants as part of a pattern of poly-drug experimentation. They are unlikely to be in touch with any Scottish drug service, other than those providing drug information. Their social and demographic profile is mixed and reflects the increased acceptance of drug use within the younger population.

Established primary stimulant drug users - These individuals will typically be using stimulant drugs regularly (weekly). Their social and demographic profile matches that of the experimenters. They may have had some contact with drug information services but are unlikely to have used any other drug service.

Problematic stimulant users - they will have been regular stimulant users for at least a year. They have a similar social and demographic profile to the first two groups. This is the group that is most likely to be looking for specialist services which do exist in some areas, but not in others and they may then instead present at mental health services.

Opiate/stimulant users - primarily opiate users who use stimulants as well. These are the individuals who are most likely to be in touch with existing services but whose needs in relation to the stimulants, may not be well served. It is from this group that the Scottish Drug Misuse Database figures about crack use have come. We could call this group the opiate/stimulant co-users. Their demographic profile is similar to the opiate drug-using group¹¹

19. One of the characteristics of psychostimulant users is the likelihood of other stimulant and other drug use at the same time (known more commonly as **poly-drug use**). Typically around 2 in 5 current drug users report taking 2 or more different illegal drugs together¹². Consuming alcohol while under the influence of drugs was even more common, with 4 in 5 current drug users having done this¹³. This supports expert opinion from the Group that **cocaine is being used with a cocktail of drugs and, in particular, alcohol.**

20. Overall, the **use of psychostimulants and, in particular, cocaine has increased in Scotland over the last five years.**

21. However, it is likely that the **prevalence may, in actual fact, be considerably higher** than survey and statistics show as there **may be a 'hidden population'** which is not being picked up through the existing data collection methods. This includes those people who:

¹¹ Scottish Advisory Committee on Drug Misuse (2002) *Scottish Advisory Committee on Drug Misuse: Psychostimulant Working Group Report*. Edinburgh: Scottish Executive.

¹² Brown, M. & Bolling, K. (2007) *Drugs Misuse in Scotland: Findings from the 2006 Scottish Crime and Victimisation Survey*. Edinburgh: Scottish Government.

¹³ *ibid*

- are using psychostimulants on a 'recreational' basis who do not see themselves as having a problem. Their use is unlikely to be accompanied by any criminal behaviour other than the possession/supply of controlled drugs.
- think they might have a problem but are reluctant to contact existing opiate based drug services. This is because they do not think treatment for psychostimulants is available or effective; feel that there is a stigma attached to attending these services; and are concerned about confidentiality issues ie their employer might find out. The opening hours may also be a barrier to people attending services as many will be in full time employment and can not attend during the day.
- are receiving treatment for opiates, but as the focus of the service is on their opiate use rather than their psychostimulant problem, the latter is not picked up; or the psychostimulant use is not disclosed for fear of having their methadone prescription withdrawn¹⁴.

22. It is recommended that the Government develops a more accurate picture of psychostimulant use in Scotland which attempts to capture data on the 'hidden population'. The National Evidence Group should consider how this might be done most effectively and whether it should be widened to include poly-drug use, if there is currently a gap in this area.

Impact of psychostimulant use

23. The impact of psychostimulant use can be on the individual, their family and wider society. Individuals who take psychostimulants generally do so orally (swallowing or smoking) or by snorting. **Psychostimulants can cause a variety of cardiovascular problems.** These include rapid heart rate, irregular heartbeat, increased blood pressure, and irreversible, stroke-producing damage to small blood vessels in the brain. Methods of ingestion such as snorting and smoking (especially the use of pipes) can damage soft tissue in the nasal passages, affecting breathing and causing burns to the throat and lips etc, and can also reduce appetite¹⁵.

24. Some people take psychostimulants intravenously. **Intravenous use** can result in cellulitis, abscesses, septicaemia, arterial thrombosis, endocarditis (a chronic infection of the inner lining of the heart and heart valves), renal infarction, and thrombophlebitis. Sharing of injecting equipment raises the risks of contracting hepatitis B and C, HIV and ultimately AIDS. A recent report demonstrated that over 85% of hepatitis C sufferers in Scotland contracted the disease from sharing needles, syringes or other paraphernalia.¹⁶ Psychostimulant injectors are also likely to inject more

¹⁴ National Treatment Agency for Substance Misuse (2002) *Treating cocaine/crack dependence*. London: National Treatment Agency.

¹⁵ Scottish Executive Effective Interventions Unit (2002) *Psychostimulants: A Practical Guide* (2002). Edinburgh: Scottish Executive.

¹⁶ Hutchinson, S., Roy, K., Wadd, S., Bird, S., Taylor, A. Anderson, E., Shaw, L., Codere, G., & Goldberg, D. (2006) Hepatitis C virus infection in Scotland: Epidemiological review and

frequently than heroin injectors which has implications for needle exchange provision.

25. Heightened libido and increased sexual activity through psychostimulant use can also lead to higher risks of unplanned sexual activity, increased sexually transmitted infections and pregnancy (particularly when psychostimulants are used in conjunction with Viagra or alcohol) and also abrasions and damage to the genitals¹⁷.

26. **Taking cocaine alongside alcohol can have a more dangerous effect** on the brain, producing another compound in the liver, cocaethylene, which is more harmful than using either drug alone. Cocaethylene exacerbates the cardiovascular effects. There is also a possibility that the culture of binge drinking (which is especially prevalent in Scotland) on an empty stomach and taking cocaine at the same time will be even more dangerous due to the potential optimisation of cocaethylene levels as the alcohol consumed reaches the bloodstream more quickly¹⁸. These are important issues for Scotland given the prevalence of cardiovascular problems¹⁹. In addition, the numbers of **drug-related deaths** where cocaine was present (sometimes with alcohol or with other drugs) have doubled over the past 5 years whilst deaths where ecstasy was present have halved.²⁰

27. There are **psychiatric problems** associated with psychostimulant use such as anxiety, panic attacks, depression and paranoia, and methylamphetamine, in particular is linked to episodes of psychosis. Often users do not associate these problems with their drug taking. There are also links between substance misuse and Attention Deficit Hyperactivity Disorder (ADHD)²¹.

28. While there is no figure for the social and economic cost of drug use in Scotland (Scotland specific research has been commissioned and will be published later this year) research has been carried out in England and Wales. It shows that the average **economic and social cost** per problem drug user in England and Wales is around £50,000 per year²² which if applied to Scotland using the 2003 prevalence rates of 52,000 problem drug users would suggest economic and social costs of problem drug use at **£2.6bn per annum**.

public health challenges. *Scottish Medical Journal*, 51: 8-15. See also Scottish Executive (2006) *Hepatitis C Action Plan for Scotland*. Edinburgh: Scottish Executive.

¹⁷ Professor Mark Bellis (2007) Centre for Public Health at Liverpool John Moores University See <http://www.ljmu.ac.uk>.

¹⁸ Julien, R. M. (2007) *A Primer of Drug Action?* Worth Publishers.

¹⁹ Scottish Advisory Committee on Drug Misuse (2002) *Scottish Advisory Committee on Drug Misuse: Psychostimulant Working Group Report*. Edinburgh: Scottish Executive.

²⁰ General Register for Scotland (2006) *Drug-related deaths in Scotland in 2005*. Edinburgh: GROS.

²¹ Goossensen, A.M., Van de Glind, G., Carpenter, P., Wijzen, R.M., Van Dunin, D. and kooij, S.J.J (2006) An intervention program for ADHD in patients with substance use disorders. *Journal of Substance Abuse Treatment* 30:253-259.

²² Home Office (2006) *Measuring different aspects of problem drug use: methodological developments*; Home Office Online Report 16/06: <http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf> (2006).

29. People with psychostimulant problems are not included in the 52,000 estimated problem drug users in Scotland. However, it is assumed that a proportion of the £2.6bn per annum can be attributed to those people experiencing problems with primary psychostimulant use or using it in conjunction with other drugs such as heroin.

30. There is also likely to be wider costs of 'recreational' psychostimulant use, for example lost labour productivity due to absence from work or poor performance following drug misuse which affects economic growth. However, it has been suggested that amphetamine use enhances productivity as it allows people who work in the trucking, building or service industry to work longer hours. It is also used to aid study by reported increased concentration and long period of revising.

31. Demand for drugs in Scotland can also have an impact at a global level as it often relies on the **exploitation of the poorest people in the producer and transit countries**. For example, Colombia remains by far the largest source of illicit coca in the world, followed by Peru and Bolivia²³. The 'Shared Responsibility' is a Colombia-led initiative to highlight in other countries the social and environmental effects that their cocaine use is having on people and communities in Colombia²⁴.

²³ United Nations Office on Drugs and Crime (2007) *Annual Report 2007*. UNDOC.

²⁴ See <http://www.sharedresponsibility.gov.co>

Chapter 3: Reducing harm from psychostimulants

32. To successfully reduce long-term demand for drugs, including psychostimulants, action must be taken to address the underlying causes of drug use such as reducing poverty, enhancing early years experience, improving mental health and creating more employment, education and training opportunities. The Group understand that this will be addressed by the Government's new drugs strategy.

33. This chapter sets out action to reduce the harm from psychostimulants by improving:

- current drugs education and information to increase knowledge and understanding and help people make informed choices; and
- the access, range and quality of services for people who are using psychostimulants – irrespective of where they might be on their drug using career.

DRUGS EDUCATION AND INFORMATION

Public information campaigns

34. *Know the Score* is a public information campaign, run by Government, which aims to increase knowledge about drug use and promote positive lifestyles and avoidance of drug use. Information is provided through a website, 24 hour helpline and a suite of materials. As well as informing potential drug users themselves, *Know the Score* offers a wealth of information for families and friends (from whom there is often the most demand). In relation to psychostimulants, the Government ran a *Know the Score* cocaine campaign in 2005-7 (which included TV and bill board advertising and awareness weekends in licensed premises). National organisations such as Crew 2000 and local partners also provide information about substance use.

35. The Group felt that it was critical that credible information is provided to people about substance use as only providing messages about the negative effects of drugs is out of step with substance users' reality or lived experiences and may turn them off important messages. It was also recognised by the Group that many people will use drugs despite Government and other messages aimed at reducing demand and therefore messages should also be focused on harm reduction.²⁵

36. Therefore it is recommended that information campaigns, at both national and local level should:

²⁵ Parker, H., Aldridge, J. and Measham, F. (2005) *Illegal Leisure: The Normalisation of Adolescent Recreational Drug Use (Adolescence and Society)*. London: Routledge.

- **target messages according to the different categories of users** (i.e. experimenters, regular stimulant users, problematic stimulant users and opiate/stimulant users);
- **include harm reduction messages** and be linked into self-assessment for those most at risk, including regular users;
- **raise awareness of the health risks that might be a result of, or exacerbated by, psychostimulant use** e.g. mental health – depression, paranoia;
- **highlight the risks of poly-drug use, in particular the risks of using alcohol with psychostimulants**, and linking it with alcohol campaigns where possible;
- **update the suite of materials** to include GHB and ketamine;
- ensure that delivery of **national and local campaigns are synchronised** where appropriate and where there is obvious common purpose and assured mutual benefit to maximise impact and achieve the best outcomes; and
- develop **national materials** that can be used at a national and local level for the targeted group.

37. It is the Group's expert opinion that substance use can change in a relatively short time due to availability and trends and therefore it recommends a responsive, intelligence-led approach to education and ready availability of a wide range of resources for use at the times when they become most relevant. Information often only makes an impact, especially with young people, when it relates directly to their current experience (not their future or past experience).

38. At a general level, it is recommended that there is a universal education programme on substances, including alcohol and tobacco, for the public. This type of general education and information needs to be real, relevant, and above all credible. It should include the possible (not 'definite') dangers of mono and poly-drug use. Normative education around substance use would appear to have some modest effects when used in this way. Providers of training packages for kinship and foster carers, funding for which is being provided to local authorities at present, could be designed to include this within their drug and alcohol provision.

Role of families

39. It is recommended that there should be **a greater role for parents** and other adult family members such as grandparents in educating their children and grandchildren about the risks of using psychostimulants. This might include specific information for parents. **Central Government and local**

partners also need to be more innovative in the ways they communicate with young people, such as using text messages and social networking sites which are increasingly being used by young people to exchange information.

Role of employers

40. The Group is of the view that there is a **considerable gap in terms of employers providing education, information and support about drugs and specifically psychostimulants in the workplace**. The previous SACDM report recommended that employers include psychostimulants in their workplace drug policies. There is no evidence of whether or not this has happened consistently at a local level. It is recommended that further work is carried out by the Government to ascertain the current position and, if needed, the Government works with employers to ensure that psychostimulant information is provided to employees as part of a broader package of information about substance use. It is also recommended that the Government considers how it might ensure employers, themselves, are educated about substance use, especially those in small or medium sized business which are likely to be hit hardest by lost productivity due to substance use, the licensed trade, as well as industries with a zero tolerance philosophy such as oil and gas.

Education in schools

41. It is also important to maximise the impact that schools can have. Encouragingly, **there appears to have been a significant drop in the reported use of drugs by both 15 and 13 year olds in the last 8 years**. Between 2004 and 2006 prevalence of drug use among 15 year old boys declined from 21% to 14%, and among 15 year old girls declined from 20% to 12%. Prevalence among 13 year olds also halved²⁶. However, a review of the effectiveness of drugs education in school showed that although there is good practice there is also room for improvement²⁷. The Government has recently established a **steering group to advise it on developing more effective substance misuse education in Scottish schools** within the wider context of the Curriculum for Excellence. Membership includes experts from education, drug agencies, NHS Health Scotland, the Police and officials from across Scottish Government.

42. The group is due to publish an interim report early in 2009 and will produce advice, guidance and proposals aimed at helping schools and authorities to achieve the improvements sought through Curriculum for Excellence and the 2007 Act so that:

- appropriate teaching materials are available and are being used most effectively;

²⁶ NHS Information Services Division (2006) *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) Report (2006)*. Edinburgh: Common Services Agency.

²⁷ Scottish Executive (2007) *Evaluation of the Effectiveness of Drug Education in Scottish Schools*. Edinburgh: Scottish Executive.

- comprehensive, evidence-based approaches to substance misuse education are integrated into wider health education and promotion in the school;
- education is planned in partnership with inputs from Health, the police and the community;
- delivery is by appropriately trained practitioners, for effective pedagogy (e.g. with interaction to develop skills);
- there is student-centred, culturally appropriate and relevant education, targeted to needs and context;
- training, networking, delivery and evaluation by practitioners is coordinated; and
- there is appropriate engagement with parents.

Peer Education

43. Peer education has an important role to play in drugs education and building up resilience to the harm associated with its use. Experience of organisation's such as Crew 2000, Fast Forward and others in Scotland has shown that whilst peer education is not the only way to deliver education around substance use it has an important role to play.

44. It benefits both the peer educators and those being targeted and takes learning out into the communities to combat ignorance and some of the mythology around substance use. Young people will often listen more closely to their peers and assess the value of what is being said taking into consideration the relevance, experience and authenticity of both the message and the messenger²⁸.

BETTER ACCESS, RANGE AND QUALITY OF SERVICES FOR THOSE WITH PSYCHOSTIMULANT PROBLEMS

45. Action to tackle problem substance use in Scotland has evolved significantly over the last 20 years, with significant increases in investment in recent years in particular. Although treatment for psychostimulants has featured among treatment services, the focus has been on opiates which historically have been, and continue to be, the main problem in Scotland. As set out in Chapter 2, we are now facing a shift in patterns of substance use with more people using psychostimulants. This is complicated by a growing trend in poly-drug use.

46. In 2005-6 approximately **9% of drug treatment services in Scotland targeted and provided specialist interventions for psychostimulant users**²⁹. Some of these are general drug treatment services which offer specific support to psychostimulant users, others are specialist stand-alone services such as Crew 2000 (Edinburgh) and INCITE (Aberdeenshire). INCITE also provides education, training and support to families of

²⁸ Shiner, M. and Newburn, T. (1996) *Young People, Drugs and Peer Education: an evaluation of the Youth Awareness Programme (YAP)*. London: Home Office.

²⁹ Corporate Action Plans submitted by ADATs to the Scottish Government (2005-6).

psychostimulant users. The evidence in Chapter 2 would suggest that the proportion of services offering treatment to psychostimulant users needs to increase in order to satisfy the growth in psychostimulant problems.

47. The paper will now go on to set out some of the barriers to providing effective services to psychostimulant users to help them recover and suggest how the barriers may be overcome by redesigning services and up-skilling existing drug workers.

Barriers to services

48. For historical reasons services are structured to focus on opiate users or people with alcohol problems. This, alongside the lack of established cocaine treatment programmes, may have resulted in **primary cocaine users being reluctant to present themselves for treatment**. They are also less likely to have knowledge of drug services and less willing to identify with the 'junkie' lifestyle³⁰. There is also evidence that because of the **nature of cocaine use** – often sporadic binge patterns – that users seeking treatment should ideally be able to access **flexible and immediate walk-in services rather than scheduled appointments**³¹. In the case of opiate users who also use stimulants, they may already be in treatment, so access in itself is not an issue. However, as discussed in Chapter 1 it may be that only their opiate use is being addressed while in treatment.

49. Improving access to services must address both of these 'hidden populations'.

50. Evidence also suggests that there is a **lack of knowledge and confidence among professional staff**, working mainly with opiate users, to provide support for people with psychostimulant problems. However, there is a growing body of literature that identifies the basic principles of helping people make changes in their substance use and how these skills are transferable across categories of substances³².

51. Scottish Training on Drugs and Alcohol (STRADA) already provide two specific courses on psychostimulants (*An Introduction to Working with Psychostimulant Users* and *Working with Psychostimulant Users: Cocaine and Crack*) as well as other courses on mental health and children and families which have sections in them which deal with the use of psychostimulants and also their interaction with alcohol. Crew 2000 and INCITE also provide training to frontline professionals and parents, as do some specialist agencies.

Redesign of services

³⁰ European Monitoring Centre for Drugs and Drug Addiction (2007) *Treatment of problem cocaine use: a review of the literature*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

³¹ *ibid*

³² Miller, W.R and Carroll, K. (2006) *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It* New York: Guilford Press.

52. It is recommended that current opiate focused **services are redesigned**, where appropriate, to make them attractive, accessible and effective at dealing with clients experiencing problems with psychostimulants (and poly-drug use). Services should not wait for people to become problem users but should seek to actively engage with people starting out on their 'drug using careers'. This may well involve outreach and detached work to the nightlife or other innovative ways of engagement, and social marketing techniques which involve other elements of society such as private and public services along with National Government Organisations³³.

53. A stepped-care approach is recommended. This approach provides different services at differing stages of peoples' substance use such as:

- **Information** and advice to people who are thinking of using or already experimenting, including outreach work;
- **Advice:** harm reduction advice and information to regular users;
- **Support** services for those regular and problematic users who require more intensive support such as counselling, cognitive behavioural therapy; and
- **Referral** on to hospital or other acute services.

54. This is visualised as a funnel which has a wide range of access points through which people are filtered down, based on self-referral or assessment, to the relevant service.

55. To make the step-care approach work some changes in practice on the ground will be required, which are described below.

Information/advice

56. Some of the ways to ensure that the information available is credible and accurate is set out in earlier in this chapter. It is also recommended that **general advice and information** for people using psychostimulants should be made available to anyone who seeks it on an '**open access**' basis. This should include the internet, GPs, Accident and Emergency, public libraries, criminal justice interventions, workplace occupational health and licensed premises. This range of access points should act as a filter to signpost individuals either through self-referral or assessment onwards to appropriate services.

57. It is recommended that local partners consider how outreach and other innovative methods can be used to engage with people who are thinking about using drugs; experimenting; or regular users to provide information,

³³ Democracy Cities and Drugs (2007) *Safer Nightlife Project*. See <http://www.democitydrug.org>

prevent harm and funnel people into services before they start experiencing serious problems.

58. Widening access in these ways will help tap into the 'hidden population' of psychostimulant users who may not attribute the problems they are experiencing such as depression, insomnia, coronary problems and so on to their substance use.

Support

59. Decisions on how to re-configure or redesign services to meet the need of psychostimulant users should be based on local needs assessments. It is recognised that the redesign of services will differ across areas, according to local need, but where there is a proven local need it is recommended that some element of **specialist psychostimulant service provision** should be provided. The type of service design should take into account that the psychostimulant using population is not homogenous. In areas where there are very acute psychostimulant problems local partners may decide to offer a stand-alone service that deals primarily with those with psychostimulant problems. In other areas with less acute problems the solution may be to employ a specialist psychostimulant nurse to work alongside existing drug workers and services.

60. Services, especially those in **rural areas**, may wish to consider how **to utilise the internet** to full capacity in providing treatment to people to help them recover. For example, this could include web cast meetings between client and service users and online support although this may require specific training for workers.

61. As with opiate services, any treatment intervention should be **accompanied by wider social care, including links to mental health services**, to fully address the needs of the client to help them recover.

62. In redesigning services consideration also needs to be given to access issues. Services will need to be innovative in their thinking and learn from good practice elsewhere in Scotland and the UK. Access could be improved by **re-branding elements of a service to attract psychostimulant users; extending opening times so that people can attend after work, college or university**; providing a walk-in service one night a week; or segregating the service by, for example, using a different part of the building.

63. Consideration also needs to be given to ensuring that there is **access to needle exchange facilities** for those people who inject psychostimulants. It is expected that access to needles will be partly addressed in the *Hepatitis C Phase II Action Plan* which is due to be published shortly by the Scottish Government, however, thought needs to be given to out-of-hours availability which is essential due to the patterns of psychostimulant use. The Plan itself will set out a range of actions for Health Boards and others around the themes of treatment, testing care and support; prevention; monitoring and

surveillance; and governance and co-ordination. The Action Plan will be supported by over £45m over the next three years and the intention is to impact significantly on the prevalence of Hepatitis C in Scotland.

How can change be effected?

64. The Group strongly recommends that the Scottish Government considers providing 'seed-corn' funding to kick-start service redesign and facilitate the change needed.

65. Bringing about this change will also require **re-training across specialist and generalist services covering psychostimulants and poly-drug-use**. It is recommended that the Government works with STRADA, who it funds, and other existing specialist providers to consider how its training packages could be strengthened and the target audience widened. Such training should highlight the barriers/perceived barriers that users may encounter/believe exist which, while addressing the training needs, which should further stimulate change and broader access. This person centred approach will enable those in need of help to reach a service which is not only accessible, but one which will truly be regarded by them as open without feeling stigmatised.

Chapter 4: Reducing supply of psychostimulants

66. Given the remit of the Group, this report has rightly focused on the scale of the psychostimulant problem in Scotland and how services could be redesigned to meet needs. However, action on the demand/harm side should also be supported by to action to disrupt supply.

67. The **main area of focus** for any successful strategy to reduce the supply of psychostimulants must be the **supply of cocaine** and the chemicals that are used either as bulking agents or in any manufacture process. Law enforcement has a continuing role to play at a local, national and international level.

Local level

68. At a local level, the **availability of psychostimulants, as with other drugs can be a barrier to regeneration and renewal** within communities. It is assumed that the Police will continue to maintain visible action against those dealing drugs and ensure all steps are taken to recover criminals' funds where they have been illegally obtained.

69. Given that psychostimulants have strong links to pubs and clubs it is recommended that the Police and other services engaged in this area of work should work with **Licensing Boards and Licensees to reduce the availability and harms within licensed premises**. It is recommended that Licensing Boards recognise the local issues and use their powers accordingly to play their part in reducing the problem. It is also recommended that each Licensing Board through their membership on the local Alcohol and Drug Action Team inform any local needs assessments of issues relating to the premises in their area and seek to act upon it.

70. It is also recommended that local Police work closely with local service providers to ensure that when drug raids occur that drug treatment services are available for those with who will no longer be able to purchase illegal drugs.

National level

71. It is assumed that the **Police will continue to engage with partners at a national and international level to identify and target** those who seek to find routes to take drugs into Scotland. The Group welcome the Government's commitment to work with the Scottish Police Agency to gain a clearer picture of the scale and extent of serious organised crime, including drug trafficking in Scotland.

Global level

72. Enforcement is a global problem and on a global scale it has been shown to work in a positive and sustainable way. There is clear evidence to show that enforcement activity at an international level has impacted on cocaine at source and through trafficking routes. There has been eradication of production areas and displacement of routes. However, in South America yields have gone up in certain areas and the displacement from the Caribbean has moved towards Africa and into Europe. We are seeing a growing number of cases involving direct importation into Scotland including the use of couriers by air. Enforcement efforts should be innovative, flexible and sustained and the Police should continue to work across borders.

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Dr Malcolm Bruce, Consultant Psychiatrist in Addiction, Lothian Community Drug Problem Service

Dawn Abell, Scottish Government

Roisin Ash, Scottish Government

Stella Fulton (Secretary), Scottish Government

SUMMARY OF RECOMMENDATIONS

73. Systems should be put in place at both national and local levels to monitor psychostimulant use to capture data on trends in all drug use, including methylamphetamine, GHB, ketamine and other substances. This information should be shared between partners to allow speedy and flexible responses to emerging trends.

74. The Government should develop a more accurate picture of psychostimulant use in Scotland which attempts to capture data on the 'hidden population'. The National Evidence Group should consider how this might be done most effectively and whether it should be widened to include poly-drug use, if there is currently a gap in this area.

75. A responsive, intelligence-led approach to education is needed, along with ready availability of a wide range of resources for use at the times when they become most relevant. Information campaigns, at both national and local level should:

- target messages according to the different categories of users (i.e. experimenters, regular stimulant users, problematic stimulant users and opiate/stimulant users);
- include harm reduction messages and be linked into self-assessment for those most at risk, including regular users;
- raise awareness of the health risks that might be a result of, or exacerbated by, psychostimulant use e.g. mental health – depression, paranoia;
- highlight the risks of poly-drug use, in particular the risks of using alcohol with psychostimulants, and link it with alcohol campaigns where possible;
- update the suite of materials to include GHB and ketamine;
- ensure that delivery of national and local campaigns are synchronised where appropriate and where there is obvious common purpose and assured mutual benefit to maximise impact and achieve the best outcomes; and
- develop national materials that can be used at a national and local level for the targeted group.

76. A universal education campaign on substances, including alcohol and tobacco, for the public.

77. There should be a greater role for parents and other adult family members such as grandparents in educating their children and grandchildren about the risks of using psychostimulants.

78. Further work should be carried out by the Government to ascertain whether employers have included psychostimulants in their workplace drug policies and, if not, the Government should work with employers to ensure this happens and to educate them more generally about substance use.

79. Current opiate focused services should be redesigned, where appropriate, to make them attractive, accessible and effective at dealing with clients experiencing problems with psychostimulants (and poly-drug use). A stepped-care approach would be used with information; advice; support and referral services.

80. General advice and information for people using psychostimulants should be made available to anyone who seeks it on an 'open access' basis.

81. Local partners should consider how outreach and other innovative methods can be used to engage with people who are thinking about using drugs; experimenting; or regular users to provide information, prevent harm and funnel people into services before they start experiencing serious problems.

82. Where there is a proven local need some element of specialist psychostimulant service provision should be provided.

83. The Scottish Government should consider providing 'seed-corn' funding to kick-start service redesign and facilitate the change needed.

84. The Government should work with STRADA and other existing specialist providers to consider how its training packages, in relation to psychostimulant use, could be strengthened and the target audience widened.

85. The Police and other services engaged in this area of psychostimulant work should work with Licensing Boards and Licensees to reduce the availability and harms of illegal drugs within licensed premises.

86. Licensing Boards should recognise the local issues and use their powers accordingly to play their part in reducing the problem.

87. Each Licensing Board through their membership on the local Alcohol and Drug Action Team should inform any local needs assessments of issues relating to the premises in their area and seek to act upon it.

88. Local Police should work closely with local service providers to ensure that when drug raids occur that drug treatment services are available for those with who will no longer be able to purchase illegal drugs.

