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Review Article

A Brief History of Addictions Treatment in the UK

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Abstract

Drawing on witness accounts, and personal experience, this paper reviews the history of addictions treatment in the UK with a particular focus on the evolution of residential services since the early 1960s. The failure of replacement prescribing in the 1960s saw the impetus for the development of in-patient detoxification services in the UK, the first of which was the drug dependency unit opened at the Bethlem & Maudsley Hospitals in 1968. The unit consisted of two wards, one for so-called 'hard drugs' (which was locked) and one for 'soft drugs' (which was open). By the late 1970s the length of time for in-patient treatment and recovery at the Bethlem & Maudsley began to be reduced from eighteen months and by the late 1980s the programme was less than twelve weeks. The rationale for a reduction in treatment time was forced by the increase in demand as the number of people addicted spiralled, but also a significant shift in resources away from residential services towards harm-minimisation interventions that came into being in the 1980s. In the 1990s there was little change in the government policy although a number of high profile casualties, including the children of government ministers, pressed home the scale of the crisis. The emergence of dual-diagnosis as a diagnostic category from the late 1990s re-invigorated interest in causal pathways and solutions less mechanistically focused on the drug itself, and re-vitalised a focus on recovery.

Introduction

The rise of drug addiction in the UK

Central to this story is the unique cultural significance of opiates which have been a reference point for tracking drug addiction and attitudes to drug use more generally in UK [1]. It should be said that although opium use was widespread during the 1800s in the UK, it all but disappeared during the early part of the twentieth century. The reason for this is not altogether clear though the devastating effect of the First World War and the economic recession in the 1920s may have re-shaped interest in the ingestion of pain killers. Apart from a sporadic re-emergence during the 1930s it was not until the late 1950s that there was a significant increase in the number of opium users which appeared to be co-terminus with drug experimentation as a feature of youth culture [2]. The 'Brain Report' (UK Ministry of Health, 1965) noted that in 1959 there were 454 registered opiate addicts in the UK. But the report also pointed to a worrying trend which was the appearance of younger addicts. In 1959 only 50 out of 454 (11 per cent) were less than 35 years old, but by 1964, 297 out of 753 (nearly 40 per cent) were under 35 (ibid: p 5). Lord Brain was particularly concerned about; "the numerous clubs, many in the West end of London, enjoying a vogue among young people who can find in them such diversions as modern music and all night dancing. In such places it is known that some young people have indulged in stimulant drugs of the amphetamine type." (ibid, p12).

Of course experimentation with drugs was far from the reserve of youth culture in the 1960s. In psychiatry new pharmacological treatments were being tested following the success of several new drugs developed during the 1950s. Clinical experiments with amphetamines, barbiturates and benzodiazepines were conducted also by some psychotherapists and psychiatrists, like R D Laing, who used hallucinogens in their practices to see if clients would be more accessible to talking therapy [3]. Notably, the source of the illicit drug market during the 1960s was the availability of medical supplies stolen directly from pharmacies, lorries and warehouses. Others drugs were obtained legitimately on prescription for psychiatric disorders such as anxiety and depression, which were then sold on to others [4].

Concern about crime associated with the illicit market prompted legislation prompted the Dangerous Drugs Act (1967) and the Misuse of Drugs Act (1971). Initial treatment strategies attempted to stabilise those with habits by prescribing drugs in an attempt to promote drug use in a controlled manner. However, prescribing was found to have two major limitations; firstly addicts seemed unable to take any steps towards cessation and secondly prescribed drugs were found to be simply used alongside the illegal substances. In the late 1960s the increasing number of registered addicts prompted a debate about the over prescribing of Methedrine by "errant doctors" (*Nursing Times*: Editorial - October 18, 1968, p1419). One such medic well-known on the streets of London and around Piccadilly was Dr Petro who was described in the press as the 'junkie doctor'. The *Nursing Times* (1968) claimed that Dr Petro had prescribed 24,095 amps of Methedrine to 110 addicts in only matter of months.

For those patients who had become addicted, early efforts at out-patient treatments were found to be ineffective in terms of weaning patients off their drugs. As a result, residential treatments began to be mapped out, initially based on the new treatment centres in the USA like Synanon, Daytop and Phoenix [5,6]. In 1968, UK psychiatrist Dr Ian Christie returned from a visit to New York and converted a ward, originally named 'the Pink Huts', in St. James' Hospital, Portsmouth, thereby establishing Europe's first concept-based therapeutic community, later re-named Alpha House [7]. Meanwhile Griffith Edwards, a Maudsley Psychiatrist, was involved in advising the Ministry of Health about the establishment of another residential

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project in Forest Hill, South London, called Featherstone Lodge, later re-named as Phoenix House. There is some debate as to how much the American influence of Day top and Synanon had on the development of UK approaches because as [8] points out, therapeutic communities for addicts in the USA tended to evolve outside of mainstream psychiatry, whereas in the UK drug treatment was very much shaped within psychiatry.

The first National Health Service (NHS) Drug Dependency Unit (DTU) was established in 1968 at the Bethlem Royal & Maudsley Hospitals. The approach was tallied to social psychiatry and group based approaches influenced by people like Maxwell Jones and Michael Foulkes, both of whom had worked at the Maudsley. The Drug Dependency Unit was led by consultant psychiatrist Phillip Connell and Brian Woollatt, an experienced clinical psychiatric nurse. Woollatt had been enticed into the job by the lead matron at the hospital who had told him he would probably not find the work with addicts rewarding but he might like working with a 'multi-disciplinary team', which was a new innovation at the time [9]. Connell's credentials were interesting as he had made a significant contribution in delineating the resemblances between amphetamine psychosis and schizophrenia [10]. With a growing number of patients presenting with amphetamine psychosis Connell had advocated the importance urine testing and his interest forged the intersection between drug misuse and psychiatry.

Amphetamines had been made available over the counter in chemists in the UK by the 1950s, acquiring the popular name; 'Mother's Little Helper', suggestive of their ubiquitous role in everyday domesticity. Drinamyl or 'Purple hearts' as they became known, were a compound of Amytal and Amphetamine and also became a popular feature of all night clubs in Soho. It was the widespread popularity of amphetamines combined with the complications arising from psychotic like conditions, that to the decision to make then prescription only. Connell and Wollatt also encountered a rather novel use of 'speed' in the form of Benzedrex inhalers, where a large mind altering dose could be obtained from breaking the inhaler (usually by stamping on it) and dissolving it in coffee. In drawing attention to the large number of patients who were abusing Benzedrex, Connell personally prompted the manufacturers of Benzedrine inhalers discontinue the use of amphetamine in the drug replacing this with an ephedrine type of vasoconstrictor, much to the annoyance of many Benzedrine users [9].

The residential part of the Bethlem and Maudsley services adopted a type of group therapeutic approach which was more generally shaping the ethos of the rest of the Bethlem & Maudsley Hospital at the time in the approach described under the rubric of the 'Therapeutic Community method'. Before setting up the residential addiction services, Woollatt had worked on the Charles Hood Therapeutic Community experiment led by the charismatic psychiatrist Bob Hobson. Though Hobson eventually plummeted into a depression, which sowed the seeds of the later closure of the Charles Hood Unit, Woollatt had made the most of the opportunity to familiarise himself with the idea of group and social therapy [9]. As to the question of whether the Bethlem & Maudsley in-patient drug unit was going to be a US influenced prototype, Woollatt was clear that he wanted to distance himself from the US approach. In 1970 Griffith Edwards invited Woollatt to the BBC to see a documentary in the process of editing about therapeutic communities in the USA. Woollatt recalled unedited footage of film taken in Daytop Lodge which was run by ex-addicts. He saw the 'very authoritarian manner' of the running of the unit and he felt that the term 'Therapeutic Community (TC)' or 'milieu therapy' in the USA seemed to "bear little or no resemblance to the democratic style community approach" that was emerging in the UK [9]. And it was the idea of a TC that would inform the vision for the Bethlem in-patient Drug Dependency Unit (DDU).

Two wards at the Bethlem Royal Hospital were allocated for the DDU residential and were opened late in 1968. Witley Two & Witley Three were eleven and ten beds respectively. Initially, Witley Three was identified as the hard drugs ward which referred to those drugs that could be injected, while Witley Two was targeted as the ward for those people using so-called *soft* drugs, that is, drugs which were swallowed or smoked. Attitudes to injecting drug users were severe enough at the time to see to it that Witley III was a locked ward. It is notable that on Witley Two, 90% of the patients admitted were amphetamine users which gives some indication of how widespread amphetamine use was at the time [9]. By the mid 1970s drugs such as barbiturates and benzodiazepines began to feature more prominently as the over use of amphetamines was brought under control. An increasing diversity of abused substances such as pills like Mogadon, Mandrax, Librium were leading to addictive conditions and even cough syrups such as Dimyril and Phensidil were increasingly the source of addictive habits.

The 1970s & 1980s

It is notable that many of the misused drugs that were becoming problematic for more people, were those prescribed by psychiatrists for mental health issues, such as anxiety. Whereas the DDU was pre-occupied with taking patient *off* drugs, the rest of psychiatry seemed inclined to *introduce* more and more drugs to the general population. This was part of a much wider culture of curiosity about drugs. Psychiatric, medical or recreational drugs seemed to offer endless possibilities. One might say that it was a psychedelic era where one small pill for man, seemed to signal one giant trip for mankind. John Lennon had professed in 1967 that 'All You Need is Love' to the first live satellite audience of over a billion people. And then in 1969 another global audience watched Neil Armstrong walking on the moon. The whole world seemed shrunk ever more as the dimensions of interior psychedelic space converged with an altered sense of outer-space, as the astronaut said to the hippie; "we've got *rockets* to take us up, and *capsules* to bring us down" and the hippie says; "yeah, I know man!".

Pharmaceutical companies led people to believe that slimming pills could cure obesity, while other pills could cure mental illness and rid us of anxiety and so forth and the crescendo of the pill to end all pills; the birth control pill, which became fashionable and widely used from the late 1960s. And as the number of people experimenting with drugs increased, so did the number of people seeking treatment. Illicit drug use became more widespread than ever, reaching an ever-younger population becoming a feature of university life. Timothy Leary's slogan rang; 'tune in and drop out'. Drug using idols; writers, poets, musicians and other artists provided role models for young people. It was ironic that the greatest media attention was the result of some artists, such as the Rolling Stones, being brought to court.

Attempts to punish and deter young people from taking drugs by making examples of high profile figures served only to increase the aura and allure of illicit substances. There was the idolatry of new drug using romantic rebels with Baudelaire, Cocteau and Burroughs, taking over where Byron and Coleridge had left off. In a new generation of popular youth culture membership was defined by pills and drug use.

By 1980 attitudes to drug misusers were changing and by the end of 1980 it was decided that the doors of Witley III (the *hard* drugs ward at the Bethlem & Maudsley) could be open. Initially, the hospital authorities were concerned that the drug users of Witley III would be dangerous to the other patients in the hospital which was somewhat skewed given that patients elsewhere in the hospital with far more serious forensic histories, were permitted to move freely around the hospital. As for protecting the other patients from the 'hard drug users', according to [9] it was more likely that other psychiatric patients would sell their medication to the DDU patients than it was for the DDU clients to pass on drugs. The uneasy status of addicted patients in the microcosm of the hospital community was a reflection of the social status of drug users generally in society, with the addict as a scape-goat subject to a sort of ritual persecution [11].

The other important message in opening the doors of Witley III was the acknowledgement that the apartheid between soft and hard drugs was unhelpful, and indeed, many of the so-called soft drugs were potentially just as dangerous as heroin. The other significant change dating from the mid-1980s was the increasing pressure to curtail the length of the in-patient treatment programme. This was partly in response to increased demand for treatment, but also a change in the political climate where funding was not so readily available for residential treatments. The new philosophy of harm minimisation emerged as a response to the financial pressure to find cheaper treatment alternatives to the expense of in-patient detoxification. This drift brought with it a threat of closure to many residential treatment centres in the addictions field (and many closed). Like other residential treatment centres in the UK such as the Zen-like sanctuary retreat of 'Promis' in Canterbury, the farm of the Ley Community in Oxford, the Phoenix Concept House in Forest Hill and Alpha House on the south coast, the Bethlem shortened its treatment programme in an effort to treat more patients more quickly. By 1989, the admission had been shortened from eighteen months (in the 1970s) to six weeks. Of course there were arguments to be made in terms of the potential of longer-term savings in cases of sustained health gain were significant, bearing in mind that 50% of the patients were found to be drug free six months after receiving six months residential treatment [12], but nonetheless, shorter treatment were the order of the day.

The 1990s

With the decrease in treatments focusing on recovery and rehabilitation, 'harm minimisation' signalled a return to more enthusiastic prescribing strategies. Traditionally, prescribed drugs had been dispensed by pharmacists but many National Health Services began to develop on-site dispensing facilities in a similar way to systems in the USA [13]. The objective was that of closer monitoring of clients, including asking clients to take their medicine on site to ensure they were not selling their prescribed drugs. It was always hoped that legal prescribing of methadone would curtail the worst effect of the illicit drug market [14], though it remained unclear as to the overall efficacy of prescribing programmes. The strongest argument in favour of prescribing by now was that it was meant to be a critical part of the armoury in the battle against the HIV and Hepatitis s [15,16]. The battle to prevent the spread of HIV was intensified by the anxiety that the increased infection among heterosexuals in Europe and the United States was initially thought to be caused by injecting drug users subsequently had sexual relationships with non-injectors [17].

By the close of the 1980s the average age of in-patients was significantly lower than it had been a decade earlier. Whereas the average age of clients in the 1970s had been in the 30s, now it was in the early 20s. The social class of clients had changed too. Whereas drug use and addiction had once been predominantly the reserve of the middle and professional classes, the diminishing price of illegal drugs opened the market to all socio-economic groups. In the early 1990s 'Skag' (the new term for heroin) had hit the streets of South London and was being sold for as little five pounds sterling a bag in some places which meant that younger people were now able to afford drugs previously available only to older users with money. At £5 a bag this was only slightly more than the cost of central London cinema ticket. The social class drift of addiction was co-ordinated by shrewd dealers who opened up new client networks with cut-price drugs enticing an ever wider consumer group. As a consequence the number of patients seeking residential treatment increased manifold.

The 1990s addict was not the archetypal rebel 'tuning in and turning on', he was now more a disenchanted urban cowboy (still more likely to be male), streetwise and quick on the draw (or 'toke' as it became known). Junkie was no longer zeitgeist and a hippy was a 'has been'. Parochially the taxonomy for drug types had evolved from the sedation of 'snow' (heroin) and 'sweet jane' (cocaine) to the more pacey names of 'smack' and 'crack'. Using had become more hi-tech as the ancient art of cooking up with a sentimental spoon or preparing an exotic bong was overtaken by microwaves and bicarbonate soda for the instant buzz of crack rocks.

Amidst all of this there was also a startling increase in solvent abuse. The inhalation of gases like nitrous oxide and ether had a long history since the activity became part and parcel of evening's entertainment in the nineteenth century following Sir Humphrey David's discovery in nitrous oxide in 1798. First reports of 'glue' sniffing began to appear in the USA in the 1960s when there was a greater accessibility of mind altering solvents with a wide range of new household toxic products like dry cleaning fluids, glues, lighter fluids, nail varnish. A similar sniffing craze was identified in the UK during the 1970s where there was a steady increase in solvent related deaths until 1980 when there were as many as 80 reported fatalities from suffocation. Glue sniffing seemed to be part of a consumer craze. Consumerism was perhaps the breeding ground for an increased appetite for hedonism and excess, a phenomenon in the US which was described as a 'culture of narcissism' [18].

This narcissistic culture was characterised by an inward folding anti-social drift towards excessive individualism. The political climate in the UK during the 1990s reflected this rampant individualism which was fostered by the monetarist allure of 'pounds in pockets' as the mantra of Thatcherism ran. When the journalist Will Self was

reported to have taken cocaine on John Major's campaign jet during a 1997 pre-election press event, it seemed an act of tragicomedy that the impact of eighteen years of Thatcherism was marked by a glib act of drug consumption. Drugs appeared to take second generation post-war children ever inwards away from the real needs for affiliation and connectedness. The pace of the illicit drug market seemed to quicken much the financial markets went through an era of 'boom and bust'. Those who were plying their trade in the illicit drug market cashed in. During the 1990s "The man" was not someone who you met on a street corner now (as Lou Reed so famously caricatured), by the early 1990s you could barely see the man because there was sequestered slick market outlet system epitomised by what became known as 'the crack house'. Crack houses could be found in high density areas such as a block of flats. You would know a crack house from padlocked gate then a full metal door with a large sized post box and inside that there was the normal front door with a dead lock and two further claw locks just for safe keeping. It took an age to open up and a series of identifications were required get in, this was business in a new age of racketeering and gangsterism [19].

New turf wars broke out with ingenious import systems. The result was an increase in drug-associated gang crime and violence linked with the high finance of the re-emergence of cocaine and crack. There were well-founded fears of cocaine use reaching epidemic proportions in the UK, as in America [20]. Drug money was easy money. The aftertaste of the 1990s was sour. As fiscal depression descended the dream of escape from the depths of mass unemployment in the UK drifted ever further away, the future was an illusion of affluence hovering above a deeply discontented polity. The number of registered addicts soared ever higher but they were probably just the tip of the drug epidemic ice-burg. The younger-generation were referred to as the 'disappeared generation'. Even though there were only a few Ecstasy related deaths, more young people died from solvents and other volatile substances compared to Ecstasy, heroin or cocaine use [21,22], but it was Ecstasy that everyone was talking about. Every generation has its tipple and Ecstasy was the drug of the choice for the 1990s generation; a hallucinogenic that would simulate the feelings of love absent in the sociocultural sphere [23]. There was a proliferation in the range of designer dance drugs that attracted a wider and younger audience willing to experiment: ketamine, aka 'special K', 'vitamin K', 'cat valium' or 'K', widely used as an anaesthetic but unique for its stimulant rather sedative qualities. A three year study in Manchester found 47% of a sample group of 750 sixteen year olds had tried an illicit substance of one form or another [24]. This represented an increase compared with previous studies of this age group. Despite reservations of efficacy, the increase in drug use among young people prompted a litany of sterile national media anti-drug advertising 'just say no' campaigns.

Alarming new trends such as 'heroin chic' emerged in the 1990s: a genre of drug abuse that drew condemnation from President Clinton as 'glorifying death'. A photograph of James King, the skinny female eighteen-year-old super-model, was published in the New York Times. The photograph was taken by David Sorrenti, King's boyfriend, shortly before his death from a heroin overdose and showed a dishevelled and painfully thin King sitting with her legs spread on a bed cutting up her jeans with a pair of scissors. Behind her there were posters of 'The Grateful Dead', 'Kurt Cobain' and 'Sid Vicious', three pop icons whose lives and deaths were bound to drug abuse. It would be putting it mildly to say that the explosion of drug use in the 1990s suggested that mainstream strategies aimed at combating drug use through liberal prescribing had not worked. The shift away from residential treatment saw a resurgence of the type of maintenance prescribing that had not worked during the 1960s with more and more clients becoming maintained indefinitely on oral methadone. The work of the unorthodox medic John Marks in Manchester with his prescribing of heroin cigarettes and John Strang in London with methadone maintenance were significant experiments during the 1990s. But it appeared that methadone prescribing was exacerbating the problem rather than relieving it, for instance in Blyth, in the North East of England, between 1995-1997 there were seventeen deaths from methadone related overdoses. And statistics from John Mark's own research provided an even bleaker picture. The outcome of his treatment of 450 addicts to whom he prescribed heroin showed that 61 of his client's had died.

The strategy of harm minimisation brought about a radical transformation of treatment aims that shifted drug work away from institutions to the street. A wide number of services sprung up geared towards providing a whole range of educational services including Community Drug Teams (CDT's) which were established in the late 1980s as out-reaching services meeting clients in a variety of settings including: home visiting, youth clubs, schools, day centres or drop-in clinics. Outreach work also evolved into drop-in or street agencies; non-statutory set-ups based in accessible locations, on high streets with a shop front, conceived as 'user-friendly' offering a flexible and confidential support to clients uncertain about the steps they wanted to take in dealing with their drug problem. The interest in hooking chaotic patients into services spurred the development of Arrest Referral Schemes (ARS) which were first piloted in 1989. These schemes involved a drug worker meeting with a user, sometimes at the police station, in an attempt to tap drug users into treatment services at the point of arrest offering an alternative to the route to custodial sentencing as the outcome for a drug related offence [25]. In the UK, more than anywhere in Europe, we saw an escalation of drug related criminal activity to the point at the turn of the millennium whereby between 52-60% of prisoners presented with a co-occurring substance abuse problems [26], prompting the critical question about the relationship between drugs and crime, and the co-occurring problem of tackling poverty [27].

Despite these best efforts the number of casualties continued to rise at an ever younger age. The struggle of Leah Betts' parents coming to terms with the death of their daughter as a result of a severe reaction to the Ecstasy tablet she took at her eighteenth birthday party in 1995, became a very public event of mourning that reflected widespread concerns of every parent. Another young casualty was Andrew Woodlock, a thirteen-year-old from Motherwell who fell into in a coma after taking three Ecstasy tablets in 1999. The loss of a life so young inculcated that the drug problem in the UK was running ever deeper to a population ever younger. Calls for a change in the direction of liberalisation and de-criminalisation fell on deaf ears in New Labour who took office in 1997. Against the backdrop of the continued rhetoric of the war on drugs it was revealed that Home Office Minister Jack Straw's own son (age 16 years) was a regular user of amphetamines. And the personal and political complexity of drug

addiction and government policy was further exposed by the heroin related death in 1999 of the son of another cabinet officer minister, Hugh MaCartney. And Prime Minister Blair himself was awakened to the challenge of managing young people misusing substances when his own son was arrested in Leicester Square for being drunk and disorderly.

Of course these tribulations in the late 1990s were not the first time that drug casualties had hovered close to the heart of Westminster; former Prime Minister Harold Macmillan's grandson died of a heroin overdose in the 1970s and in 1977 the 20-year-old son of the Environment Secretary, Peter Shore, was found dead at a squat not far from his parents' home in Putney, again a heroin overdose was the verdict. In 1987 Olivia Channon, a student at Christ Church College Oxford and daughter of Paul Channon, the Tory Trade and Industry Secretary, was found dead at the age of 22 after consuming a cocktail of alcohol and heroin and in the same year former Cabinet Minister Cecil Parkinson's 27 year old daughter Mary was fined for possessing cocaine. In 1994 Nicholas Forsyth, son of Michael Forsyth the Home Office Minister, was expelled from Rannoch School after repeated incidents of drink and drugs.

We might have predicted that there would have been a steady series of personal alerts to politicians and ministers about the perils of drug misuse. But nonetheless many people working in the field of substance misuse felt that the government was at best tokenistic about tackling drug misuse, and at worst ambivalence. Governments rely on the economy generated from the drug industry. The tax from cigarettes and alcohol alone account for nearly 10% of total tax revenue in the UK. As [28] points, tobacco exports alone in the USA 1980s contributed $25 billion to the trade ledger in the USA. The medicalization of the drug problem has deepened in the last fifty years as the pharmaceutical industry has grown ever stronger and more influential. We might even think of the late twentieth century as an epoch of the 'pill mentality' [29], that is to say, in the West we have seen the way in which emotional and health problem have been subject to pharmaceutical regimens. We take vitamin pills, pills for preventing pregnancy, for getting to sleep, for staying calm and so forth. The politics of sobriety and a drug free society are overshadowed by an economic reliance on the drug industry.

Conclusion

2000 & forward where?

Dual diagnosis [30] might well be described as a quiet paradigm shift in the field of substance misuse treatment. The concept of co-occurring psychiatric problems invited a much greater focus on the mental health conditions that might be situated alongside the problem of substance misuse. With dual diagnosis, aetiology is considered alongside the question of precedent, that is to say is substance misuse viewed as a primary or secondary factor? Some models consider dual diagnosis in terms of a co-factor phenomenon or bidirectional aetiology, that is to say, a mental health problem emerging concurrently with substance misuse. However, more recently there is we have come to understand that most people with dual diagnosis have been shown to report their first mental disorder *pre-dating* their history of substance misuse [31]. This suggests that mental disorders, including those that have previously remitted, can be markers or causal risk factors for secondary substance use disorders. Further clarification of aetiological factors, including the identification of subtypes of dual diagnosis, may have implications for developing more effective prevention efforts and treatment.

Rates of dual diagnosis have varied considerably in the UK. For instance in East Dorset, a south coast county in the UK, [32] found 12% of patients in addictions services and 12% of adult mental health patients in East Dorset were assessed to have a dual-diagnosis. Meanwhile [33] used a brief screening tool to detect problematic alcohol, drug use, psychosis and common mental health symptoms with two groups of patients in South London (50 substance misusers and 50 community mental health patients) diagnosing 92% of patients with a primary alcohol problem and 88% of those with a primary drug problem with co-occurring mental disorder. Meanwhile 38% of the community mental health patients were screened as having a concurrent drug problem. In another study, in a psychiatric continuing care facility in a large Canadian city, a cross-sectional survey with 207 successive mental health outpatients found that nicotine, alcohol and cannabis were the most frequently abused substances [34]. Cocaine, heroin, hallucinogen, amphetamine, and inhalant use were rarely reported. Excluding nicotine, 45% of the patients met the criteria for substance misuse at some point during their lifetime (mainly alcohol and/or cannabis) while 14% were currently found to be misusing a substance. However, 69% of patients with a primary substance misuse diagnosis were found to be clinically depressed.

A general pattern emerges from these studies; that between 70-90% of problem drug users have concurrent clinical mental health problems and between 12-40% of mental health patients have a concurrent drug misuse problem. Another general pattern is that among the adult mental patients alcohol and/or cannabis abuse are the most common co-factor substances while among the patients with a primary substance misuse diagnosis, depression, social phobia and personality disorder are the commonest co-factors. For instance in a cross-sectional survey of 615 current heroin users in Sydney found that 46% of the cohort met the diagnostic criteria for Borderline Personality Disorder (BPD) and 71% for Anti-Social Personality Disorder (ASPD) [35]. Gender differentials have been less of a feature in studies of dual diagnosis but where these have been studies there does not appear to a significant difference in rates. For instance psychiatric and substance misuse co-morbidity were assessed in 716 opioid abusers seeking methadone maintenance [36]. 47% of the men in the sample and 48% of the women were diagnosed with dual diagnosis, the most common diagnoses being antisocial personality disorder (25.1%) and major depression (15.8%). It was noted that psychiatric comorbidity was associated with a more severe substance use disorder. Another Australian study of methadone maintenance patients (n=62) found that 70% of males and 89% of females had a co-morbid psychiatric illnesses [37].

The different rates of dual diagnosis may point to geographical variations (urban, rural and national variations), although it is possible there are inconsistencies in screening tools that produce unlike results. These methodological inconsistencies were highlighted in an epidemiological case-control study with practitioners from generic mental health and substance misuse services in Essex who were asked to assess dual diagnosis among their client group (n=2341) [38]. The study highlighted that even pragmatic diagnostic criteria was subject to inter-relating time-frame variation (for instance were problems

still considered current) and there were basic core disagreements such as whether a personality disorder should be categorized as a 'mental health problem'. There were also disagreements about whether clients who were being treated primarily by Substance Misuse Services, but were also taking prescribed antidepressants, should necessarily be viewed as having a 'mental health problems' suggesting that the anti-depressant drugs may have been abused by some clients in the same way as illicit substances. It might only be possible to finally diagnose an underlying the presence or absence of an underlying condition when a client has ceased their drug use. For instance in a follow-up study with patients detoxified from alcohol it was found that during the first year, 25% of the patients who remained abstinent from alcohol and drugs were diagnosed with a major depressive [39].

It is unlikely that it is only of late that large numbers of drug users have started to experience co-morbid mental health problems; it is rather the case that there has been a clearer recognition of the complexity of co-morbidity and substance misuse. The fact that most treatments in the drug field have been delivered with the drug problem primarily in mind has created mindlessness about the more important underlying mental health problems that have been left untreated. It may be this major oversight that has been a crucial factor that has contributed to the failure of addictions treatment over the last two decades. We have witnessed a spectacular failure in the experimental liberalisation of addiction treatments since the 1960s which has seen a shift away from therapy towards strategies of pharmacological maintenance that has done nothing to limit the drug problem and has seemingly only serve to deepen it. When [40] concluded that; "we can no longer accept the argument that the medicalisation of addiction prevents the development of drug cultures and markets" [41] he only told half the story because we can now say that medicalisation of the drug problem has served, moreover, to exacerbate the problem. In this era of evidence based medicine one can only deduce that the pharmaceutical industry holds such sway that the obvious evidence contrary to efficacy is ignored.

It should be noted that drug free Therapeutic communities in the Europe and the USA have proved effective in bringing about sustained abstinence and reduced recidivism among treated clients [42,43]. Future service development should be geared towards increasing the number of residential detoxification facilities with programmes of rehabilitation, including help with access to re-housing, education and employment attachment. Residential and rehabilitation treatments, while apparently expensive, are however, cost effective in terms of savings from the reduction in the costs associated with any number of interventions including health, legal and criminal. Indeed, when set against the average cost of crime alone for expenditure on drugs; residential treatments more than pay for themselves in terms of the savings when individuals cease criminal activity [44].

Residential treatments can either be secure or non-secure and there is no evidence to suggest that treatment has to be undertaken voluntarily for it to be effective [45]. The reality is that many drug users are already a captive treatment audience; take for instance the number of prisoners that have a drug problem. It seems preferable to steer drug users into voluntary residential treatments while accepting that many users will find their own way into residential security in one way or another despite our best efforts to instil an agenda of treatment. What is needed is a return to recovery-focused interventions and a phasing out of maintenance strategies. This will require change in policy, and also a re-orientation of practice necessitating re-training for staff working in the field. Resources will need to be re-directed to services that have explicit aim of developing medication free interventions with greater emphasis on therapy. We might hope that an understanding of dual-diagnosis will bring about a paradigm shift whereby professionals begin to look beyond the outer casing of a patient's drug misuse and begin to consider the probability that the drug habit may be a symptom of an underlying mental health.

It is here that therapies inclined towards thinking in-depth about the patients' histories, might begin to make in-roads into tackling those who are addicted, and importantly see a robust route to working with children and young people whose life trajectories appear to make them vulnerable. Interventions can be carefully targeted at those vulnerable children and young people, rather than the scatter fire attempt at prevention in schools that occurs at the moment. When it comes to children and young people, there is a glimmer of hope on the horizon because we have recently seen the first downturn in fifty years of the number of children and young people experimenting with drugs. According to the NHS Information Centre schools survey [46], the proportion of 11 to 15-year-olds who said they had ever used drugs fell from 29% in 2001 to 17% in 2011, while those who reported drinking regularly fell from 20% in 2001 to 7% in 2011. An even smaller percentage reported getting into difficulties with alcohol or drugs. It is perhaps too early to start to talk about a change in the landscape of substance misuse in the UK, though we might wonder whether we are witnessing the start of a new chapter.

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