

# Effective Interventions Unit

## PSYCHOSTIMULANTS: A PRACTICAL GUIDE

### **WHAT IS IN THIS GUIDE?**

This guide explores the use of psychostimulants in Scotland, examines the problems associated with their use and discusses the evidence on interventions and service design. The guide includes a description of how services have been designed, or reconfigured, to address the needs of psychostimulant users.

### **WHAT IS THE AIM?**

To provide information and evidence to support the provision of services to psychostimulant users in Scotland, with a focus on the needs of the Drug Action Teams (DATs), their associated agencies and practitioners.

### **WHO SHOULD READ IT?**

Anyone involved in developing, designing, implementing or evaluating services for drug users.

### **WHO CONDUCTED THE RESEARCH?**

The guide draws heavily on the published research literature and the work conducted by the Psychostimulants Working Group (PSWG) who reported in August 2001. The membership of the PSWG is set out in Appendix 1. The Scottish Drugs Forum (SDF) conducted a qualitative research study to inform this work. Anita Morrison and Linsey Duff at the EIU prepared this guide.

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## CHAPTER 1 INTRODUCTION, AIMS AND METHODS

For the last two decades, the prevalence of psychostimulant use has been much lower in Scotland than in other parts of the UK. However, by 2001 there were anecdotal reports of an increase in use in some parts of Scotland, and some concern that services were unable to address the needs of psychostimulant users. In June 2001, the Scottish Advisory Committee on Drug Misuse (SACDM) agreed to establish a Working Group to review the extent of psychostimulant use in Scotland and make recommendations for future policy and practice.

The Psychostimulants Working Group (PSWG) was established in 2001. It had a wide membership including representatives from the Scottish Executive, statutory and voluntary agencies (see Appendix 1). The PSWG met from late 2001 until they reported in August 2002. The psychostimulants included in the review exercise were amphetamines, cocaine and crack cocaine. The PSWG examined the extent of the problem in Scotland, the effects of use and the range of potential prevention and treatment measures. A full copy of the SACDM report on psychostimulants is available from the Substance Misuse Division at the Scottish Executive or at [www.drugmisuse.isdscotland.org/publications/abstracts/sac\\_psycho\\_report.htm](http://www.drugmisuse.isdscotland.org/publications/abstracts/sac_psycho_report.htm)

The Effective Interventions Unit (EIU) was represented on the PSWG and agreed (as part of its remit to disseminate evidence and good practice in the drugs field) to prepare a research-based guide for Drug Action Teams (DATs), service providers and practitioners drawing on the work of the PSWG. The aim of this guide is to address the following key questions:

What are psychostimulants?

Who uses psychostimulants?

What are the problems associated with psychostimulant use?

What is the evidence for the effectiveness of treatment, care and support interventions?

How can services be designed to meet the needs of psychostimulant users?

## METHODS

This guide draws on data from the following:

- **A review of the international research literature** on psychostimulant use and interventions to address psychostimulant use. Standard databases and websites were searched for relevant literature including the Cochrane Library, Medline, EMBASE, SOSIG, ASSIA, NHS eLibrary, NIDA, Drugscope and the World Health Organisation.
- **A qualitative study** of psychostimulant users' views and experiences conducted by the Scottish Drugs Forum. One-to-one interviews and focus groups were conducted. The study sought to identify the views and service needs of different groups of stimulant users, including both primary and secondary psychostimulant users. The total sample of respondents was thirty-three. A summary of the key findings can be found in Appendix 2.
- **Oral and written evidence** presented to the PSWG and provided to the EIU by a range of experts including representatives from COCA, COCA Scotland, Turning Point Scotland, Public Health Institute for Scotland (PHIS), the Piper Project (Manchester), St Mary's Hospital London, Glasgow City Council, Higher Insight and WEST Edinburgh.

## CHAPTER 2 PSYCHOSTIMULANT USERS AND THE POTENTIAL PROBLEMS

### What are psychostimulants?

Psychostimulants are substances that excite the central nervous system. They have the potential to produce feelings of alertness and wellbeing. There are a whole host of **naturally** occurring psychostimulants including caffeine, nicotine, ephedrine and cocaine. However, there are also **synthetic** psychostimulants, which are principally amphetamines.

- **Cocaine** (coke, charlie, snow). This refers to cocaine hydrochloride, a white powder that is water soluble. It is usually taken nasally or by injection.
- **Crack cocaine** (rock) – This refers to cocaine alkaloid. It is purer and more concentrated than cocaine and is absorbed into the body faster than cocaine. It is not water soluble and is usually inhaled after heating (usually in a pipe).
- **Amphetamines** (speed, whizz). There are three basic types of synthetic amphetamines. (lævoamphetamine, dextroamphetamine and methylamphetamine). The most widely available is usually a powder containing the first two of these types. It can be snorted, dabbed from finger to mouth or injected. Smoking is not common.

### What is the legal position?

The UK Misuse of Drugs Act (1971) lists the drugs that are subject to control and classifies them as either A, B or C. Psychostimulants fall into all three classes under the Act. Class A includes psychostimulants that are prepared for injection (including cocaine and amphetamine). Class B includes oral forms of amphetamine, dexamphetamine, methylamphetamine and methylphenidate. Class C includes benzphetamine, pemoline and phentermine.

### Who uses psychostimulants?

Overall there appears to be a small, but recently growing problem with primary psychostimulant use that varies across Scotland (PSWG 2002). However, this is not straightforward. There are also a substantial number of primary opiate users who also use psychostimulants. The research evidence presented to the PSWG clearly demonstrates that psychostimulant users are not homogenous group. For illustration PSWG categorised users into four groups (PSWG 2002);

- **Youthful experimenters.** This group are likely to experiment (often opportunistically) with psychostimulants and very few are likely to be in touch with services relating to their use. Indeed, many of these users may not be experiencing any negative effects from using psychostimulants.
- **Regular stimulant users.** This group are established users of psychostimulants, typically using at weekends. They may have some contact with drug information services, but unlikely to have been in touch with services for problems relating to their use.
- **Problem stimulant users.** This group are a sub-set of the above. They are regular users who may be experiencing some problems with their use of psychostimulants. This group may be in need of services which (in many areas) do not exist.
- **Opiate and stimulant co-users.** This group are primarily opiate users who also use psychostimulants. Data clearly show that the Scottish drug using population are poly-drug users. These individuals may well be in contact with services but their psychostimulant use may not be addressed.

There is no one single source of reliable information on psychostimulant use in Scotland. However, it is possible to build a picture of psychostimulant use among the Scottish population using information from a number of sources including: national surveys, drug seizure statistics and data from the Scottish Drug Misuse Database on psychostimulant use among the drug treatment population. While this is not ideal, building such a picture does provide some information for service planners.

## Survey Data

In 2001, a **national survey of smoking, drinking and drug use among young people** in Scotland was conducted by the National Centre for Social Research and the National Foundation for Educational Research. Fourteen percent of 12-15 year olds reported use of any illegal drug 'in the last year'. Levels of stimulant use among school pupils, however, were low with only 1% reporting use of cocaine, 1% reporting amphetamine use and none reporting use of crack.

Comparisons with the previous survey (1998) show no change in the use of cocaine or crack and a drop in amphetamine use (from 3% to 1%). As with other drug types, more pupils had been offered stimulants than had tried them. In 2000, 7% of 12-15 year olds said they had ever been offered amphetamines, cocaine 6% and crack 4%. The comparable figures for 1998 were 11%, 6% and 3% respectively. Thus, there had been a decrease in the proportions offered these drugs.

**The Scottish Crime Survey (SCS)** provides information about levels and patterns of drug taking among adults throughout Scotland. As part of this survey, almost 3,000 respondents aged 16 to 59 self-completed a questionnaire about their knowledge and use of drugs of misuse. As with the schools survey, findings from the SCS suggest that use of cocaine and crack cocaine among the general adult population is comparatively rare. Further, a comparison of results from the 2000 SCS and the previous survey, in 1996, reveals no significant change in levels of use of cocaine or crack cocaine between the two surveys.

The highest levels of lifetime cocaine use were found among young males aged 25-29 (10.5%) whilst cocaine use 'in the last 12 months' was greatest among males aged 20-24 (5.4%). Use of crack cocaine was rare, with no respondents reporting its use 'in the last 12 months'. More respondents reported lifetime amphetamine use (16.5% of males aged 25-29 and 15% of males aged 20-24), however amphetamine use 'in the last year' was less common than cocaine use across all groups, except males 16-19. These data are presented in Table 1, along with figures for cannabis (the most commonly used illicit drug in Scotland) for comparison.

**Table 1. % of adults reporting use of psychostimulants and cannabis by gender and age**

Age & Use	Cocaine		Crack Cocaine		Amphetamine		Cannabis	
	M	F	M	F	M	F	M	F
16-19 Ever	3.8	5.1	1.0	2.9	6.7	8.1	25.2	24.3
	12 months	0.0	1.5	0.0	0.0	1.0	0.7	10.6
20-24 Ever	8.3	4.3	1.0	2.2	15.0	15.2	46.3	32.6
	12 months	5.4	3.8	0.0	0.0	3.4	0.0	17.6
25-29 Ever	10.5	2.0	2.3	0.7	16.5	8.1	42.9	25.2
	12 months	0.8	0.7	0.0	0.0	0.5	0.7	15.8

Source: 2000 Scottish Crime Survey

As a measure of the prevalence of drug use, and particularly hard drug use, the Scottish Crime Survey has a number of limitations. The findings presented above are based on a sample of less than 700 adults aged 16 to 29 across Scotland. Further, the SCS is a household survey and will probably under-represent certain groups in the population, such as homeless persons and those in prisons, hospitals and other residential establishments. Respondents may choose to under-report their drug use because of its criminal nature or its social unacceptability. Nevertheless, the SCS provides a useful minimum prevalence level of drug use in Scotland.

Data from the **Health Education Population Survey (HEPS)**, commissioned by the Health Education Board for Scotland, however, provide some evidence of an increase in cocaine use amongst adults under 35 years over recent years. Between 1996 and 2001 the percentage of respondents aged 16-34 years reporting use of cocaine 'in the last 12 months' increased from 0.9% to 4.1%, although these figures are based on an even smaller sample size than the SCS.

**The national prevalence study**, published in 2000, gives estimates of the numbers of problem drug misusers in Scotland. The prevalence study, however, focuses only on opiate and benzodiazepine misuse. It does not cover psychostimulant use.

### Scottish Drug Misuse (SMR24) Data

There were a total of 10,591 'new'<sup>1</sup> problem drug misusers in contact with drug services and reported to the Scottish Drug Misuse Database (SDMD) in 2000/01. Of these, 556 (5.2%) reported cocaine (including crack cocaine) as one of their drugs of use.

Whilst cocaine users represent a relatively small proportion of the total treatment population, their numbers have **increased considerably** over the last five years. Compared with the 556 individuals reported in 2000/01, there were only 154 cocaine users reported in 1996/97. The proportion of the treatment population reporting amphetamines as one of their drugs of use fell from 12% in 1996/97 to 5%.

Almost two thirds (63%) of the cocaine users reported to the database in 2000/01 reported cocaine as a secondary drug of use and an opiate as their main drug, whilst 8% reported use of cocaine alone. All but one of the cocaine only group were male. Their employment and accommodation situations tended to be more stable. For example, just over half (51%) were currently in employment. The comparable figure for the database as a whole was 13%.

It is, however, important to be aware of some of the limitations of the SDMD data. Drug treatment services in Scotland tend to be geared towards the needs of opiate users. Also, in relation to cocaine use in particular, there will be a group of young professionals who are unlikely to seek assistance for their drug use from treatment services.

### Drug Seizures

Table 2 presents detailed cocaine seizure statistics for police force areas in Scotland, compiled by the National Criminal Intelligence Service (NCIS) and Scottish Drugs Enforcement Agency (SDEA). These show an increase in the quantity and value of cocaine seized in a number of police force areas in the last couple of years, i.e. 2000 to 2001. For example, in Tayside the quantity of cocaine seized rose from 130 gms in 1998 to 1,191 in 2001, whilst in Grampian it increased from 150 grams to 3,767 over this same period. It is important to remember that these figures may

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<sup>1</sup> The definition of 'new' is a) the individual is attending the service for the first time ever, or b) there has been a gap of at least six months since their last attendance.

reflect a change in police practice rather than a real change in the amount of cocaine available. Overall, however, the scale of change does suggest some increase in the availability in some areas.

**Table 2. Cocaine seizures: quantity and value (£) by police force areas 1998-2001**

POLICE FORCE AREA	1998		1999		2000		2001	
	Grams	Value (£)	Grams	Value (£)	Grams	Value (£)	Grams	Value (£)
Central	11	550	47	2,350	107	5,350	59	2,950
Dumfries & Galloway	*	*	*	*	252	20,000	410	24,000
Fife	102	10,200	2	200	1,485	132,730	366	34,420
Grampian (Cocaine)	150	12,840 – 17,120	313	26,820 – 35,720	679	58,200 – 77,600	3,767	262,500
Grampian (Crack)	317	79,250	469	117,250	154	38,500	887	221,750
Lothian and Borders	880	70,360	221	13,260	5,877	352,590	734	29,360 – 44,040
Strathclyde **	13,857		6,339	507,120	14,249	1,139,920	8,749	437,448
Tayside	130	7,808	108	6,476	1,020	61,226	1,191 ***	71,491

\*Very minimal amounts of a few grams seized

\*\*Parameters differ for Strathclyde: 13,857g (Oct '98-March '99); 6,339g (Apr '99-March 2000); 14,249g (Apr 2000-March 2001); 8,749g (Apr 2001-Sep 2001)

\*\* As at 04/11/01 for Tayside

n.b Northern has not compiled records of cocaine seizures prior to 2000 other than through Home Office Crimesec Forms which are now archived, therefore, seizure figures are approximates and not included in this table

Source : NCIS/SDEA

## Other studies

The National Treatment Outcome Research Study (NTORs) is a longitudinal cohort study of drug users in England and Wales recruited from drug treatment services (see [www.ntors.org.uk](http://www.ntors.org.uk)). Most study participants are multiple drug users. Stimulants were the main problem drug for 13% of the NTORs sample (Gossop 2000). The most frequently reported pattern of stimulant use was among primary heroin dependent participants. The primary stimulant users were most likely to approach residential rehabilitation programmes for treatment. Substantial improvements in substance misuse and other behaviours were achieved at follow up.

## What are the problems associated with psychostimulant use?

As noted earlier in this chapter, there are psychostimulant users who will not currently be facing any significant problems associated with their use. However, the research literature identifies a whole range of difficulties that can be faced by 'problem' users. Some of these problems are specifically associated with psychostimulant use but many are well documented among the primary opiate using population. Some of these are serious, and some potentially fatal. These include:

- Psychological problems
- Physical problems
- Social problems

### Psychological problems

Psychological problems due to cocaine and amphetamine use appear to be common with chronic use, high dose, or binge episodes. Typically, clinicians have observed anxiety among their clients while using psychostimulants and symptoms of depression after an episode of use. Insomnia also appears to be common and may result in individuals using sedatives such as alcohol, benzodiazepines and opiates to 'come down'. A study by Farrell and colleagues suggest that psychiatric symptoms are found in 40% of stimulant users (Farrell 1998). In a further study, one in five cocaine users had received help for a psychiatric problem (Donmall 1995). These can include: anxiety, agitation, insomnia, depression, psychotic illnesses and eating disorders. Stimulant use has also been linked with suicide (ACMD 2000). Respondents in the SDF study cited mental health problems as a key problem and a barrier to recovery from stimulant use.

I didn't think there was a problem, just thought I was depressed, but my worker pointed out that it was the coke.

SDF Focus Group Respondent  
2002

### Physical health problems

A range of physical symptoms and conditions have been observed among psychostimulant users. These include heart disorders (Ghuran 2000), overdose, cerebrovascular accidents, convulsions and seizures (PSWG 2002). Mortality associated with accidents among psychostimulant users has also been highlighted in the literature (ACMD 2000). Many of the potential physical health risks are specific to the route by which the drug is administered. For the small number of those injecting psychostimulants, there are the well documented risks of HIV, Hepatitis C and other injecting related infections (including cellulitis and abscesses). Intranasal use can lead to sinusitis, a loss of sense of smell and atrophy (destruction of the lining of the nasal passages), nasal septum perforation and problems swallowing.

### Social problems

Data from research studies suggest that psychostimulant users (predominantly problem users) can have a range of social problems to contend with including family breakdown, breakdown of other social relationships, associated criminal behaviour (mostly property crime and violent crime) and homelessness (PSWG 2002; SDF focus groups 2002). Respondents in the SDF study cited the breakdown of family relationships, debt and problems associated with criminal activity as key difficulties. The social problems cited by both the focus group respondents and observed in the research literature are very similar (if not the same) as for opiate users. This suggests that an integrated approach to treatment, care and support which aims to address all the health and social problems commonly faced by drug users is just as appropriate for primary stimulant users facing problems as it is for primary opiate users.

Demented in the heid, either when taking it or trying to get money for it. Also, the breakdown in relationships with everybody, my girlfriend, mum, friends and that.

SDF Focus Group Respondent 2002

## CHAPTER 3 THE EFFECTIVENESS OF INTERVENTIONS

### What is the evidence for the effectiveness of interventions?

The review of the research literature and the evidence provided to the PSWG identified a range of specific interventions that have been tried with psychostimulant users. These fall into three broad categories:

- Pharmacological interventions
- Psychological and psychosocial interventions
- Complementary therapies

### Pharmacological interventions

A number of systematic reviews have looked at **pharmacological treatments** for psychostimulant users. A whole range of drugs has been tried and overall, there is **little evidence** to strongly support any single treatment for cocaine or amphetamine users. The focus of research and practice has been on **symptomatic** medication that relieve symptoms of withdrawal, rather than medications that provide a substitute. The Departments of Health clearly state in their guidelines that there is no indication for the prescribing of cocaine in the treatment of withdrawal (Departments of Health 1999).

Controlled trials on treatment for cocaine have mostly focused on desipramine. A meta-analysis shows benefits for promoting abstinence among cocaine users, but no effect on their retention in treatment (Levin 1991). Carbamazepine has also been advocated. However, there is currently no evidence to support the clinical use of carbamazepine in the treatment of cocaine dependence (Lima 2002). A further systematic review examining the use of anti-depressants examined 18 randomised controlled studies that concluded that there was no evidence for supporting the clinical use of antidepressants in the treatment of cocaine dependence (Lima 2002). Disulfiram (antabuse) shows promise when alcohol dependence is also identified alongside cocaine use.

Finally, a systematic review that addressed the use of dopamine agonists for cocaine dependence concluded that current evidence does not support their clinical use (Soares 2002). The authors suggest that given the high rate of drop-out in the population, clinicians should consider the use of psycho-therapeutic measures to help retain patients in treatment settings. This is echoed by a recent systematic review which confirms the lack of clinical evidence supporting the use of a range of drugs, and advocates the use of psychological therapies to help keep patients in treatment (Silva de Lima 2002).

As with treatment for cocaine users, the overall research evidence on treatments for amphetamine dependence is **limited**. However, a number of potential treatments have been studied. Fluoxetine, amlodipine, imipramine and desipramine appear to have very limited benefits for amphetamine dependence (Srisurpanont 2002).

Fluoxetine may decrease craving in the short-term and imipramine may increase the duration of adherence to treatment. A further systematic review on treatments for amphetamine psychosis found very limited evidence on effectiveness (Srisurpanont 2002). The results of two studies among amphetamine users show that agitation and some psychotic symptoms may abate within one hour of an antipsychotic injection.

Dexamphetamine sulphate is the most frequently studied drug for amphetamine users. It is also currently prescribed in England and Wales for the treatment of primary amphetamine use, though the Departments of Health Guidelines suggest that prescribing should be restricted to particular

groups (Departments of Health 2002). These studies have generally prescribed dexamphetamine sulphate to long term amphetamine injectors. There does appear to be growing evidence for the role of prescribed dexamphetamine. In response, a two centre randomised controlled trial of dexamphetamine substitution as a treatment of amphetamine dependence is underway in England funded by the Department of Health. The study will assess the effectiveness of the treatment, describe the nature of benefits and harms associated with the treatment and contribute to the development of best practice guidance. This study will report later in 2002.

## Psychological and psychosocial interventions

**Psychological and psychosocial interventions** are widely used with psychostimulant users, sometimes as a standalone intervention, and sometimes in conjunction with a pharmacological intervention. With few pharmacological interventions available, the quality of counselling and support available is crucial to the successful outcome of treatment and support among psychostimulant users. There is a wide range of possible interventions including **cognitive behavioural therapy, contingency management and community reinforcement**.

As with pharmacological treatments, the evidence on the effectiveness of psychological and psychosocial interventions with psychostimulant users is currently **limited, but promising**. There are a number of studies underway in this area including a systematic review of psycho-social treatments for psychostimulant dependence. This review falls under the auspices of the Cochrane collaboration library of systematic reviews. Further, an evaluation of a brief intervention model for young non-injecting stimulant users in London (16-22 years) is underway. The later evaluation is being funded by the Department of Health and will report in summer 2003.

Overall, systematic counselling forms the basis of most community-based treatments for psychostimulant users. Some authors advocate counselling for short-term, occasional (and non-injecting) users with no other treatment intervention. For longer-term, 'problem' users (including injectors) some authors argue for counselling plus symptomatic medication (e.g. fluoxetine). A range of approaches has been tried. One study examined the impact of coping skills training and suggested it could be beneficial for avoiding relapse in cocaine users (Monti 1997). A further study used material incentives (usually vouchers) as rewards for cocaine free urines (Higgins 1994). A controlled trial of this approach indicated there were benefits to using incentives and counselling when compared to counselling alone. Anecdotal evidence suggests that some crack and cocaine users can benefit from structured programmes, like cognitive behavioural therapy.

The lack of available psychosocial treatments or interventions is also quoted in the research literature as a **barrier to service utilisation** among psychostimulant users. Evidence suggests that those seeking help for psychostimulant use problems were less likely to have received treatment than opiate users (Farrell 1998). The major barrier to service up-take appears to be the perception of services as providing treatment and care for opiate users. This was observed among users in the SDF focus groups (SDF 2002). However, this is not a situation particular to Scotland. The National Cocaine Treatment Study in England in the mid-1990's showed that most treatment services were not attracting cocaine users (Donmall 1995)

## Complementary therapies

Complementary therapies are also increasingly offered to psychostimulant users. Service providers report the provision of a wide range of complementary approaches to drug users (and psychostimulant users specifically) including reflexology, aromatherapy, reiki and acupuncture.

There is little clear evidence of their effectiveness. However, this may be because there are few well designed studies of their effectiveness. The available evidence suggests that these approaches appear to be capable of attracting users into treatment and encouraging them to

remain in treatment (PSWG 2002). Current research emphasises the need to consider the role of complementary therapies in a broader treatment plan, rather than as standalone interventions.

A recent randomised controlled trial of the use of **acupuncture** in the treatment of cocaine addiction does not support the use of acupuncture as a stand-alone treatment, or when only minimum psychosocial treatments are provided (Margolin 2002). The authors emphasise the need for further research to identify the possible role of acupuncture in a broader treatment plan for cocaine or amphetamine users. In this study, there were no differences between groups in treatment condition or in treatment retention.

However, a further randomised controlled trial of **auricular acupuncture** for cocaine dependence showed that those participants who received acupuncture were more likely to provide cocaine negative urines relative to controls. Finally, a controlled study conducted in the early 1990s showed limited benefits of acupuncture over 'placebo' acupuncture for crack-cocaine detoxification (Lipton 1994).

### Key findings on the effectiveness of interventions

**To conclude**, there is little evidence to strongly support any single pharmacological intervention treatment for cocaine or amphetamine users. There is a wide range of possible psychological and psychosocial interventions including cognitive behavioural therapy, contingency management and community reinforcement. The evidence of effectiveness of these approaches is limited, but promising. Further studies are underway. Finally, there is little clear evidence of the effectiveness of complementary therapies but they may attract users to enter, and remain, in treatment.

## CHAPTER 4 SERVICE PROVISION

Making decisions about service provision for psychostimulant users will be complex. As outlined in Chapter 2, there is **no homogeneous group of psychostimulant users**. This is clear from the research literature and is reinforced by the findings of the SDF focus groups. Participants felt that there should be different approaches to treatment, care and support that recognise the diversity of users, and the range of problems that they may have. Further, there is limited research evidence on the **most effective ways** to provide services for psychostimulant users.

It is important, however, to emphasise that there is evidence that interventions can work. This has been clearly demonstrated by the NTORS follow-up of psychostimulant users. The key is to maximise the effectiveness of treatment, care and support by ensuring that the interventions are appropriate to the **assessed needs** of the individual, provided in the most suitable way and at a time when their motivation is high.

These are core themes of the EIU's document on integrated care, 'Integrated Care for Drug Users: Principles and Practice' (October 2002). The principles and elements of practice identified in this document - accessibility, assessment, planning and delivery of care and information sharing - apply equally to primary opiate users, poly drug users and primary stimulant users. The aim of integrated care is to **combine and co-ordinate** all the services required to meet the assessed needs of the individual (including psychostimulant users). It requires collaborative working between agencies at each stage in the progress of the individual from treatment and care, through to rehabilitation and reintegration into the community.

This represents a shift away from a health focussed '**shared-care**' approach to a **wider 'integrated' approach** that would include a range of service providers that can address other problems such as housing, employment and training, criminal justice and debt. This could potentially include; generic and specialist health services, employment, education and training services, social services, the criminal justice system, housing services, debt counselling, family support services and other information and support services. Criminal justice entry routes such as DTTOs and Drug Courts may increase the number of psychostimulant users in touch with drug treatment services. Many areas across Scotland are moving towards an 'integrated' model of service provision. To read more about integrated care go to:

<http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>

### Importance of Needs Assessment

It is important to be clear at the outset what the local need for services may be. As advocated in the EIU's 'Integrated Care for Drug Users: Principles and Practice', **needs assessment** is a fundamental activity when planning, designing and reviewing service provision for drug users. A needs assessment of psychostimulant use and service need would try to establish:

- the number of psychostimulant users in their area
- characteristics of psychostimulant users in their area
- types of interventions and services that would be appropriate and credible to users.

It is important to look at the current treatment population (who are primary heroin users) and try to establish the level of problematic psychostimulant use among this group. At local level, it may be possible to draw some information from management information and SMR24 data on opiate users who also use psychostimulants.

A number of DATs and drug projects have conducted local needs assessments to inform service development. Some projects (including the Piper project for stimulant users in Trafford, see

example) were developed using results from action research projects. There is a growing experience base in this field. This includes the mapping work of COCA and COCA Scotland (see example). The EIU will be drawing on this to produce a guide to conducting needs assessment (specific to the Scottish context) in early 2003. Some information on needs assessment and reviewing services is available in Annex 3B of the integrated care document:

<http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>

In the meantime, a workbook on conducting needs assessment in the substance use field has been prepared by the World Health Organisation (WHO). This is a useful introductory resource. It can be downloaded at:

[http://www.who.int/substance\\_abuse/PDFfiles/needsassessment.pdf](http://www.who.int/substance_abuse/PDFfiles/needsassessment.pdf)

An action research project was conducted to assess the need for a psychostimulant service in Manchester (prior to the establishment of Piper). This was accomplished using 'privileged access' workers to find out more about patterns of drug use and potential problems.

COCA is a national organisation that supports agencies and professionals working with issues of crack and cocaine addiction. COCA Scotland can help local agencies develop a regional understanding and response to crack and cocaine. They have recently undertaken a mapping exercise in Scotland. For further information contact [cokenet@globalnet.co.uk](mailto:cokenet@globalnet.co.uk)

### How should services be provided for psychostimulant users?

If a **need to address psychostimulant use** and its associated problems has been identified in the area, the next step is to consider how to address this need (bearing in mind that psychostimulant users are not a homogenous group). Simplistically these can be set out as **three main options**, but they are not mutually exclusive.

Reconfigure / redesign existing generic services to meet the needs of psychostimulant users (e.g. by providing training and advice to primary care professionals)

Reconfigure / redesign existing specialist services to meet the needs of psychostimulant users (e.g. by providing specialist stimulant workers)

Design new services targeted to meet the needs of psychostimulant users.

The approach will depend upon the **characteristics of the area** and the established size and nature of the psychostimulant using population. For example, it may be appropriate to have specific services for stimulant users in large urban areas, but more appropriate to have specialist workers placed in existing drugs services in other areas.

Some **further specific questions** for service planners and service providers:

Is there a need for generic services to be more aware of the needs of psychostimulant users and to provide services for them?

Is there a need for specialist drug services to be more aware of the needs of psychostimulant users and to provide services for them?

Is there a need for services for psychostimulant users that are gender specific, or specific to minority ethnic groups?

Are there new or revised assessment tools and referral protocols required that are specific to working with psychostimulant users?

Are there key partnerships between agencies that need to be developed to provide better services for psychostimulant users? (e.g. between criminal justice and specialist workers)

Is there scope to include users (and former users) in developing or revising current services to address the needs of psychostimulant users?

### What are the key characteristics of services for psychostimulant users?

The limited evidence on providing services for psychostimulant users suggests that services must be (PSWG 2002, EIU 2002):

- Responsive
- Accessible
- Credible
- Develop clear assessment procedures
- Employ staff with specific competencies

#### Responsive Services:

The evidence presented to the PSWG suggests that when a psychostimulant user presents at a treatment or care service it will be crucial that they are dealt with quickly and appropriately. Rapid intake into treatment should help capitalise on high motivation and improve treatment outcomes. This may not necessarily be a drug service. In many cases, psychostimulant users will approach their GP for help. GPs need to be aware of the problems of psychostimulant users and respond promptly.

If you look at a worker with a 40 client case load and a crack user comes in and gets told 'I can see you in two weeks time for half an hour and every two weeks after that'. What good is that?

(Aidan Gray, COCA, Druglink 2002).

#### Accessible Services:

Ensuring services are **accessible** to psychostimulant users is also crucial. The individual and service characteristics that can affect accessibility of services are discussed extensively in the EIU's 'Integrated Care for Drug Users: Principles and Practice'. This is available at: <http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>. In the case of primary psychostimulant users, it will be important to provide services that are available in the evening and / or at weekends. We know that many psychostimulant users are in full-time employment and may find regular attendance during standard work hours problematic.

#### Credible Services:

Across health and social care, evaluations (including evaluations of services for drug users) emphasise the need for services and interventions to be **credible** to the target population. Recruitment of clients can be problematic if the service is not perceived as credible. Overall, there is limited understanding of how to engage with those individuals experiencing problems with their psychostimulant use. Respondents in the SDF focus groups felt that drug services are primarily, and predominantly, geared to dealing with problems of opiate use and that workers were often unsure about how to address the problems of psychostimulant users (SDF 2002). They felt that there was an information and training deficit among professional health and specialist drug agency workers regarding psychostimulants. Respondents also indicated that stimulant users are not keen on discussing their drug use with GPs, due to GPs' lack of knowledge about stimulants.

### Clear Assessment Procedure:

Services need to be clear about their **assessment** process for primary psychostimulant users, or indeed how to include assessment of psychostimulant use in their daily practice with co-users. Effective assessment practice is essential to ensure that the individual receives the treatment, care and support that they need. There is a whole range of different assessment tools in use with young people and drug users that may be suitable. However, some of the scoring systems used in some assessment tools do not lend themselves to measuring psychostimulant use because they assume that use is regular rather than episodic. COCA has been developing assessment tools specifically for use with psychostimulant users. You can obtain these from COCA at [cokenet@globalnet.co.uk](mailto:cokenet@globalnet.co.uk)

### Staff with specific competencies:

'Integrated Care for Drug Users: Principles and Practice' illustrated the importance of **employing and developing staff** with training in drug related issues. Many of the staff skills required to deal with opiate users will apply equally to the care of psychostimulant users. An empathic approach and good awareness of the problems related to psychostimulant use are essential. However, staff may need to be trained in **specific competencies** including (for example) cognitive behavioural therapy. The PSWG recommended that training modules on psychostimulant use should be developed by STRADA. The development of this module is underway and it will be available for specialist workers from November 2002. Further, STRADA's introductory course 'Knowing Where to Start' will shortly include materials on psychostimulants.

### Are there examples of current service provision?

The PSWG identified a number of services that have been established for psychostimulant users in the UK. However, few of these are in Scotland. It is important to emphasise that specific services for this group are probably not feasible and appropriate in some areas of Scotland. Nonetheless, many of the interventions and services provided could be made available through existing drug services.

For the purposes of this guide we have selected two project examples for illustration. These are set out in the boxes below.

- The Piper Project (Manchester)
- The Edinburgh Stimulant Users Service (eSUS)

Further, given the problems identified in the North East of Scotland, there are plans to develop a service or services for psychostimulant users locally. It is anticipated that the development and effectiveness of this service will be evaluated.

If you would like further information on these projects, or on other projects across the UK that provide services (or include provision) for psychostimulant users, please contact EIU at [EIU@scotland.gsi.gov.uk](mailto:EIU@scotland.gsi.gov.uk)

### **Example 1 The Piper project (Peer Intervention Project for Education and Research)**

The Piper project is a specialist service within Trafford Substance Misuse Service in Manchester with a remit to work with stimulant users. Priority is given to working with crack cocaine users, though Piper works with all stimulant users. The service was established in 1996 and has been delivering services since 1997. The need for the service was identified by an action research project looking at the needs of crack cocaine users in the area.

A **two tier service** is in operation:

1. **A low threshold 'walk-in' service** offering a drop-in service and auricular acupuncture. Advice and information on drugs, drug use and drug treatment is provided. However, the service is holistic in its approach and also commonly provides advice on general health, social and welfare problems and provides advocacy.
2. **Individual one-to-one appointment based service.** This involves formal assessments and ongoing structured case-work. Internal referrals are commonly made for shiatsu massage, counselling, vocational guidance, housing and benefits advice and services delivered by Trafford SMS and Trafford Healthcare NHS Trust. This casework tends to be intensive (up to 4 hours per week) for a relatively short period (often 6 months). Clients are assessed within 3 working days.

The project did not set out to provide services based on any particular philosophy. However, by client preference, the service is predominantly abstinence-based.

### **Example 2 Edinburgh Stimulant Users Service (eSUS)**

Edinburgh Stimulant Users Service represents a joint approach between two voluntary sector partners to expand services aimed at young persons who are experiencing problems derived from their use of psychostimulant drugs. The partners are West Edinburgh Support Team (WEST) which established the Edinburgh Centre of Cognitive Therapy for Substance Abuse in 1999 and Crew 2000 which has, in tandem, provided a Peer Support Programme during the same period.

The overall aims of the project are:

- To enable young drug users to take positive action to reduce and eliminate their use of psycho-stimulant drugs
- To design and develop services that can fill gaps in provision for the stimulant drug users
- To match the needs of young stimulant drug users with the services available
- To offer a service that complements the work of other public and voluntary sector agencies dealing with drug and substance users

Crew 2000's existing services provide the following entry points:

- Engagement with young people through outreach (often clubs)
- A one-stop facility in Edinburgh City Centre
- A telephone helpline facility

If people are experiencing problems with their psychostimulant use (estimated by the project at 30-40%) they will be referred for further help and advice. Commonly they will be referred to:

- Crew 2000 Peer Support Programme
- Edinburgh Cognitive Therapy Centre (ECTC)
- Services offered by local community drugs teams, in particular for primary opiate users.

## CHAPTER 5 KEY FINDINGS AND FURTHER RESOURCES

### Key Findings

A number of key findings can be drawn from the research literature, SDF focus group research and evidence presented by the PSWG to the Scottish Executive.

#### Scope and nature of the problem

- **There is no current, or anticipated, epidemic of psychostimulant use in Scotland.** However, the use of cocaine and crack cocaine does appear to have increased recently. There are variations in level of use across Scotland. The figures for Aberdeen and its surrounding area are particularly high for crack cocaine.
- **Psychostimulant users are not a homogenous group.** For the purposes of this guide, users have been categorised into four key groups. Many psychostimulant users are not currently facing problems with their use. However, there are both primary psychostimulant users and co-users of opiates and psychostimulants likely to be facing problems with their drug use.
- The limited research on the health and social consequences of psychostimulant use suggests that **problems are wide ranging, including physical and mental health problems and social problems** (including criminal activity and relationship breakdown). However, many users will not currently be facing these problems.

#### Interventions and service provision

- There is a need for drug services to be **more accessible and responsive** to psychostimulant users across Scotland. In the main, existing drug services in Scotland are perceived as geared towards the needs of opiate users. Psychostimulant use by opiate users is also often not addressed at these services.
- **DATs and partner agencies have to decide the most effective ways** to provide services to psychostimulant users in their area. In particular, whether to make existing services more attractive (and credible) to psychostimulant users, or whether to provide services specifically for this group. These decisions should be made locally and be based on local needs assessment exercises.
- **Specific interventions also need to be geared towards the assessed needs of psychostimulant users.** There is little evidence to strongly support any single pharmacological treatment for cocaine or amphetamine users. The focus of research and practice has been on symptomatic medications that relieve symptoms of withdrawal.
- Several reviews highlight the need to focus on **providing psychological and psychosocial interventions to psychostimulant users.** Research also point to the potentially useful role of complementary therapies for this group, principally to help maximise retention in treatment and care programmes.
- An **effective assessment process** is crucial to ensure that services can address the potentially complex needs of psychostimulant users. There is a wide range of assessment tools available. Some tools focus on regular injecting drug use and may not be appropriate for all psychostimulant users. Further information on assessment can be found in the EIU's 'Integrated Care for Drug Users: Principles and Practice' at <http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>

- Service planners and service providers should consider whether **new partnerships between agencies and service providers** need to be developed to ensure the needs of psychostimulant users are adequately met. This may involve developing specific protocols and tools to support the partnership.

### Monitoring and evaluation

- **Monitoring and evaluation** of new services and interventions, and approaches to make existing services more responsive and attractive to psychostimulant users, will be important. Currently there is a lack of good quality monitoring and evaluation data on prevalence of problems associated with use and service provision for psychostimulant users.

### FURTHER RESOURCES

A number of useful materials and websites have been identified while preparing this guide.

**Drugscope** – Drug Search pages

<http://www.drugscope.org.uk/druginfo/drugsearch/>

**Scottish Drugs Forum**- Drug Information (stimulants section)

<http://www.sdf.org.uk/>

**NI DA (USA)** – Info Facts section

<http://www.nida.nih.gov/Infobox/cocaine.html>

**Cocaine Anonymous**

<http://www.cauk.org.uk/>

**Medline Plus** – links to research articles and useful websites on cocaine and amphetamines

<http://www.nlm.nih.gov/medlineplus/cocaineabuse.html>

<http://www.nlm.nih.gov/medlineplus/amphetamineabuse.html>

**National Treatment Agency** – Models of Care Work

<http://www.nta.nhs.uk/>

**Crew 2000**

<http://www.crew2000.co.uk>

## Appendix 1 Membership of Psychostimulants Working Group

### Members

Kay Roberts (Chair)	Greater Glasgow Primary Care NHS Trust
Dr Alex Baldacchino	Clinical Addictions Research Group, University of Dundee
Mike Cadger	Crew 2000
Dr Tom Gilhooly	Parkhead Health Centre
Sally Haw	Health Education Board for Scotland
David Liddell	Scottish Drugs Forum
Nicki Matthew	Drugs Action, Aberdeen
Anita Morrison	Effective Interventions Unit, Scottish Executive
Dr A Scott Wylie	Alcohol and Drug Services, Stobhill Hospital
Paul Stroner	Information and Statistics Division
Matt Hamilton	Seconded - Scottish Drugs Enforcement Agency (until March 2002)
Colin Campbell	Seconded - Scottish Drugs Enforcement Agency (from April 2002)

### Secretariat

Marion Goldsmith	Scottish Executive, Substance Misuse Division
Sandra Wallace	Scottish Executive, Substance Misuse Division

## Appendix 2 Summary of SDF focus group research

### Introduction

The Scottish Drugs Forum (SDF) were commissioned by the Psychostimulants Working Group of the Scottish Advisory Committee on Drugs (SACDM) to undertake a short project on the service provision needs of psychostimulant users in spring 2002. This work has also helped inform the present document on integrated care for drug users.

### Aim

The primary aim of the study was to obtain a snapshot of the views and experiences of stimulant users on their needs and available service provision.

### Methods

The two qualitative methods were used: one-to-one interviews and focus groups. The study focused on three psycho-stimulants: cocaine, crack cocaine and amphetamine. The study sought to identify the views and service needs of different groups of stimulant users, including both primary and secondary psychostimulant users. The total sample of respondents was thirty-three. Questions related to seven key themes:

- Their reasons for psychostimulant use
- The problems they experienced relating to stimulant use
- The services they had accessed
- The support they had received at services
- Their views on service satisfaction
- Their views on future service provision

### Results

- The study showed that stimulant users are not a homogenous group. They include opiate users who also use psychostimulants, primary (and heavy) psychostimulant users and recreational users.
- Users felt there was an information and training deficit among professional health and specialist drug agency workers regarding psychostimulants.
- Users felt that drug services are primarily, and predominantly, geared to dealing with problems of opiate use.
- Stimulant users are not keen on discussing their drug use with GPs, due to GPs' lack of knowledge about stimulants. There was also concern about losing their methadone script if the GP knew about their stimulant use.
- Many respondents stated a preference to be seen by drug agency workers who had personal experience of drug use.
- Alternative therapies were regarded positively by respondents as a treatment option for those experiencing problems.
- Respondents expressed a need for employment skills and help in finding work.
- Respondents expressed a desire for counselling to explore the reasons behind their drug use.

## Conclusions

Overall users felt:

- There should be different approaches to care which recognise the diversity of users.
- Short-term prescribing of dexamphetamine may be helpful to keep users off the streets.
- Drug agency workers and health care professionals generally need more information and training about psychostimulants.
- There is a need for improved co-ordination between agencies.
- There is a need for early access to confidential, trustworthy advice and information without recourse to a GP.
- The present variety of treatment approaches should be encouraged.
- Employment support and associated aftercare services are needed.
- Ex psychostimulant users should be involved in delivering services.

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