

Written evidence from the British Psychological Society

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Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

About this Response

The response was jointly led on behalf of the Society by:

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We hope you find our comments useful.

British Psychological Society response to the Health and Social Care Committee

Drug Policy Inquiry

The Committee is seeking written submissions on the health consequences of illicit drugs policy including on:

Health and harms:

1. What is the extent of health harms resulting from drug use?

The psychological health harms can be wide-ranging depending on the composition of the substance

itself, the method of consumption, and frequency of use. Consequences of problematic drug use can be of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them (Nutt et al., 2010). At the individual level these include:

- Drug-specific and drug-related mortality such as lethal overdoses or the contraction of blood borne viruses resulting from the use of non-sterile needles. These viruses can then be transmitted sexually, thus placing others at risk. Contraction of these diseases is frequently accompanied by stigma, self-recrimination and wider social discrimination - all factors which impact psychological wellbeing (Jackson-Best and Edwards, 2018).
- Drug-specific and drug-related damage to physical health such as drug induced seizures, strokes or self-harm (which has a clear psychological component).
- Psychological dependence can also lead to drug-specific impairment of mental functioning – for example amphetamine-induced psychosis and mood disorders.
- Loss of tangibles such as income, housing, job, or freedom (resulting from criminal imprisonment) and loss of intangibles such as damaged relationships with family members, friends and the wider community. These losses usually have a detrimental impact on psychological wellbeing and can lead to further problematic drug use.

It is also worth noting the psychological health harms resulting from drug use can impact individuals beyond the individual drug user. For example:

- Illicit drug use often increases the likelihood of direct or indirect injury to others. This includes incidence of domestic violence- which have far reaching psychological consequences (Boles and Miotto, 2003), fetal harm (Day and George, 2005), or secondary transmission of blood-borne viruses (Gilchrist et al., 2017).
- Beyond the actual criminal act of using the drug, illicit drug use often requires or leads to an increase of physical crime at the population level (Nutt et al., 2010).
- Adversities faced by communities and families secondarily affected by drug use can include child neglect (Dube et al., 2003), family unit breakdowns (Barnard, 2007), and decline in community reputation and economic prospects due to wider public perception of the issue (Cusik and Kimber, 2007).

As evidenced above, problematic drug use is both a public health burden and detrimental to our wider social fabric. Due to the range and complexity of the issue, quantifying the health-related harms of drugs comes with major challenges (Best et al., 2003). However, understanding the psychological drivers and underpinnings of illicit drug use provides a way to determine the pathways into and out of addiction. It is therefore important to take into account the psychological component of the harm resulting from illicit drug use.

Prevention and early intervention:

- 2. What are the psychological reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.***

The development and onset of drug misuse is driven by the interaction of biological, social and psychological factors (BMA, 2013). There is also a significant heritability factor, expressed in sensitivity to rewards which, when combined with less developed cognitive control (impulsivity), should not be discounted (Agrawal and Lynskey, 2008). When these pre-dispositional factors evolve in certain social contexts such as childhood adversity, social deprivation, easier access to drugs, and pro-drug peer norms, frequent use of drugs and a higher likelihood of addiction can develop. However, because drugs provide such powerful reinforcement, anybody who uses drugs is at risk of becoming a problem user or addicted.

Individuals experiment with drugs for a variety of reasons and social and environmental factors such as class, gender and race can impact the levels of marginalisation and stigma faced by drug users as well as influence their access to resources and support (Ahern et al., 2006). Because the pathways to drug dependence are complex and varied, treatment needs to be multi-modal and diverse. A young person who becomes a problem drug user might miss valuable learning and social developmental opportunities and these broad deficits need to be addressed in the course of recovery or “rediscovery” of what rewards life can offer apart from drugs (Dingle et al., 2015).

It is worth underlining the importance of prevention since evidence shows that the onset of drug use in adolescence is associated with an excess risk of drug dependence when compared to the probability of drug dependence when the onset of drug use occurs in adulthood (Wagner and Anthony, 2002; Jordan and Andersen, 2017).

3. *How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.*

The priority for children and young people deemed to be at risk of developing substance misuse problems is to build skills, bolster self-esteem and foster resilience by focusing on the following:

- Listening
- Conflict resolution
- Refusal
- Identifying and managing stress
- Making decisions
- Coping with criticism
- Dealing with feelings of exclusion
- Making healthy behaviour choices.

NICE guidelines advise applied psychologists working with young people who might present with both substance misuse and co-existing serious mental health conditions such as psychosis to “take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism. Be direct in your communications, use a flexible and motivational approach”.

We support this premise, since the initial assessment, engagement and motivational approach creates a context for building a therapeutic alliance and increasing the likelihood of sustained change. Furthermore, early identification of substance misuse enables health or care staff to intervene before dependence and more severe addictions develops.

However, for this process to be successful and sustainable, health and care workers need to have appropriate training and be skilled and confident in initiating and delivering interventions ranging from identification and screening to offering advice.

Treatment and harm reduction:

4. How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

These are two overlapping questions.

Efficacy is dependent on providing evidence based interventions (EBIs). Even in cases where non-evidence based interventions are effective, the mechanisms or processes involved can remain unclear. As a result, it is difficult to validate impact results and the programmes can be difficult to replicate (Strang et al., 2012). A benefit of delivering EBIs is that both the service user and therapist know what is being delivered. Even if no gain is made something is learned which can inform next steps. For example, the intensity of the treatment might need to be increased, the treatment or approach may not be effective, or the approach is correct but needs to be augmented by another intervention.

A range of psychological therapies, such as Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT), and Family Therapy (FT) have proven to be effective to treat individuals with drug addiction. This is supported by numerous controlled outcome studies attesting to the superiority of these treatment interventions.

A key general finding is that effect size (also known as the impact or degree of therapeutic change) of treatment interventions that are supported by a psychological evidence base is variable but durable (La Roche and Christopher, 2009; Duncan and Reese, 2012; Weersing, 2016). This needs to be viewed in the context of the inherent treatment resistance, or tendency to relapse, that defines addiction. This “treatment resistance” becomes particularly pronounced with higher frequencies of drug use as the behaviour becomes compulsive as opposed to episodic or occasional drug usage (Boyle et al., 2000).

BPS members have reported that more senior and highly trained clinicians, including clinical and counselling psychologist posts, have been omitted from tenders for service contracts over the past decade. Given that psychologists are responsible for leadership, training, supervision and quality assurance in delivering evidence based psychosocial interventions, there is a risk that much needed services will be less widely available. The BPS is concerned that this could result in fragmented care and a higher likelihood of individuals not being matched to the services and support they require in

order to address their addiction or wider patterns of behaviour leading to misuse of illicit substances.

See for example Bradley et al., (2005) for a meta-analysis of a range of psychological therapies; Lundahl et al (2010) for a meta-analysis of MI; and Prendergast et al (2006) for a review of contingency management studies; Li Wen et al (2017) for meta-analysis of MBCT studies; BCT and FT are supported by NICE Guidance (CG51; 2007).

5. *Is policy is sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government's criminal justice-led approach.*

The British Psychological Society has no comments to make at this time.

Best practice:

6. *What would a high-quality, evidence-based response to drugs look like?*

An evidence-based response needs to be interdisciplinary and demonstrated to be impactful in order to inform larger-scale programs where the knowledge and resources of trained practitioners can be pooled and used to greater effect. While this does not negate the need to address specific drug-abuse behaviours, where commonalities exist, working collaboratively increases efficiency.

Given that many problem drug users have co-existing mental health conditions, these conditions also need to be addressed as part of the remedial process (Drake et al., 2007). For example, posttraumatic stress disorder (PTSD) and depression are common co-morbidities and need to be treated in tandem as part of an integrated care plan (Sofuoglu et al., 2014).

However, it is worth emphasizing that these cases can be more difficult to treat since they often require the involvement and support of more highly trained and specialised psychologists (Kelley and Daley, 2013). Therefore an evidenced-based response needs to be accompanied by the identification of treatment and geographical coverage gaps, support for current practitioners, commissioning of senior roles, and funding to support training routes that directly address this need.

7. *What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?*

The British Psychological Society has no comments to make at this time.

References

Advisory Council on the Misuse of Drugs (ACMD). (2003). Hidden harm: Responding to the needs of children of problem drug users. London: Author.

Agrawal, A. and Lynskey, M. (2008). Are there genetic influences on addiction: evidence from family, adoption and twin studies. *Addiction*. 103: 1069-1081.

Ahern, J., Stuber, J., and Galea S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug Alcohol Dependence*. 88(2-3):188-96.

Barnard M. (2007). *Drug addiction and families*. Kingsley, London and Philadelphia.

Best D., Gross S., Vingoe L., Witton J., and Strang J. (2003). *Dangerousness of drugs. A guide to the risks and harms associated with substance misuse*. London: Department of Health.

BMA (2013). *Drugs of Dependence: the role of medical professionals*. London: BMA Board of Science.

Boles, S., and Miotto, K. (2003). Substance abuse and violence: a review of the literature. *Aggression and Violent Behavior*, 8(2)155-174.

Boyle, K., Polinsky, M. L., and Hser, Y.-I. (2000). Resistance to Drug Abuse Treatment: A Comparison of Drug Users Who Accept or Decline Treatment Referral Assessment. *Journal of Drug Issues*. 30(3), 555–574.

Bradley, B., Greene, J., Russ, E., Dutra, L., and Westen, D. (2005). A Multidimensional Meta-Analysis of Psychotherapy for PTSD. *The American journal of psychiatry*. 162. 214-27.

Cusick, L., and Kimber, J. (2007). Public perceptions of public drug use in four UK urban sites. *International Journal of Drug Policy*, 18(1), 10-17.

Day, E., and George, S. (2005). Management of drug misuse in pregnancy. *Advances in Psychiatric Treatment*, 11(4), 253-261.

Dingle, G.A., Cruwys, T. & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers of Psychology*, 6, 1795.

Drake, R. E., Mueser, K. T., and Brunette, M. F. (2007). Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, 6(3), 131-6.

Dube, S., Felitti, V., Maxia, D., Chapman, D., Giles, W., and Anda, R. (2003). Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study. *Pediatrics* 111(3).

Duncan, B. L. and Reese, R. J. (2012). Empirically Supported Treatments, Evidence-Based Treatments, and Evidence-Based Practice. In *Handbook of Psychology, Second Edition* (eds I. Weiner, G. Stricker and T. A. Widiger).

Gilchrist, G., Swan, D., Shaw, A., Keding, A., Towers, S., Craine, N., Munro, A., Hughes, E., Parrott, S., Mdege, N., Strang, J., Taylor, A., Watson, J., (2017). Preventing blood-borne virus infection in people who inject drugs in the UK: systematic review, stakeholder interviews, psychosocial intervention development and feasibility randomised controlled trial. *Health technology assessment*. 1-312.

Jackson-Best, F., and Edwards, N. (2018). Stigma and intersectionality: a systematic review of systematic reviews across HIV/AIDS, mental illness, and physical disability. *BMC Public Health*, 18:919.

Jordan, C., and Andersen, S. (2017). Sensitive periods of substance abuse: early risk for the transition to dependence. *Developmental Cognitive Neuroscience*, 25, 29-44.

Kelly, T. M., and Daley, D. C. (2013). Integrated treatment of substance use and psychiatric disorders. *Social work in public health*, 28(3-4), 388-406.

La Roche, M. J., and Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: a cultural perspective. *Professional Psychology: Research and Practice*, 40(4), 396-402.

Li Wen, A., Howard, M., Garland, E., McGovern, T., and Lazar, M. (2017). Mindfulness treatment for substance misuse: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*. 75.

Lundahl, B., Kunz, C., Brownell, C., Tollefson, D., and Burke, B. (2010). A Meta-Analysis of Motivational Interviewing: Twenty-Five Years of Empirical Studies. *Research on Social Work Practice*. *Research on Social Work Practice*, 20, 137-160.

NICE (2018). [Online] Drug misuse prevention - quality standard [QS165]. Available at: <https://www.nice.org.uk/guidance/qs165/chapter/Quality-statements> [Accessed 14 March. 2019]

NICE (2017). [Online] Drug misuse prevention: targeted interventions. Available at: <https://www.nice.org.uk/guidance/ng64> [Accessed 15 March. 2019]

NICE (2011). [Online] Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Available at: <https://www.nice.org.uk/guidance/cg120/resources/cg120-psychosis-with-coexisting-substance-misuse-assessment-and-management-in-adults-and-young-people-review-proposal-> [Accessed 15 March. 2019]

Nutt, D., King, L., and Phillips, L. (2010) Drug harms in the UK: a multi-criteria decision analysis. *The Lancet*, 376(9752), 1558-1565.

Prendergast, M., Podus, D., Finney, J., and Greenwell, L. (2006). Contingency management for treatment of substance use disorders: a meta-analysis. *Addiction*. 11, 1546–1560.

Skeers V. (1992). Illegal methamphetamine drug laboratories: a new challenge for environmental health professionals. *Journal of Environmental Health*, 55, 6-10.

Sofuoglu, M., Rosenheck, R., and Petrakis, I. (2014) Pharmacological treatment of comorbid PTSD and substance use disorder: recent progress. *Addictive Behaviors*, 39(2), 428-433.

Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D., and Humphreys, K. (2012). Drug policy and the public good: evidence for effective interventions. *The Lancet*, 379(9810):71-83.

Wagner, F. and Anthony J. (2002). From first drug use to drug dependence: Developmental periods of risk for dependence upon marijuana, cocaine, and alcohol. *Neuropsychopharmacology*, 26:479–488.

Weersing, V. R., Jeffreys, M., Do, M. T., Schwartz, K. T., and Bolano, C. (2016). Evidence Base Update of Psychosocial Treatments for Child and Adolescent Depression. *Journal of clinical child and adolescent psychology: the official journal for the Society of Clinical Child and Adolescent Psychology*, American Psychological Association, Division 53, 46(1), 11-43.