



The Eden Lodge Practice

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Psychotherapy. Counselling. Hypnotherapy.

Member: British Association for Behavioural & Cognitive Psychotherapies.
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11 April 2007.

Chris Edwards,
Drug Legislation Section, Drug Strategy Unit,
Home Office,
2 Marsham Street,
London SW1P.4DF.

Dear Mr/Ms. Edwards,

Public Consultation: Independent Prescribing of Controlled Drugs:

Having studied the above proposals we are at a loss to understand how such radical changes would have long term benefits, or for that matter long term satisfactory outcomes for addicts. Nor are we able to see how it would benefit the public

We note that the ostensible objective of the proposals is to increase the safety of both the addict and the public, and that the Advisory Council on the Misuse of Drugs (ACMD) have advised that there is no evidence that expanding the availability of potentially toxic, highly addictive and psycho active drugs, which cause both severe mental and physical damage to addicts will lead to increased abuse. Such a claim is grossly misleading; one only has to look at the well documented current diversions and abuses that are commonplace within methadone prescribing, to be aware of just how misleading it is. We would also point out that such a claim is a contradiction in

terms, and that all of the medical evidence points to the fact that continued use of such drugs will, sooner or later exacerbate their known harms.

We would also remind you that despite world wide evidence to the contrary, which the Government and the ACMD failed to reflect, we were informed that cannabis was downgraded because it was considered by the latter to be relatively harmless. Since then there has not only been an escalation in the growth, distribution and use of cannabis, which we were also assured would not happen, more and more people are being admitted to hospitals with cannabis related psychosis. The fact that not one member of the ACMD who advised the Government had any direct expertise in addiction, psychosis, or schizophrenia, combined with the subsequent damage that has been inflicted as the result of their recommendations, does not lend any credibility to claims they are inclined to make.

There are as you are no doubt aware, various definitions of what constitutes addiction, nevertheless, the more credible ones such as those defined by the World Health Organisation, and the American Psychiatric and Medical Associations, contain reference to someone continuing to using a substance, notwithstanding severe negative effects on virtually every area of their life. It follows that any process or facility that prolongs such an all encompassing disease rather than seeking to address it with abstinence focused intervention, leading to recovery and rehabilitation, is counterproductive to that persons long term benefit. Your proposals and the recommendations of your advisers seek to contradict that inescapable truth. We would also point out that the proposed legislation contravenes both the wording and spirit of Harm Reduction as defined by the International Harm Reduction Association (IHRA)

Since neither quantity nor frequency of usage is relevant to the diagnostic criteria for addiction, claims that reduced and or controlled use by either quantity or frequency reduces harm, whether or not such usage is 'supervised' does not in any way alter the presence of addiction. Nor for that matter have such measures successfully demonstrated long term, (defined as a minimum of 5 years,) beneficial impact on morbidity or mortality. Claims to the contrary, together with the studies, they are based on are of limited value. None of them are able to show that such reduction leads to any significant or long term benefits. It is also noted that both the experiments and evidence supporting these studies have been restricted both by time and numbers involved. Further in many cases results have been deliberately biased by the adding to, or subtracting from the parameters of universally recognised criteria for addiction.

A further important consideration is that for improvement of any disease to be ethically claimed, all aspects of it have to be measured. Current claims of harm reduction, whether it is by substitution, supervised prescribing, reduced frequency, or quantity, etc, and which is not abstinence focused, have failed to demonstrate any influence on long term morbidity or mortality. We therefore submit that the ostensible reasons for the proposed legislation are gravely flawed

We would argue vehemently that extending the facilities for the supply of controlled drugs, thereby not only enabling addicts to continue the harm they are causing

themselves and others, but actually making it easier and more convenient for them to do so is the antithesis of the medical ethos of ‘*First do no harm*’. In cases of addiction, any reduction in quantity, and/or frequency has yet to be shown as other than transient; as such it cannot be regarded as harm reduction.

We are aware that the goal of abstinence, the foundation stone for recovery, the ultimate, uncompromising measure, for judging the success of addiction intervention outcomes, has been deliberately abandoned by the Government’s Drug Intervention Strategy. This surrender to allowing addiction to continue, and in many cases unnecessarily prolonging it, whilst simultaneously failing to reduce demand, wilfully ignores the wealth of research and evidence based practice that the course of addiction can be arrested through cost effective, therapeutic efforts of mainline and allied healthcare professionals, accompanied by self help and 12 step programmes.

The fact that such evidence has, and continues to be deliberately and wilfully disregarded, exposes the claims by various Government bodies to use only evidence based practice to be no less than a prevarication of the truth. We regard the current proposals as further evidence of the Government’s intentions to continue disregarding indisputable research and evidence based practice with its fully documented, recognisable and measurable benefits to addicts and society.

It becomes apparent that such seemingly irresponsible action is a covert step to decriminalising drugs, which in turn will permit politicians to continue making facile claims of success in reducing crime, where in reality it is only crime *figures* that are being reduced.

We believe that such legislation will serve only to keep people locked into addiction. There is also the realistic probability that it will imply it’s alright to use drugs because they’re readily available on the NHS, thus accelerating the demand and escalating the widespread addiction prevalent in our society. We acknowledge that this will be of considerable benefit to the powerful lobby representing the interests of the pharmaceutical industry, some of whom are currently masquerading as ‘pro choice’ or ‘drug treatment agencies’.

We would like to think that the foregoing would influence the proposed changes, to the extent that they were abandoned. Realistically, we recognise that is highly unlikely, since no doubt the decision to implement the ‘proposed legislation’ has already been taken, and that you’re so called Public Consultation process is no more than a public relations exercise, reflecting the endemic deceit and spin under which the current administration operates.

Yours sincerely

Peter O’Loughlin.
For and on behalf of the Eden Lodge Practice,

CC. Right Hon. David Davies MP.