RESIDENTIAL TREATMENT DIRECTORY INSIDE

DDN
Drink and Drugs News
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'We are only scratching the surface of need... NICE estimates that only 6 per cent of harmful and dependent drinkers access services...'

A RISING TIDE

CHALLENGING TIMES FOR ALCOHOL SERVICES

Families First

The first Adfam/DDN family conference



Thursday, 15 November 2012 – BIRMINGHAM

While addiction can tear families apart, family support can be a huge factor in driving the successful recovery of both the individual and the whole family.

This conference will bring together family members –many of whom are providing support networks around the country – along with policy-makers and professionals. This is a must-attend event for family members affected by substance use and for all agencies and organisations who genuinely want to support them

Family members £90 + vat
Professionals £145 + vat

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Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

CONFERENCE PROGRAMME

9.30–10.30am **Coffee and registration**

10:30am **Opening session**
Chaired by Adfam chief executive **Viv Evans**, the session will include a national overview from NTA chief executive **Paul Hayes**, and **Christine Tebano**, founder of Parent Support Link, will give her personal perspective of setting up a family support service.

11:30am **Coffee break**

11:50am **Session two**
Alex Copello, consultant clinical psychologist at University of Birmingham, will present research on coping strategies for families and **Niamh Eastwood**, director of Release, provides advice on families, legal rights around bail, arrest, search warrants, and access to treatment.

12:30pm **Lunch**
Including relaxation therapy and the family groups' exhibition area.

1:45pm **Workshops**
Small practical workshops including help with criminal justice, practical coping strategies, boundary setting and the impact of alcohol

2:45pm **Afternoon session**
Dr Steve Brinksman, chair of SMMGP, will provide a GP's perspective on families affected by drug and alcohol issues and **Karen Biggs**, chief executive of Phoenix House, will examine how treatment services provide support for families.

4pm **Finish**

DDN Drink and Drugs News

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Editorial – Claire Brown

Word to the wise

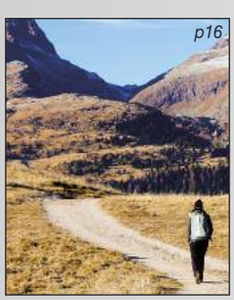
Why public health must not miss the message

'We are struggling to meet the levels of demand... we feel "rushed off our feet"... we realise we're only scratching the surface of need.' These comments from the service featured in our cover story (page 8) will ring true with so many of you. Coming from experienced workers at a community alcohol service, they should strike a note of panic with those planning the new public health landscape.

With the rise and rise of risky drinking and parallel increase in alcohol-related diseases, there's a burgeoning demand on resources at both ends of the spectrum, from prevention and early intervention work to end-of-life care – a trend that runs completely at odds with the chronic underfunding of alcohol services. Will Public Health England (PHE) listen to the expertise of specialists in this field? Its head, Duncan Selbie, (page 12) says he is looking forward to doing just that and making sure policy is evidence based. When PHE launches in the spring we'll see how responsive his organisation turns out to be to the stark evidence under its nose.

We know life's tough out there at the moment. This is our eighth anniversary issue and during that time we've seen the treatment landscape change beyond recognition. Let's hope our sector's expertise takes its place alongside value for money in the new Public Health England.

This issue



FEATURES

REGULARS

NEWS IN BRIEF

MYANMAR OPIUM INCREASE

Opium poppy cultivation in Myanmar increased by 17 per cent this year and has risen for six years in a row, according to UNODC, despite a 'significant increase' in government eradication efforts. The country is the world's second biggest opium grower after Afghanistan, accounting for around 25 per cent of illicit poppy cultivation worldwide, says *South-East Asia opium survey 2012 – Lao PDR, Myanmar*. Opium prices in Myanmar have also increased by 15 per cent, mainly as a result of currency fluctuations, and although smaller in quantity, cultivation in Lao also increased by 66 per cent this year. 'Eradication alone is not an effective response to reduce opium poppy cultivation,' said UNODC's Jason Eligh. 'We must remember why farmers grow poppy – in most cases it is because they need cash to buy food to feed their families.' *Available at www.unodc.org*

SHOCKING STATISTICS

The average age of death for homeless people is now 47, compared to 77 for the general population, according to Crisis, with the average age for homeless women even lower, at 43. Homeless people have 20 times the likelihood of dying from drugs, says *Homelessness kills*, and between seven and nine times the chance of dying from alcohol-related causes. 'For too long homeless people have been failed by the health system – frequently left unable to register with a GP or access the specialist services they need,' states the charity. *Available at www.crisis.org.uk*

BOOMER BOOZERS

The 'baby boomer' generation is the greatest burden on the NHS in terms of alcohol-related health costs, according to Alcohol Concern's new 'alcohol harm map', which offers a complete picture of alcohol-related health costs across England by local authority. Inpatient costs for the 55 to 74 age group – at £826m – are more than ten times those of 16 to 24-year-olds, the group usually associated with binge drinking. 'It is the middle-aged, and often middle-class drinkers, regularly drinking above recommended limits, who are actually requiring complex and expensive NHS care,' said chief executive Eric Appleby. *Available at www.alcoholconcern.org.uk*

Time for a 'fresh approach' to policy, says UKDPC

There should be a wholesale review of both the Misuse of Drugs Act and the drugs classification system, according to a report from the UK Drug Policy Commission (UKDPC).

The culmination of a six-year study, *A fresh approach to drugs* also calls for reduced sanctions for drug possession, more consistency in controls over all psychoactive substances, including alcohol and tobacco, and a review of penalties for all drug offences, although it recommends that the production and supply of most drugs should remain illegal.

Much of the spending on tackling illicit drug use, which UKDPC estimates at around £3bn per year, is not based on evidence, it says, with some policies – including seizures by police and border agencies – having 'little or no' impact. 'With some 42,000 people in England and Wales sentenced annually for drug possession offences and about 160,000 given cannabis warnings, this amounts to a lot of time and money for police, prosecution and courts,' the report says. 'On top of this comes the cost to the individual in terms of damage to employment prospects', with people also deterred from seeking help because they are 'doing something illegal'.

Existing drug policies have struggled to limit the damage caused by drug use, and are unable to keep pace with the ever-developing range of new substances, it says. With fewer resources available, a 'radical rethink' of responses is called for, says the report, which analyses how policies and interventions could be improved to create a 'fresh approach', with evidence taking priority and an 'environment that works to reduce dependence' and safeguard communities.

The report makes a range of other recommendations, including more action to tackle stigma and support families, as well as transferring responsibility for drug policy from the Home Office to the Department of Health and creating a cross-party political forum to develop dialogue about future policy direction. All drug policies should undergo 'rigorous and continual scrutiny' to make sure they are providing value for money, it adds, with a new independent body established to coordinate research.

DrugScope said it supported a review of the Misuse of Drugs Act, including the use of civil rather than criminal sanctions for personal possession of some drugs, and – although other recommendations were more challenging – serious public debate was welcome. 'The media and our politicians have an important role to play in shaping this debate, which should not be reduced to a black and white adversarial argument,' said chief executive Martin Barnes. 'Progress in this highly emotive and politicised arena will occur when policymakers and politicians can more openly express their views without fear of opprobrium.'

Meanwhile, a report from the London School of Economics and Political Science (LSE) says that international policy drug policy needs radical reform to 'remove outmoded, unscientific thinking'. Empirical data showing that the current system has failed is 'overwhelming', says *The global drug wars*, with the human cost of many international policies – which governments pursue through a mix of 'bureaucratic and ideological inertia' – rendering them 'unjustifiable'.

Available at www.ukdpc.org.uk and www2.lse.ac.uk

Scots consider methadone evidence

The Scottish Government has commissioned an independent expert group to 'objectively consider the evidence' supporting the role of opiate replacement therapy in treating problematic drug use.

The panel will make recommendations to the government to ensure that 'such medical interventions are being used appropriately and in line with the international evidence base'.

The move follows the announcement of a record number of drug-related deaths in Scotland in 2011 (*DDN*, September, page 4), of which methadone was 'implicated in, or potentially contributed to', 47 per cent. Although it was not known how many of the deaths were among people who had been prescribed the substitute medication, the *Daily Record* newspaper ran a number of articles highly critical of methadone prescribing and demanding a public inquiry.

The expert group will be led by chief medical officer Harry Burns, in collaboration with the independent Scottish Drugs Strategy Delivery Commission, and is expected to deliver its recommendations next spring.

'I highly value and respect the important work being done across Scotland by clinicians and professional practitioners in treating people seeking to tackle their own drug addictions,' said minister for community safety and legal affairs Roseanna Cunningham. While prescribed drug treatment had saved 'many thousands of lives in Scotland', however, it was the responsibility of professionals to 'determine the most appropriate treatment for each person seeking medical help with addiction problems', she added.

'The Scottish Government is clear that prescribed drug treatment is not, and cannot be, the only treatment option available on the pathway to recovery. People have a right to a full range of treatment and support options and to decide, in consultation with professionals, what is best for them.'

The chief medical officer's intervention could hopefully 'help to establish a consensus', said Scottish Drugs Forum (SDF) director David Liddell. However, it was unfortunate that methadone had become a 'political football', he added, with the numbers on substitute prescriptions used as evidence that Scotland's drug strategy was not working – a 'simplistic' analysis. 'We need to have our best politicians thinking more deeply about why people use substances and what responses can be made,' he said. 'Methadone is merely a response to a large-scale problem and it does not seek to address the cause. Politicians realise this fact in private but sadly their public utterances would sometimes suggest otherwise.'

SDF 2011/12 annual report available at www.sdf.org

Young adults seeking heroin or crack treatment at 'all-time low'

The number of young adults entering treatment for heroin or crack is at its lowest recorded level, according to figures released by the NTA.

There was a 23 per cent fall in the number of 18 to 24-year-olds seeking treatment for heroin in the last year alone, to just over 4,000, says *Drug treatment 2012: progress made, challenges ahead*, and down from more than 11,000 seven years ago.

Of the total treatment population, nearly 30,000 people successfully completed their treatment in 2011-12, up nearly 2,000 from the previous year and three times the number from seven years ago, while the total number of people seeking heroin treatment for the first time has fallen to just over 9,000 from nearly 48,000 in 2005-06. Heroin remains the main problem drug, with over 96,000 of the total treatment population of 197,000 seeking treatment for heroin dependency, and 63,000 for heroin and crack. Powder cocaine accounted for just 5 per cent of the treatment population, and cannabis 8 per cent.

The current recession had not produced the same levels of youth unemployment as in the 1980s, said NTA chief executive Paul Hayes – although unemployment and hopelessness among the young remained 'fertile territory for addiction' – and combined with this had been the scale of investment in treatment over the last ten years, something that 'cannot be guaranteed' in the current climate. 'There is a risk that squeezed local authorities will disinvest, not necessarily from treatment services, but from allied services that support recovery.'

The only age group whose numbers were increasing, however, were the over-40s, who now made up almost a third of the entire treatment population and represented a 'particular challenge', said Hayes. 'Some became addicted in the heroin epidemics of the '80s and '90s and are only coming into treatment now, and many are at risk of death as their health fails.' There were 802 drug misuse deaths among over-40s in 2011, says the report, 300 more than a decade ago and 500 more than among the under-30s.

Methadone remained 'an absolutely crucial first step for many people', Hayes stated, although too often in the past it had not been used as 'a platform for recovery'. 'The majority of, but not all, people with an opiate problem will pass through substitute medication, and it's important that it's available,' he said. 'But it's also important that it doesn't become a prop.'

The challenge was to deliver 'a truly integrated, balanced and recovery-oriented system,' said DrugScope chief executive Martin Barnes, something the treatment sector was capable of with the necessary resources and support. 'In difficult economic times there is a strong and compelling case for national and local investment in drug and alcohol treatment,' he said. 'We need to continue to make this case as the local funding and commissioning environment is changing, with the election of police and crime commissioners, the introduction of the new public health system and the establishment of Public Health England. Despite encouraging trends in declining drug use, drug and alcohol dependency continue to blight the lives of many, with harms and costs for individuals, families and communities.'

Meanwhile, a private members' bill to make lessons on drugs, alcohol and relationships compulsory in schools (see feature, page 10) has been introduced by Diana Johnson MP under the 'ten minute rule bill' procedure. The Relationship, Drug and Alcohol Education (Curriculum) Bill is backed by a range of organisations including Adfam, Mentor, Alcohol Concern and Turning Point.

Report at www. nta.nhs.uk

See news focus page 6

FORWARD FOR RECOVERY: Phoenix Futures service users have successfully completed their 1,800-mile sailing challenge around the coast of the UK, the Voyage of Recovery. The 80ft Tectona sail boat set sail in early August and arrived back in Plymouth on 25 October. Being part of the voyage gave 'a real sense of achievement that will stay with me forever,' said Donna Barry from Wirral. 'I've returned focused and at peace with myself.' Phoenix Futures chief executive Karen Biggs is profiled on page 18.

Budget cuts could reverse falling drug use rates among young people

Ongoing budget cuts and restructuring in the public sector are putting young people's services at risk and could threaten progress in reducing levels of drug and alcohol use (see story, left), says a report from the UK Drug Policy Commission (UKDPC) in association with DrugScope and Mentor.

Cuts to generic services could have a knock-on effect on substance misuse problems, warns *Domino effects*, with young people's services particularly vulnerable as provision often comes via 'a patchwork of funding streams' and a perception of them as peripheral to 'core business'.

While many treatment services for young people have so far been protected from budget restrictions, wider youth services that play an important role in 'drug prevention, problem identification and sustaining treatment benefits' are being harder hit, says the report, which draws on interviews with staff members from a range of services across nine local areas.

Ongoing upheaval in the public sector also means that services aimed at young people will need to compete with adult care budgets for funding, the document points out, with many organisations already cutting or reducing specific activities and looking for efficiency gains by reducing posts or sharing staff.

'Drug use among young people has fallen sharply over the last decade, at the same time as we saw a sustained investment in young people's services,' said report author and UKDPC director of policy and research, Nicola Singleton. 'That investment helped create joined-up services that allowed early intervention before specialist drug services were needed. Now these services are threatened by a combination of financial pressure and the speed and scale of the current public service reforms.'

Many young people who need help for drug or alcohol problems are also experiencing mental health issues, difficulties at home or school or involvement with the criminal justice system, said DrugScope's director of policy and membership, Marcus Roberts. 'Unfortunately, we've been hearing concerns from DrugScope's member agencies for some time now about the impact of local spending cuts and structural reforms on young people's drug and alcohol treatment. This report provides evidence that significant changes in the way that services are planned and commissioned, coupled with severe budgetary pressures, are threatening to undo the progress that has been made in treatment for this group over the past decade.'

HOW DO WE KEEP UP THIS MOMENTUM?

Fewer young people than ever are entering treatment for heroin and crack problems, and more people of all ages are successfully completing their treatment, says the NTA. What's behind the trends, and can they be maintained? ***DDN*** reports

Figures released by the NTA last month (see news story, page 5) show that the number of young adults entering treatment for heroin or crack is now at its lowest recorded level. In 2011-12, 4,268 18-to-24-year-olds came into treatment for heroin, down from 5,532 the previous year and from more than 11,000 in 2005-06.

Overall drug use – problematic or otherwise – among the young also appears to be falling, with 19 per cent of 16-to-24-year olds reporting using drugs in 2011 compared to 25 per cent in 2005. Fears that large numbers of young people would start to experience problems with substances like mephedrone also appear – so far – to be unfounded.

'While the number treated for mephedrone has risen in recent years, this has been offset by a corresponding decline for similar substances, such as ecstasy,' says the NTA's report, with the actual numbers remaining 'small compared to other drugs'. The total number of 18-to-24-year-olds coming into treatment for the first time for any drug fell from 18,500 in 2005-06 to 12,655 in 2011-12, a trend that's 'particularly encouraging', says the agency.

As the report states, the only age group where the numbers entering treatment are going up is the over-40s, who now make up almost a third of the entire treatment population. However, there's 'no evidence of swathes of people in their 40s and 50s starting to use heroin and crack', says NTA chief executive Paul Hayes. 'It's a population that started using 20 or 30 years ago.'

Much has been made of these trends in the media, so what's behind them? 'I'm surprised that everyone's surprised,' says Hayes. 'It's been going on for ten years.' The 'original pool' of people with heroin and crack problems is shrinking, he points out, while the current recession has so far not produced the same levels of youth employment that led to the heroin epidemic of the 1980s.

'I also think that young people are savvier about drugs like heroin and crack than they were in the '80s. And, like all social phenomena, drug use will ebb and flow as fashions change. One of my pet theories is that there's been a reduction in smoking, and if there is a gateway drug – particularly to cannabis – then it's tobacco. It's also cheaper to drink alcohol than smoke cannabis, and there's a plausible argument that the stronger cannabis that tends to dominate the market now puts a lot of people off.'

There is also a tendency to talk about the 'demographic of young people as something that doesn't change', he says. 'People are growing up in different familial and cultural environments than they were in the '80s.'

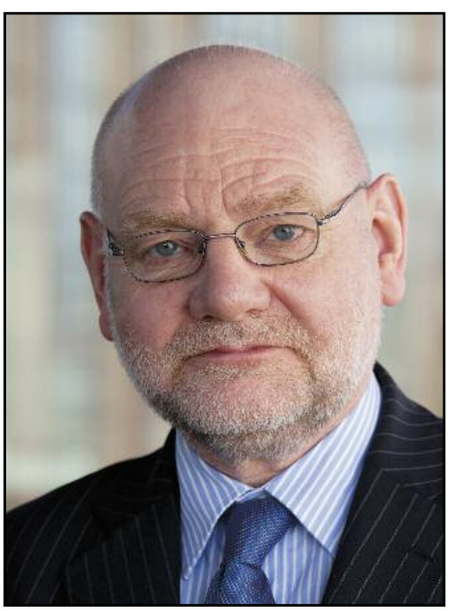
While all of this is encouraging, as the agency says, Hayes isn't complacent, warning of the risks associated with the economic climate and spending squeeze. 'The lesson from Greece is that disinvestment comes at a heavy price,' he says, with cuts in treatment and harm reduction services leading to the number of newly diagnosed HIV cases among injecting drug users rising from around ten in 2009-10 to 190 the following year.

In the UK, however, the biggest funding threat remains to the 'surrounding services – those allied to long-term recovery', he stresses. Direct investment in drug treatment will form part of the budget going to local authorities from next year and there will be 'mechanisms to ensure that's protected', he says, adding that 'we would expect it to be in local authorities' interests to continue to invest at that level'. As Public Health England will have responsibility for alcohol as well as drug treatment, however, another challenge will be balancing the two – 'meeting the unmet need around alcohol without disinvesting in drugs'.

The UK's treatment system has been 'big enough to accommodate anyone who wants to take advantage of it' for a number of years now, with methadone continuing to play a vital role, but the oft-made case for a need for more rehab places is overstated, he says. 'Many people in rehab drop out and end up in the community system, and there's no overwhelming evidence of a huge level of pent-up demand to go into rehab that's not being met. In a small number of cases there are commissioners who are more reluctant to provide it than we'd like, but the big story isn't community versus rehab, it's the difference between the rehabs themselves.'

On the subject of polarisation, arguments around decriminalisation and legalisation add little of value to the debate about improving treatment outcomes, he believes. 'Both extremes of this argument don't want to acknowledge that things are getting better, because that doesn't fit the radical change that either Peter Hitchens or Danny Kushlick want. It's very difficult to get a hearing for boring, bureaucratic clinical stuff. Seventy seven per cent of MPs [in a UKDPC-commissioned ComRes poll] said the system wasn't working. What I'd like to say to them – with more people successfully completing their treatment and drug-related crime falling – is what would it look like if it was?'

Drug treatment 2012: progress made, challenges ahead **available at www.nta.nhs.uk**



'Young people are savvier about drugs like heroin and crack than they were in the '80s. And, like all social phenomena, drug use will ebb and flow as fashions change.'

Paul Hayes

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Drug dealers are getting dogs hooked on heroin so they will attack police. Injections of the class A narcotic make the animal junkies extra fierce and aggressive as they are forced to go through detox.
Mirror news story, 8 October

Britain on drugs is where China is on hanging, Saudi Arabia on beating, Russia on censorship and the Taliban on girls' education. Drugs policy is the last legislative wilderness where 'here be dragons', a hangover from days when abortion and homosexuality were illegal and divorce expensive. It petrified home secretaries of left and right alike, Jack Straw and Jacqui Smith as much as Kenneth Clarke and Theresa May... The mere word drugs gives every politician the heebie-jeebies and turns libertarians into control freaks.
Simon Jenkins, *Guardian*, 16 October

Outside of Parliament, the drugs debate merely exists as a mildly titillating red herring for the public, the media, academics and politicians to feast on, while the damage continues. In respected arenas of debate such as *Newsnight*, in revered academic institutions and in the broadsheet media, the same talking heads – the celebrity legalisers and the zero-tolerance brigade – are wheeled out to lock horns in an often ill-informed, and ultimately pointless, war of words.
Max Daly, *Guardian*, 8 October

When I wrote a pamphlet advocating legalisation of cannabis in 2001, I was congratulated by friend and foe alike for my 'courage'. But it required no courage. On the contrary, for the first time in my career I felt the warm embrace of the liberal establishment. Interviewers asked me what questions I would like, confided that they had lined up a reactionary nutter to argue for prohibition, and quizzed me with almost embarrassing bias in my favour.
Peter Lilley, *Prospect*, 17 October

For all [the UKDPC's] careful analysis – their report is the result of six years' research – their conclusions remain somewhat theoretical. The fact remains that legalising or decriminalising drugs would still be a giant leap into the unknown. Yes, we can draw on lessons from the likes of Portugal, Holland and Switzerland, all of which have experimented with drug decriminalisation programmes, often successfully. But what works for one country does not necessarily work for another. Especially when it comes to our different national predilections for getting out of our heads.
Colin Freeman, *Telegraph*, 22 October

I've seen enough young people taking drugs to know that the 'illegal' label acts as come-on rather than turn-off. And I've seen enough mothers at the school gates on legal drugs to realise that 'legal' is often lethal.
Cristina Odone, *Telegraph*, 15 October

Last year three-quarters of admissions to hospital where alcohol was the main cause were the result of chronic problems rather than one-off binges. Stephen Dorrell, who heads Parliament's health select committee, suggests the government's alcohol strategy should now place more emphasis on public health. The party was fun. The hangover will be long, and painful.
Economist editorial, 6 October

LEGAL LINE

Release solicitor Kirstie Douse answers your legal questions in her regular column

WILL I GET INTO TROUBLE FOR TURNING A BLIND EYE TO MY TENANTS' CANNABIS PRODUCTION?

READER'S QUESTION:

I am a landlord of a flat that I own and rent out, and I think the tenants may be growing cannabis. I live in a different city so I'm not there often, but the last few times I have visited recently one of the rooms has always been locked. I have also noticed quite an increase in the electricity usage – the tenants pay for this but the bill is still in my name. They're good tenants – I don't want to make them leave. Could I get in trouble if they are doing this?

KIRSTIE SAYS:

There is potential for someone involved in the management of premises (eg a landlord) to be charged and prosecuted with an offence under section 8 of the Misuse of Drugs Act 1971, if they knowingly permit or suffer that property to be used for the production of a controlled drug.

Just being suspicious that production is occurring is not enough to be an offence, but being wilfully blind or ignorant of what is happening is likely to be. In your case, you have your suspicions and if you choose to ignore them without question there is a risk of prosecution.

If the police do investigate production of cannabis at your property, and consider your involvement or knowledge of this, they will look at the particular facts of the case. It will be relevant that you live far away and don't attend the property much, as this would indicate little opportunity to have knowledge of the tenant's actions. However, they will also take into account whether in the circumstances you should have known what was going on and just ignored it. The electricity bill being in your name and the increase in energy use would probably be used to indicate that you should have at least queried what was going on and in not doing so you were being intentionally ignorant.

Any action a landlord has taken to stop the illegal activity will be very important. Managers of properties often try to avoid prosecution for this offence by recording any warnings where they suspect a tenant is engaged in illegal activity. Although this tends to be used more in hostels/supported accommodation, it is something you can consider. Many tenancy agreements have clauses relating to criminal activity, and state that a breach of this can be grounds for possession and eviction. Taking these steps is likely to go in a landlord's favour, if not to avoid prosecution then to reduce any possible sentence.

Depending on the seriousness of the offence, considering the level of knowledge or involvement, there is a risk of a prison sentence for this offence. However, a community order is the most likely sentence, depending on any aggravating/mitigating factors including previous convictions for the same or similar offence.

Will you share your issue with other readers? Kirstie will answer your legal questions relating to any aspect of drugs, the law and your rights through this column. Please email your queries to claire@cjwellings.com and we will pass them on.

For more information about this issue please contact the Release legal helpline on 0845 4500 215.

'We realise we're only scratching the surface of need... and whenever we visit other health and social care agencies, or deliver training, we generate more referrals.'

Stem

Rising demand, increasing bureaucracy and a client group with complex needs are just some of the challenges facing alcohol services. **Hazel Jordan** offers a frontline perspective

As area manager for Islington Community Alcohol Service I'm aware that, despite the hard work of the team, we are struggling to meet the levels of demand. We feel 'rushed off our feet' and know that other alcohol services are in the same position. We realise we're only scratching the surface of need in Islington and whenever we visit other health and social care agencies, or deliver training, we generate more referrals – while NICE estimates that only 6 per cent of harmful and dependent drinkers access services, the estimate for Islington is 10 per cent.

Following the introduction of the alcohol strategy and increased awareness of alcohol harm, alcohol services are expected to extend their range of activities. We now offer preventative work and brief interventions to hazardous and harmful drinkers, as well as partnership working with probation. While we wholeheartedly support this strategic direction we need increased capacity to put it into practice, and at a local level we receive many requests to extend our activities further, such as working to reduce anti-social behaviour among street drinkers. There's so much more we could do, but we don't have the capacity to respond.

We also expect demand to continue to rise. Between 2001 and 2009 there was an increase in consumption levels and a 25 per cent increase in liver disease (37 per cent of which was alcohol related). While consumption seems to have reached a plateau, we expect referrals to alcohol services to increase, as people often approach services at a late stage of problematic drinking. The increase in prevention and early intervention work will also generate increased referrals to specialist treatment services, and is already doing so locally.

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It's estimated that alcohol harm costs society £21bn per year. It's the third biggest lifestyle risk factor for disease in the UK and 44 per cent of violent crimes involve alcohol, yet alcohol services have been chronically underfunded for many years. In order to reduce alcohol harm, in line with the alcohol strategy, investment is desperately needed. At this crucial point, we are extremely concerned that there is a serious risk to funding for alcohol services as a result of disinvestment from local NHS and local authority budgets and the transfer of funds to Public Health England, lifting the ring fence for drug and alcohol treatment funding. It's essential that funding for alcohol services is protected.

A high proportion of our clients have complex and multiple needs including poor levels of physical and mental health, traumatic personal histories, homelessness or insecure housing, unemployment, poverty, domestic violence, involvement with the criminal justice system and child safeguarding issues. There are also particular groups who need specialised treatment, such as older people with dementia, parents whose children may be at risk of harm and groups who

ming the TIDE

require additional support such as interpreting services.

Our role as alcohol workers is to coordinate treatment plans to address the full range of needs our clients bring. Alcohol use cannot be tackled in isolation. Pathways and joint working between different sectors, for example between mental health and alcohol services, can be difficult to establish and maintain and clients with both mental health needs and alcohol problems can easily fall through the net. In a climate of public expenditure cuts, we are finding coordination increasingly difficult as partner services are reduced. This in turn puts further strain on our capacity and stress on staff. The most vulnerable clients with the highest needs are losing out.

Strategic planning is needed at senior levels within the different sectors to ensure that joint working is possible at service delivery level. The alcohol strategy and NICE guidelines include such principles as 'one size does not fit all' and 'person-centred' care, and NICE guidelines also recommend a 12-week limit for alcohol interventions. The guidelines refer to a 'more intensive community intervention' and this fits better for clients with complex needs. They can and do recover from addiction, but this often takes time. In the context of stretched resources, however, the 12-week limit is often taken as the guideline for commissioning services and this risks failing to meet the needs of some of the most vulnerable members of society.

We are very concerned that, in the current climate, these most vulnerable people may be at risk of losing their services if payment by results (PbR) is introduced without specific safeguards. If PbR only focuses on final results – *ie* full recovery – services may be tempted to cherry pick those clients who are more likely to make progress quickly. Furthermore, some of the work we do with these vulnerable clients who are not ready to stop drinking is about minimising harm. This work directly contributes to Department of Health priorities of reducing alcohol related deaths and hospital admissions but there would be no results demonstrating recovery. It is absolutely vital that services that mitigate harm to the most vulnerable people, and their families and communities, are preserved if PbR is introduced.

Both adult family members and children can be profoundly affected by the drinking of a family member, and we are fortunate in Islington to receive funding to run a service for adult family members. There is clear evidence that involvement of adult family members in treatment can improve outcomes for alcohol and drug users. We also receive funding towards our family service for children, young people and families affected by parental alcohol and drug use via the Safer Islington Partnership. Parental alcohol and drug misuse is one of the three major causes of children being accorded child protection status, and young people affected by parental alcohol use have higher levels of alcohol problems and other mental health problems themselves.

Despite the evidence that services for families lead to better outcomes, we are concerned that they may be seen as 'extras' and risk losing their funding. It is essential that a clear funding pathway is identified for services working with children and families affected by parental alcohol and drug as currently neither children's services or adult substance misuse services see themselves as responsible for funding these crucial services. Investment to save the enormous human and financial cost of taking children into care makes sense.

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Then there are issues of bureaucracy and paperwork. Over the years the amount involved with our work has increased dramatically. We fully support the use of thorough assessment and care planning, national frameworks and guidelines but the level of detail that is specified by our national framework, *Models of care for alcohol misuse*, and its local implementation has resulted in staff and clients being required to complete at least ten forms, some of them lengthy, before a client starts structured alcohol treatment. Six of these forms need to be signed by the client, and we also need to enter every contact with a client onto an electronic database.

This is extremely time consuming and we would prefer that the paperwork was streamlined so we could spend more time with the clients – the activity that is key to understanding their needs and supporting them to meet their goals. Often clients present in great distress and/or are very unsure about engaging in treatment, an completing and signing multiple forms can be counter-productive to engaging some people at this stage.

As experienced alcohol workers we feel that outcomes for clients would be improved if we were able to exercise our professional judgement and if paperwork were streamlined. At a broader level, the amount of bureaucracy involved in commissioning and procurement of services places a huge burden on the capacity of services, effectively excluding smaller local services from the process. During the tendering process, members of the commissioning and procurement teams and managers of services spend many days carrying out their respective roles and clients and staff experience long periods of uncertainty about the future of the service.

When services are restructured and/or change hands there is a great deal of change to manage and adjustment required from clients and staff. We are fortunate to have a three-year contract that can be extended for a further two years. Often this commissioning process is repeated every three years. We aim to provide stability and structure for our clients but this is difficult amidst constant upheaval.

Longer contracts would help to reduce this upheaval. We also think clients would benefit if the commissioning process was streamlined and some of the resources spent on the commissioning, procurement, monitoring and restructuring of services diverted to direct service provision which is so desperately needed.

Hazel Jordan is area manager for Islington Community Alcohol Service, Blenheim CDP

With a bill aiming to ensure compulsory drug and alcohol education in schools making its way through Parliament, a new Adfam briefing looks at the role that education can play in prevention. **DDN** reports

The aim of the Relationship, Drug and Alcohol Education (Curriculum) Bill 2012-13, which has its second reading in the House of Commons later this month, is to make drug and alcohol education a compulsory part of the national curriculum.

Although many believe that effective education on substance issues should be a fundamental part of children's schooling, an internal review by ministers into Personal, Social, Health and Economic education (PSHE) that began two years ago has yet to report. 'Those working in the education sector tell us that schools infer from this that government sees PSHE delivery as irrelevant to education,' comments drug education charity Mentor, with 60 per cent of schools delivering drug and alcohol education once a year or less. Even then it is often 'poor, incomplete or totally irrelevant', the charity says, with 16-year-old pupils reporting that they get the same lessons as 11-year-olds.

Among the organisations urging the government to support the private members' bill – which is sponsored by Labour MP for Hull North, Diana Johnson – is Adfam. The call comes in a new briefing paper based on a roundtable discussion with service providers, drug charities and representatives from the children's sector, civil servants and the police, on the theme of 'where next for demand reduction?' in today's financial and political climate. The group looked particularly at how parenting and family relationships can influence young people's decisions.

'Reducing demand represents a major strand of the government's drug strategy, but progress has been slow compared to reform of the treatment system and the concentration on recovery,' says Adfam chief executive Vivienne Evans. 'It's harder to tell who's "responsible" for reducing demand, since so many cultural factors are involved – whose fault is it if demand goes up, and who do we credit if it goes down?'

While demand reduction is not the 'sole preserve' of drug education in school, it does present an opportunity for 'consistent, available and evidence-based interventions with most young people', states *Demand reduction, drug prevention and families*. Ensuring that education is delivered effectively across the country is 'a major, achievable and testable goal, so it's understandable that people focus on it sometimes', says Evans. 'It's interesting that the new bill was introduced by an opposition MP, but we are calling on government to support it and renew the focus that's been lacking during the ongoing delay with the PSHE review. Reducing demand for drugs should not be a partisan issue.'

The briefing is also clear that demand reduction initiatives need to look at root causes of behaviour, rather than simply focusing on a particular substance. 'The roundtable felt that it was not enough to show a school group "this is what cannabis looks like" or bring in someone in recovery to say "don't make the mistakes I made",' Evans explains. 'Robust demand reduction interventions need to ask what are the reasons young people use drugs? Yes, some will be experimenting like many young people do, but others might be impacted by other risk factors, including their parents' own use of drugs or alcohol.'

While there aren't the same discussions around 'recovery' for young people as there are for adults, it's still important to maintain a wider perspective, she says. 'We're less likely to be dealing with chemical addiction, so we need to examine the factors which support them to make positive choices around drug and alcohol use, and which might stop it becoming problematic or dependent' – such as confidence, self-esteem and healthy relationships with partners and friends as well as parents.

n cure

'It is not enough to show a school group "this is what cannabis looks like" or bring in someone in recovery to say "don't make the mistakes I made".'

The briefing also calls on the government to make sure that families have access to the most up-to-date information to enable informed discussions with their children – has it been doing enough to support families in this respect? 'I think there's a difficulty here,' Evans states. 'Government can't be too prescriptive or else their message won't be taken seriously by people whose own experiences contradict official messages – with "safe" drinking limits that many people regularly exceed, for example. But, on the other hand, if they say "we'll just leave it up to the parents" then it shows a lack of concern on what is a very important national issue.'

While government talks about the importance of supporting families, there is 'little evidence that there is consistent policy to back up the rhetoric,' she says. 'Ensuring a consistent approach towards drug education which is family inclusive would be a good starting point.' The new commissioning landscape also poses significant threats – as well as some opportunities – for family support services, which are often a vital local resource for parents, she continues. 'Ultimately this is about supporting open, honest and healthy relationships in families, rather than the government giving out one message to parents and saying "tell this to your children, and they'll never touch drugs".'

The briefing also wants local authorities and commissioners to recognise the knock-on effects that cutting young people's services can have – does she feel the full impact of cuts to wider services is appreciated or understood by government? 'Understanding at government level doesn't necessarily translate into local action, where the cuts are really being made. Evidence has suggested that Eric Pickles' *Best value statutory guidance*, which told local authorities not to make disproportionate cuts to the voluntary and community sector, hasn't been heeded,' she says.

'I think the point made by the *Domino effects* report (see news story, page 5) is the key argument – young people's drug use is actually falling, and we risk undoing this if disproportionate cuts to young people's services go ahead. If we can convince the government that this would be a demonstrable failure in one of its key aims from the drug strategy, we might see stronger directives.' **DDN**

Briefing at www.adfam.org.uk

Places are still available for the DDN/Adfam *Families First* conference in Birmingham on 15 November. Details at: drinkanddrugsnews.com/adfam-conference-2012

FAMILY MATTERS

STIGMA STICKS

Listening to families can help them overcome stigma, says **Joss Smith**

FAMILIES ARE OFTEN HIDDEN FROM POLICY DISCUSSIONS AROUND DRUGS AND ALCOHOL AND STIGMA IS NO DIFFERENT.

The impacts of stigma on the whole family can be insidious and pervasive, leaving families frozen with the trauma and suffering that comes with having a loved one abusing substances.

We know that a well-informed, well-engaged and well-supported family member can have a positive impact on their loved one's recovery and on their own health and wellbeing. We also know that stigma and shame prevent families seeking that support. Adfam wanted to talk to families further to understand how this stigma manifests itself in their everyday lives and how they feel it prevents them and their relative from making positive changes. We spoke to four focus groups around the country, families who have either experienced or are still experiencing stigma from communities, professionals and even friends and families. We didn't seek to generate stats but wanted to share their often unheard narratives and thoughts on how things could change, and we launched the report *Challenging stigma; tackling the prejudice experienced by the families of drug and alcohol users* on 31 October.

One of the most striking experiences the families described was that of isolation. Once people knew, or it was rumoured, that someone in the family was using substances, the phone stopped ringing, people crossed the street to avoid them, trust disintegrated at work or people became twitchy about their property. One wife whose husband was using cocaine said: 'I've stopped going out and communicating with anyone, and I can't mention his name to my family as it is like mud. They probably think I am an idiot and going to become untrustworthy.' The families also talked about a sense that this label was going to stick with them and their family no matter what they did. One family member in Lambeth said: 'I got people saying "oh you must be a low life because why would you want to be with a heroin addict?"'

Hope and persistence were very apparent, however – hope that their loved ones could make positive changes and recover. But to support the substance user, they needed help themselves. Families' lives can be led into chaos, and attempting to maintain faith in the recovery journey takes an extraordinary level of resilience and strength. One mother said: 'Even if it's your own child, other family members or neighbours can make you feel very hurt, very depressed and you're very stressed out already. By people not supporting you it makes it worse. You think it is something you did.'

With the help of specific services, families can begin to understand addiction and recovery and find the strength to support their loved one appropriately. As one family member explained: 'You get great strength to support them in the end, but it takes a long time to get used to the idea of what has happened.' These family support services do exist – not as many as we would like and not in all areas that they need to be, but often the sense of shame and stigma stops families reaching out. The stigma that families face needs to be challenged. We need to find a way for families to access support, improve the quality of their own lives and help strengthen the recovery journey of their loved one.

Joss Smith is director of policy and regional development at Adfam, www.adfam.org.uk

The first City Health conference, held in London, set the scene for planting drug and alcohol treatment at the heart of the new public health agenda. DDN **reports. Photos by** Gill Bradbury

'Drug and alcohol problems are a symptom rather than the cause, and we need to treat the individual, not the symptom.'
Hugh Morris

'We are all in this together – no one owns health.'
Duncan Selbie

'We have been worried about the rampant moralism of recovery.'
Eliot Albers

Public h

The formation of Public Health England (PHE) will herald a new era for delivering drug and alcohol treatment, Hugh Morris, chair of the London Drug and Alcohol Policy Forum, told delegates at the first City Health conference in London. There would be a real opportunity to work with individuals within their social context to address all of their needs, and the emphasis would be on partnership working across all areas of health that boost a client's wellbeing.

'Drug and alcohol problems are a symptom rather than the cause, and we need to treat the individual, not the symptom,' he said. To achieve this in the current culture of budget tightening and cost cutting would mean being innovative and learning from examples of good practice around the world.

This was echoed by Duncan Selbie, chief executive of newly formed PHE, who said it was 'a stroke of genius' to bring public health back into local government by giving them a legal duty to improve health, as historically this had always been the case.

'We are all in this together – no one owns health,' he said, before emphasising the importance of making improvements to people's access to employment, housing, and local community infrastructure. He promised to concentrate efforts on the poorest groups in society and to address current health inequalities that have created a 15-year gap in life expectancy, depending on postcode.

In common with all public services, 'cost savings across back office functions must be pursued', he said, but pledged that budgets for next year would be kept at current PCT levels. He told delegates that it was up to them to show that what they did worked and make the case for maintaining their budgets, and also stressed that 'the biggest savings will be made by early health interventions'.

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How would drug and alcohol treatment fare as part of the new public health approach, delegates wanted to know.

'Can you give us a guarantee that we won't be forced off maintenance scripts?' asked Eliot Albers from the International Network of People who Use Drugs (INPUD). 'We have been worried about the rampant moralism of recovery – can you give us reassurance?'

Selbie stressed that PHE would be professionally led and would make sure treatment was evidence based. 'There's nothing moralistic about that,' he said. He left the conference promising 'a much deeper conversation' in six months time, when PHE was fully staffed.

In the following session on urban health dynamics, Professor Phil Hanlon of Glasgow University looked at 'what's next for the health of society'. The UK's 'trivial' drug problems of the 1970s were now comparable to Afghanistan, 'because we've taken the benefits of modernity and pushed them too far,' he said. 'We've created consumerism and more people feel stressed, overwhelmed and unhappy.' Public health was on the brink of transformation, he suggested, and we were in for 'a bumpy ride, but not a continuation of the same'.

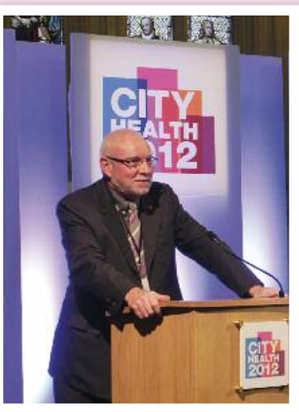
Senator Larry Campbell brought his perspective on 'changing the status quo' from Vancouver, where, as mayor, he had been involved in dynamic harm reduction efforts including the first safe injection site in North America.

Forming a coalition to look at crime prevention and tackling addiction had been the way forward, he said, including neighbourhood groups, NGOs and businesses. They had involved VANDU, the local network of drug users, from the start, and had welcomed homeless people to the free meetings by offering refreshments. One of the many tangible outcomes was Insight, the registered injection site, which offered healthcare in all its forms.

'You can change the status quo but it takes a single group of like-minded people who are prepared to go down a voyage of discovery,' said Campbell. 'You can go all over the world and find programmes and what works, but it takes effort on the part of citizens to get involved.

'You have to be in it for the long run,' he added. 'You have to fight people and

'We've created consumerism and more people feel stressed, overwhelmed and unhappy.'
Professor Phil Hanlon



'You have to fight people and know that you're in it to save lives.'
Senator Larry Campbell

'We need to let the public know about the real dangers, rather than just saying "drink responsibly".'
Professor Mark Bellis

'The situation with hepatitis C is going to get grimmer'.
Professor Graham Foster

ealth challenge

know that you're in it to save lives.'

Professor Mark Bellis brought the focus back to the UK with a sobering look at drinking habits, likening the picture to Hogarth's Gin Lane.

'Around 50 per cent of all violence in England and Wales is alcohol related and around 50 per cent of adults avoid city centres at night because of alcohol,' he said. Cheap alcohol and longer opening hours shaped the way we drink, with people drinking more in a single night out than government recommendations for a whole week.

'It's illegal to sell alcohol to a drunk person but just three people were prosecuted in 2010,' he said. Furthermore, city centre statistics did not reflect the wider damage to families and from incidents and regular drinking habits in private environments: 'People are dying in part due to a toxigenic approach.'

The range of options for tackling this included environmental management, earlier support, limiting alcohol sale times and increasing prices.

'We need to let the public know about the real dangers, rather than just saying "drink responsibly",' he added.

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Speakers considered the 'traditional' public health challenges, such as infectious diseases, alongside emerging issues, such as new drugs and evolving social behaviours.

A very modern public health problem was presented by Dr Owen Bowden-Jones of Central North West London NHS Trust, who looked at the continuing rise of club drugs. At this year's Glastonbury Festival, benzylpiperazine (BZP) overtook cannabis as the drug most confiscated by police. In an anonymised survey in Soho by drug intervention database Tictac, urine samples showed a high concentration of new psychoactives – so-called 'legal highs'. A further sign of their popularity was in the growth of online sales outlets, from 314 sites in 2010 to 690 a year later.

Given evidence of usage, the small numbers of people presenting for drug treatment indicated that users of new psychoactives either did not encounter problems, or if they did, they did not want to be associated with traditional drug services or consider them appropriate for their needs, said Bowden-Jones. Through setting up the Club Drug Clinic in Chelsea and Westminster Hospital, it was established that there was a definite need for the service. By making self-referral easy, by email and by mobile phones via QR codes, they had attracted clients with an average age of early 30s from across London and beyond.

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Reminding delegates of some of public health's toughest challenges, professor of hepatology, Graham Foster, warned that the situation with hepatitis C was 'going to get grimmer', with many older patients now needing palliative care.

'The virus is spreading and the epidemic is getting bigger,' he said, adding that the Health Protection Agency's figure of 6,000 infections a year was a 'gross underestimate' and that the problem would get much bigger in the next ten years.

'We need a new treatment model that deals with patients where they want to be treated,' he said. The population of active drug users had shown a good success rate for cure and for disease-free survival – 'therapy can be given, people can be treated, they can be cured'. A study in Bristol had shown that by treating just a small proportion of injectors, the spread of hep C could be halted and the disease eliminated.

To eradicate hep C would need political support, funding – which wouldn't be cheap, but a viable alternative to expensive deaths or homeless people dying on the streets – and staying power for a concerted effort over the next ten years.

'If we do nothing it's going to get worse on our watch – it's going to be us stepping over bodies on our way to work,' he said. 'We can eliminate this and we should.' **DDN**

ENTERPRISE CORNER

A SENSE OF PURPOSE

Helping people to regain their stake in society can help to transform lives, says **Amar Lodhia**

We've been trying to get our heads around government policy on 'joined-up' working between departments to tackle multiple social disadvantage.

Trawling through the well-presented but often redundant strategy documents, it is evident that while self-employment is an incredibly powerful social change platform – yes we've proved it – the pennies haven't dropped in Whitehall yet. Surprising, because from where I am standing self-employment could be a way for them to swap the pennies falling out of their holey pockets for pounds in the public coffers. If I was prime minister I'd certainly put 'rocket boosters' under that.

Instead, David Cameron announced in his law and order speech last month that he is going to put 'rocket boosters' under payment by results (PbR). His hope is that the social investment market will enable the voluntary sector to deliver these contracts. Mr Cameron may actually be beaming himself to a starship in a far away galaxy, but it is definitely not one called 'Enterprise' (or social enterprise) – again the prime minister has missed the majority of the voluntary sector out.

Earlier this year, in partnership with a 'magic circle' law firm, we completed the development of our social investment vehicle. As it stands, to attract investment and deliver any type PbR contract would prove nothing short of a bureaucratic and regulatory headache, even if we managed to work around the regulation.

Staying on the subject of law and order, with 90 per cent of the prison population suffering from a mental health issue, what needs to be done inside is 'retributive rehabilitation'. Breaking the cycle of reoffending, which costs the taxpayer over £15bn annually, requires giving offenders positive purpose by designing a system that enables them to overcome the barriers and stigma they face on the outside – *ie* access to employment with a criminal record, and housing provision. Many of the adult offenders we interviewed as part of our research for the MoJ found that many offenders do not have a fixed address when they leave, and often they have to travel long distances (which cost more than £46) on release. So offenders may often commit crime just to get food and a roof over their heads.

At the Conservative Party conference, I co-hosted a fringe event with ResPublica and I reiterated my message that rehabilitation is done best through finding one's 'purpose'. I have spent half a decade working with people to find their purpose and stake in society and having personally found mine through entrepreneurship, I was able to transform my life from a young homeless, substance misusing offender to a serial entrepreneur – so I'd like to think I am a living example of my own message.

For me, the key purpose will be not only to tackle the raft of problems, but to unlock the aspiration the prime minister so passionately wants to prove Britain can have. We must never forget that great talent can come from anywhere. We all want the same thing – to transform our country into what it should be, a leader in skills, the best place in the world to do business, and a population made up of talented entrepreneurs who have aspiration to succeed.

If you are interested in seeing our work in action, email me for a free ticket to attend our grandest event of the year on the 14th November 2012 during Global Entrepreneurship Week.

I'd also be interested in hearing your views. Contact me at ceo@tsbccic.org.uk and follow us me on Twitter @amarlodhia or @tsbclondon – don't forget to use the #tag DDNews

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC)

LETTERS

'I don't wish to hail Mr Hayes as a great visionary, but on this occasion maybe he did get it right. Is there a chance that by winning an important moral victory, we will have lost the battle?'

BE CAREFUL WHAT YOU WISH FOR...

At several conferences over the last few years, including at least twice at *DDN* service user involvement conferences, I have had the pleasure of hearing NTA chief executive Paul Hayes speak. At these events he has been challenged on why funding for drug treatment has been made available to tackle perceived drug related-crime, and several times faced impassioned pleas that drug use should be seen as a health issue, not dealt with by the criminal justice system. On each occasion Mr Hayes has agreed with the questioner, but urged them to take a pragmatic approach, pointing out the competition that budgets would face within a wider health and social care context.

I came across a 'conference special issue' of *DDN* from 2008 and Mr Hayes says: 'Service users as a group are unpopular with the public, compared to old ladies who need hip replacements or babies in incubators. You are seen as the authors of your own misfortune – there is no way we can hide from that.'

Mr Hayes impressed on delegates that while the NTA was working to transform the negative image of drug service users and challenging attitudes towards them, its main business was to use criminal justice-led funding to improve treatment.

'We are in the business of doing good by stealth. Reject the victim label, but also the fantasy that if everyone would stop stigmatising you everything would be alright,' he urged. This view was so deeply unpopular that on several occasions what he was saying was drowned out by loud booing from the audience.

Fast forward four years and the UK's visible recovery movement has made great inroads into challenging stigma and having substance misuse recognised for the health problem it undoubtedly is. This will culminate in April of next year when responsibility for drug treatment will be administered by the new Public Health England. Surely this is being hailed as a major victory within the field, and there is much rejoicing across the land?

It would seem not. All I currently hear is concern that drug treatment budgets will be plundered by other areas of public health, and how the future removal of ring fencing will lead to vast reductions of the amount spent on treatment, with local directors of public health diverting the money to old people's services or child welfare. I don't wish to hail Mr Hayes as a great visionary, but on this occasion maybe he did get it right. Is there a chance that by winning an important moral victory, we will have lost the battle to maintain the high levels of funding the field has been enjoying. Is it a case of be careful of what you wish for? I hope not.

T Small, by email

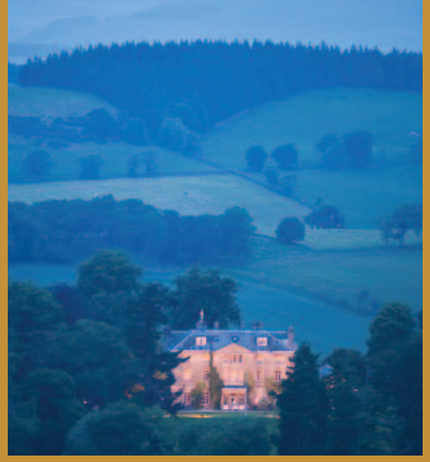
CORRECTION

In our last issue, the article *Joint Forces*, (*DDN*, October, page 15) was attributed to Cinzia Altobelli. It was in fact written by her colleague Cat Payne, therapeutic practitioner/tutor at Action on Addiction's Families Plus team.

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.





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THE ROAD LESS TRAVELLED

Methadone's dominance over Suboxone in substitute prescribing may have more to do with cost than effectiveness. It could be time for a reassessment, say Neil McKeganey, Christopher Russell **and** Lucy Cockayne

Within the drug treatment field there are few more controversial subjects than the role of substitute prescribing. For some people, drugs such as methadone and Suboxone represent a lifesaver, enabling individuals to reduce or cease their use of street drugs and stabilise their lives as a prelude to their eventual recovery and rehabilitation. For others, the prescription of these drugs on a maintenance basis is little more than a form of state-sponsored addiction.

The importance given to recovery in the UK drug strategy has brought renewed attention to the role of substitute prescribing, with the NTA recently publishing revised guidance on how to maximise the beneficial impact of opiate substitute treatment within a recovery-oriented treatment system.

In the period since the mid-1960s, when Vincent Dole and Marie Nyswander undertook groundbreaking work, methadone has become the mainstay of addictions treatment in countries across the globe. In the UK it is estimated that something in the region of 166,000 drug users are receiving opiate substitution treatment, the vast majority of whom are being prescribed methadone.

We know from research that methadone reduces drug users' risk of overdose, needle and syringe sharing, and of becoming HIV and HCV positive. Research in Edinburgh has also shown that drug users who are prescribed methadone have a significantly reduced risk of dying from drug-related causes (Kimber *et al*, 2010). We also know that drug users prescribed methadone commit fewer crimes, remain in contact with drug treatment services for longer and have a more stabilised lifestyle. But what we do not know is how good methadone is at enabling individuals to recover from being psychologically or physically dependent on opiate drugs.

The Edinburgh based research undertaken by Kimber and colleagues gave some cause for concern in this respect, with evidence showing that methadone may lengthen, rather than shorten, the period over which individuals remain drug dependent. The drug users who had been prescribed methadone in this general practice based study had a mean injecting career of some 20 years compared to a mean of nearer five years for those who had not been prescribed methadone. 'Exposure to opiate substitution treatment was,' the authors pointed out, 'inversely related to the chances of achieving long term cessation.'

Along with the worry that methadone may lengthen the duration of an individual's dependency, there has also been growing concern at the increasing proportion of drug-related deaths that are in some way connected to methadone. In Scotland, for example, some 47 per cent of drug user deaths were recently shown to be connected with methadone (*DDN*, September, page 4), although it's not known what proportion of those deaths involved individuals who had sourced their methadone on the streets rather than being prescribed the drug.

In the light of those concerns it's understandable that attention has come to focus on other substitute medications that may offer some of the benefits of methadone without the additional risks. One such drug, the buprenorphine/naloxone combination Suboxone, has been licensed for use in Europe since 2006.

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According to the National Institute for Health and Clinical Excellence (NICE) there is very little difference between buprenorphine and methadone in terms of their therapeutic effect and therefore, according to NICE, the decision as to which drug to prescribe should be based upon an assessment of the individual drug user's circumstances.

On the basis of that advice one might have thought that Suboxone and methadone would by now be prescribed at a broadly similar rate. This is certainly the case in Norway, with methadone prescribed to 56 per cent of those receiving opiate substitution treatment compared to 44 per cent who are on Suboxone. In Sweden, 48 per cent of those on opiate substitution treatment are receiving methadone, compared to 52 per cent who are being prescribed Suboxone.

The picture in other European countries, though, is strikingly different. In Germany, 81 per cent of opiate substitution prescriptions are for methadone compared to 19 per cent for Suboxone. In Denmark, the proportions are 82 per cent for methadone and 16 per cent for Suboxone, and within Scotland it has been estimated that there are around 22,224 drug users being prescribed methadone compared to what is likely to be only a few thousand being prescribed Suboxone. Similarly, within England, the vast majority of those drug users on opiate substitution treatment are being prescribed methadone rather than Suboxone.

The preponderance of methadone over Suboxone prescribing in some countries but not others is puzzling and may have more to do with the relative price of the two drugs than their therapeutic effect. NICE, for example, has advised that because methadone is the cheaper of the two drugs it should be the first-line treatment. Similarly, the national clinical guidelines ('orange book') reiterate the view that if both treatments are equally suitable methadone should be the first choice treatment. Within a treatment culture focused on enabling drug users to become drug free, however, there may be a reason for considering the wider use of Suboxone.

In recent research in Scotland, drug users prescribed Suboxone were substantially more likely to have experienced a drug-free period than were those prescribed methadone (McKeganey *et al* 2012). In this study the researchers followed two groups of drug users over an eight-month period – one group had been prescribed methadone and the other Suboxone. Importantly this was not a randomised controlled trial and the total number of drug users followed – at 109 – was not large. Nevertheless the findings from the study research were striking.

The two groups of drug users were similar in terms of their age, gender, number of days they had been using heroin over the last three months, and the ages at which they began using heroin and at which their heroin use became a problem. The groups were also similar in their desire to be helped and in their mental health. Where the groups differed was in their readiness for treatment, with the Suboxone group scoring higher than those being prescribed methadone on this measure.

Despite the multiple similarities between the two groups they differed markedly in terms of their treatment outcomes. In the case of those drug users prescribed Suboxone, the mean number of days on which they used heroin over the last three months fell from 38.6 days at study intake to 8.5 days at the eight-month interview point. In the case of the methadone patients the reduction was from 37.4 days at intake to 24.1 days at the eight-month interview point. Whilst both Suboxone and methadone were associated with a significant reduction in the frequency of heroin use, the effect size for Suboxone was substantially greater than that for methadone. Both treatments were similarly effective in enabling drug users' attempts to remain drug free (preventing relapse) where the individual had ceased his or her drug use at the outset of the study.

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Within a treatment culture where increasing attention is being directed at becoming drug free, and where there is mounting concern at the increasing proportion of drug-related deaths associated in some way with methadone, Suboxone may come to be prescribed much more widely within the UK even despite its greater cost, and we may come to see much closer parity between the two drugs as part of an opiate substitution treatment regime.

The research described in this article was supported by an unrestricted, unsolicited investigator-initiated request from Reckitt Benckiser who had no role in study design, data collection, analysis, interpretation of data, writing of the manuscript, or the decision to submit the manuscript for publication.

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A referenced version of this article is available on our website, www.drinkanddrugsnews.com

Post-its from Practice

Time to change

We must stop talking numbers and develop a real interest in positive health outcomes, says Dr Steve Brinksman

During October each year we have the annual SMMGP conference, which this year was in London. It was our first conference since becoming a registered charity and as such it was followed by our first ever AGM.

The day was well attended as always and had a stimulating line up of speakers and challenging topics. Taking part in a question and answer final session with Linda Harris from the RCGP and Pete Burkinshaw, chaired by Post Its from Practice's previous contributor, Chris Ford, it became clear to me that shared care as we know it must change. To clarify, I do genuinely believe that a primary care based treatment system cannot be effective if it entails no more than a GP signing prescriptions for OST. And whilst I know this is not what happens in most shared care schemes, to date this is what our contracts have usually paid us for.

We are moving into an era where public health is to be the driving force behind drug and alcohol commissioning, albeit, I hope, with strong links with progressive minded and proactive clinical commissioning groups. We must recognise that those of us in primary care working with drug and alcohol users need to show the added value of the care we deliver above and beyond the provision of a prescription. If we are not able to do this – especially in a landscape of competitive retendering of services – then economies of scale will dictate that providers consider reducing costs by employing centrally based doctors rather than the multi-practice approach currently found in many areas.

So not only do we need to loudly proclaim the obvious benefits of primary care treatment both as provider and users of these services, but also we need to highlight the less obvious but still tangible benefits that occur as a result of this.

Primary care based treatments offer easy access to locally based programmes that can be delivered by practitioners with an intimate understanding of the local community – services that are delivered in a non-stigmatising setting and that can accommodate the complexity of poly-drug use in people who often have other co-morbid medical conditions.

The time has come for us to move away from the blunt instrument of a payment system that is purely based upon the number of patients prescribed for, and I issue a challenge to both primary care practitioners and more importantly to commissioners to develop mechanisms that measure the positive health outcomes achievable in primary care and stop simply counting 'bums on seats'.

Shared care has contributed dramatically to improving services, something we can be proud of. It may well now become a historical note in the evolution of drug services, however I believe in transforming it – we can usher in an era where primary care is acknowledged as a major provider of evidenced based, recovery orientated high quality care within an integrated treatment system; and one that keeps the individual at the centre. It is a place where those wishing to embrace abstinence, and where those whose recovery ambitions might entail many years in treatment, can both be supported.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP. www.smmgp.org.uk. He is also the RCGP regional lead in substance misuse for the West Midlands.

Voyage

With its Voyage of Recovery just completed, **David Gilliver** talks to Phoenix Futures chief executive Karen Biggs about overcoming polarisation and embracing change

When Phoenix Futures won 'best employer' at the recent Third Sector Excellence Awards, one of the reasons cited – alongside the organisation's commitment to volunteer involvement – was that 11 per cent of the staff and 10 per cent of management had graduated through the service themselves. 'That's part of who we are,' says chief executive Karen Biggs. 'We came from a self-help origin, and the fact that graduates of our services and service users are deeply involved in the culture of the organisation we take for granted. You forget that that's impressive to other people.'

She's been chief executive since 2007, overseeing 700 staff and nearly 90 services across community, prison and residential settings, following a 17-year career at Stonham Housing Association. Much of her time there was spent running supported housing services for prolific offenders, and a feeling that she was ready for a change coincided with being headhunted for the Phoenix Futures job. 'When I saw the other candidates I thought I didn't have a chance,' she says.

It was meeting Phoenix's service users, however, that convinced her that the position was something she wanted. 'As part of our recruitment process we get our service users to take people around – they spend a good few hours with them before they see us or the board, and that was the experience I had. They gave us a tour of the house, talked about their programme and their life, and I thought, "if this is the core of the organisation – if the people going through that programme are so aware and passionate and active – then I really want to lead it."'

One aspect of the staff involvement that impressed the awards was the organisation's annual 'innovation factor' competition, which encourages employees to come up with new ideas, with a cash prize for the best. 'Lots of third sector organisations say "we're really innovative" so we challenged ourselves to prove that,' she says. 'We knew that people from across the organisation had really good ideas, but we didn't always get to hear them.'

The fact that the ideas are implemented by the organisation also encourages people to think big, she says – 'we get lots of little ideas where we'll say "just go ahead and do it"'. The first winning entry was the Phoenix Forest, where a tree is planted for everyone who's stayed drug or alcohol free for a year after completing treatment. 'We do an annual planting and it's a mark on the landscape for recovery – there's all sorts of symbolism from that, because you normally plant trees for people who are dead. They're tiny trees at the moment but there's a lot of them. I didn't think we'd ever get a better idea, but we did.'

The follow-up was the Voyage of Recovery, which saw groups of service users taking part in a sea voyage around Britain (*DDN*, March, page 15). 'The idea doesn't have to – and this one certainly doesn't – save the organisation money, but it has to be able to deliver what we do in a different way and pursue our mission,' she says. 'The panel said, "clearly it's the best idea but we can't do it – it's going to cost us £70,000 and it's a hundred service users currently in treatment going around the country." But I thought we can't not do it because we're scared of it.'

The 1,800-mile sea voyage has had a profound effect on the lives of those who have taken part, she stresses. 'I've lost count of the number of times I've been told, "it's an experience I would never have expected, it's given me the courage to go on with the next part of my life". A guy in his mid-30s told me told me that not only had he never been on holiday – that isn't uncommon among our service users – but he'd never left Birmingham his whole life, and he had the courage to say, "yes I want to do this". That tells you so much about the disadvantage we deal with.'

The trip was 'by no means a holiday', however. 'They've had to work really hard, but just to go and do something different was really important. I feel it's our responsibility to be able to give our service users experiences that they've never had before, because that could be the key to unlock the potential for recovery – that's a good enough reason.'

The effect has also been felt further afield, helping to raise awareness in local communities as service users raised money for their leg of the voyage through activities like packing customers' bags in the supermarket. 'As they're doing that, with a Phoenix t-shirt on, people are asking "what's Phoenix?" We're reaching people we would never have reached and raising the profile of the services.'

A core belief of those services is that people have the potential to rebuild their lives, she states. 'We first meet people because of their drug and alcohol issues, but if we just did treatment we'd only be doing half the job. Giving them experiences like the voyage, but also the employment stuff we do, the housing stuff, that's what makes the difference.'

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From being abstinence-based in its early days, Phoenix Futures now delivers both abstinence-oriented and harm reduction services. Coming from outside the sector – 'I still feel like the new girl,' she says – the polarisation between the two was something she didn't understand.

'I genuinely didn't get it. I'd worked in an organisation that delivered services for people fleeing domestic violence as well as for perpetrators of domestic violence. I thought if you can do that within one organisation why can't you deliver two different types of treatment that ultimately are aimed at the same thing? Yes, we came from an abstinence-based organisation but we've grown and developed – we did some of that organically and some of it was a strategic decision. I think as a sector we're starting to get over [the polarisation] but it's been quite hard. It's because people believe so passionately in what they do – that creates that ideological drive that sometimes is really helpful but sometimes isn't.'

On the subject of polarisation, as the cuts and restructuring continue, there's been criticism of services transferring from the NHS to the third sector, with RCGP chair Clare Gerada stating that 'if we only have the third sector and general practice we won't achieve anything' (*DDN*, July, page 18). How does she respond to those views?

'I think we've got to be really careful that that doesn't become the new big fight, because that would be so self-defeating,' she says. 'But my response is the same – you need a multiplicity of providers. There are some things that I think the bulk of the third sector are good at and some things that the bulk of the statutory sector are good at. For Phoenix I'm really clear about what we do, and I think we really stretch the organisation – geographically and in terms of the settings we provide services in – prison, community, residential and then branching out into the employability, housing and family stuff. For me that's enough.'

Phoenix looks to its partners for clinical provision, she explains. 'If we go into tenders we look for good partners who share our vision and have high levels of clinical governance. Sometimes it will be a third sector organisation and sometimes it will be a statutory organisation, and we've got some nice arrangements with mental health trusts. I'm not saying it's really easy, because there's a dynamic that happens in those services between statutory staff and third sector staff – NHS and Phoenix staff – but for me that's where that dynamic should happen, because they're working out on the ground how to move people through a treatment pathway more quickly. That's where the real impact's going to be.'

e of discovery

'We first meet people because of their drug and alcohol issues, but if we just did treatment we'd only be doing half the job...'

Her vision for Phoenix Futures is not to be the biggest but 'one of the best', she states. 'I want us to be really clear about what we're good at and to deliver good, local, responsive services so I can be sure that if one of my family members needed these services, it wouldn't matter where they lived, we could provide a service that met their needs. And we wouldn't say, after six months, "goodbye – go and find someone else to sort out your housing and family issues, and you need a job but someone else will help you with that."'

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Phoenix Futures' aim is networks of local services, some delivered by themselves and some in partnership, that 'really settle people on their recovery journey', she says, with the organisation clear about the point its job is finished, the person has the confidence to out on their own, and the community – whether a recovering community or the local community – takes over.

She's expressed concerns in the past that the transfer to Public Health England would divert money away from specialist services for vulnerable groups, but feels that the sector now needs to accept that change is happening. 'I think it's a challenge but I think we need to positive about it. Our day job is motivating people to change, and we can't be frightened of change.

'It's going to ask us to demonstrate and explain our services in a different way and think about ourselves differently – how we contribute to the overall health and wellbeing of those local communities. If we think we should be funded because we have a right to exist then we're not going to get anywhere. I think there's a real risk that we don't respond as a sector to that challenge, but it's there to play for really. And if it creates a different response from the sector – "let's think about how we deliver a service that's integrated into our local communities, so we have closer ties with housing and we're able to involve families and carers more in the treatment of their loved ones" – then that's not a bad thing, surely.' **DDN**

FIGHTING RESPONSE

A Calderdale-based service is combining treatment provision with hosting an emerging recovery community. Michelle Foster explains the 'warrior down' concept

I took a call from a friend in December, who had been contacted by the desperate mother of a 43-year-old daughter. The daughter, who we'll call Rachel, had been out of a residential rehab for a couple of weeks and was back in a full-blown alcoholic episode, drinking around the clock and falling in and out of taxis and in and out of hospital.

The physical repercussions were immense, but the obsession to drink had turned Rachel into an emotional and mental wreck. Her behaviours swung from aggressive and arrogant to those of a frightened child. Rachel's partner had had enough and was taking their daughter away to stay with family for the duration of Christmas. All concerned knew it was crunch time for Rachel and that this period could decide whether she would live or die.

This call to us was nothing new – a cry for help, sometimes by a loved one, sometimes by the addict. For an organisation like The Basement Recovery Project (TBRP) the question is how can we respond, and how did we respond?

My own journey into this world has been defined by the Pennines, especially the Calder Valley. I was born in Todmorden and brought up in Burnley. My life became unmanageable and my recovery journey started back in the hills of Todmorden, but it's only in retrospect that I can look on these hills and valleys with fondness – a sense of belonging and of how their presence creates small communities that become families supporting each other. Our response to an addict who is struggling – like Rachel – has been happening for years, in communities just like this.

The basement operates in an unusual environment of being both service provider and host of an emerging recovery community and this dual responsibility requires careful management, not least in maintaining appropriate boundaries in how we respond to someone like Rachel's mother's request for help. It's not our place as a provider to outreach someone who hasn't asked for help, but as a recovery community we can adopt the 'warrior down' approach to reach out into the community and provide assertive support.

What do I mean by this? Adopted from a peer-to-peer programme originally designed to provide support and community referrals for Native Americans in recovery, 'warrior down' is the cry to signify that a warrior has been wounded or incapacitated and needs help. The warrior down initiative creates a response team to provide support and finds the resources to get that person back into their recovery process.

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Recovery isn't just staying sober – it's a way of experiencing life through new eyes, new thoughts, and a new spirit. Re-establishing one's life following treatment for alcohol or substance abuse or incarceration requires a community effort. Without the support of a knowledgeable family and community, many who try to return to healthy, productive lives find themselves frustrated by the need for a job, training, education, housing, mental health care, medical support or connections with others who value sobriety and healthy behaviours.

Throughout the evolution of the UK recovery movement there has been close liaison with colleagues and friends in the USA, and it was in 2011 that Phil Valentine came to the UK and told us about the White Bison Warrior Down Program. The whole warrior down ethos and philosophy had an immediate resonance to those in recovery communities in the north of England, where small but influential groups of addicts have come together to create abstinence-based recovery communities.

They have done this most obviously in NA and AA – many got there via prison or simply stopped taking methadone and dropped out of treatment. It's very rare to find people in abstinence-based recovery who got there via community methadone treatment and, similarly, the rooms of Alcoholics Anonymous have facilitated peoples' recovery and been the driver for them to reach out to those who are still in battle.

Given the numbers of people entering recovery it was only a matter of time before people started to relapse, and we asked ourselves how we should respond. This really is brand new territory. Treatment professionals are not used to assertively reaching out to people who relapse – people in 12-step fellowships may respond with comments like 'God or drink and drugs will bring them back – one way or the other', but neither standard treatment assertive outreach or benign 12-step fellowship felt like the right thing to do.

The people who had relapsed had become our friends and allies. They were

almost family, and you don't leave one of your own out there on the battlefield, in the madness of addiction, to die. You go and get them and do everything you can to get that warrior back into their recovery process.

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Our warrior down response teams are driven by ethical governance as opposed to clinical governance, and they work across geographical boundaries. We have allies in Blackburn who have been utilising this approach for years, alongside people from Liverpool. Our approach is made up of informal coalitions of work colleagues, treatment professionals, friends and family members, as well as those supporting family members like Loved Ones Unite and Al-anon, faith-based group members and peers in recovery. They operate inside the recovery system, but outside of the treatment system. They respond to anyone who is in need, at any stage of their journey.

Many recovery slogans and clichés have become part of people's lived reality. People in recovery know that 'you alone can do it, but you cannot do it alone', because they have tried it on their own and failed time and time again. They know that 'I can't but we can', they have been that addict or that alcoholic who has sat on their own thinking about recovery while ordering two bags of brown and one of white. Then there is the addict whose thinking turns to drinking: 'I've never really had a problem with alcohol, it was just gear and crack – I'm sure I'll be OK having a drink.' These experiences prove that an addict on their own is indeed behind enemy lines – rhetoric soon becomes reality when you realise that we really are in this together.

So last Christmas we mobilised a member of the warrior down team and throughout the Christmas period this elder visited Rachel every day – sometimes she would refuse to communicate, some days she didn't even know that the elder had called. A leaflet about TBRP was left at her home and contact numbers put up on the kitchen notice board, and throughout this time our elder simply made sure Rachel was as safe as she could be. Some days that involved a call for an ambulance, and some days it was removing the alcohol that had amassed in vast quantities around the house.

Slowly, the communication between these two addicts started, and by the new year Rachel started to turn a corner and engage with a range of support services. Today, Rachel is six months abstinent and learning about the mutual benefits of one addict supporting another. She is contributing to her recovery community.

It's not for us to speculate how Rachel's Christmas, and more importantly her life, would have been had the elder not intervened. All we can say is that warrior down provides an opportunity for people at any stage of their journey. In the last year or so, I personally have seen this support for ten people back from the battle – from those who have never approached treatment services and are in early recovery, to those who have had years of sobriety, to those who now work in the field and have lost their way.

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Today, all are sober, happy and re-engaged with living, and today I am sober, happy and living a life beyond my wildest dreams. The family of the Calder Valley gave me this over twenty years ago, so today I do my own service to the warrior down team and hold out a hand to others who need help.

Recovery is owned by the individual and the community they belong to. Our treatment system, as it is currently configured, cannot respond in this way. When Phil Valentine spoke of warrior down he also illustrated that recovery communities have existed for years and years, and treatment as we know it is relatively new. This was a 'light bulb moment' for many who work in the field. For me, it illustrated the limitations of our systems, reoriented the addict at the centre, and reminded us of the power of kinship. So forget the battle of the rhetoric of treatment and recovery and see beyond it, as the magic of 'warrior down' prevails.

For more on the warrior down program visit http://bit.ly/SDe14g

Michelle Foster is CEO of The Basement Recovery Project, www.thebasementproject.org.uk; www.facebook.com/basementproject

VOICES OF RECOVERY

FINDING IDENTITY

Only when we start valuing each individual where they are now, rather than where we would like them to be, will we take the road to recovery-orientation, says **Alistair Sinclair**

IT'S BEEN A BUSY FEW MONTHS. After Weston's recovery walk on 22 September, where I talked about our shared humanity and 'messy' love, I walked in Brighton with over 3,000 people at the fourth UK Recovery Walk and talked about community strengths, family and the need to build recovery networks grounded in the 'five ways to wellbeing'.

A few days later I attended a recovery coaching conference in London and since then I've delivered some training, written various proposals and reports, helped facilitate UKRF recovery seminars (the most recent involving 100 people in North Lincs) and continued to spend a lot of my time on trains. Along the way I've participated in a 'researching recovery' seminar at Manchester University, met with two of the chairs of the recovery partnership to talk about plans for a recovery festival in London next spring, agreed new UKRF work in Hertfordshire and London and taken part in planning for next year's national service user conference in Birmingham.

So, lots of activity and not a lot of personal recovery, because, while I've been busy, I've become ill. My 'black dog' (Churchill's term for his depression – I quite like it) has recently, as it does from time to time, become much larger and is nipping at my heels. Which has left me considering my 'identity' – or rather I've been thinking about the many 'identities' that combine, in all their colourful combinations, to make up who I am at any given time.

At the recovery coaching conference one of the speakers talked about the different identities we have; some of them out there in the open and some hidden from the world, secret. This idea that the 'addict' (or the 'depressive') is just one identity among many has left me thinking about 'authenticity' and the tensions that exist within the recovery movement.

Am I more 'authentic' because I have 'issues' with substances and a deep personal acquaintance with a 'black dog'? Does this qualify me to stand up in front of people and talk about 'wellbeing' and 'recovery-orientation'? Do I have greater 'value' because I have given up illegal drugs? Is this integral to my 'recovery'? I still use legal drugs. I might take anti-depressants again. Does this make my recovery less 'authentic'? Where is my recovery? Do I need to find a place where all my identities are valued and nurtured or do I need to subscribe to some political/treatment version of recovery and be 'cured'. Will 'abstinence' make everything alright?

Lots of questions, and answers remain elusive. But I think when I reach a point where I can value myself and all my identities, when I can be at ease with myself, I'll be on my road to recovery. And when services start by valuing each and every individual where they are now, recognising their strengths in the 'now', and not where they would like them to be (payment for a result determined by others) then we'll be on the road to recovery-orientation.

I often sit in rooms where people introduce themselves as 'in recovery' and I say 'I'm Alistair, I'm from the UKRF'. That's me playing it safe. We all like safe. Being a director of the UKRF is not the biggest part of my identity. Recovery starts with honesty. I'm 'recovering' and, 'ill' or not, like everyone else I have something to offer.

Alistair Sinclair is a director of the UK Recovery Foundation (UKRF)

In the third part of her story, **Marie Tolman** books into rehab and allows herself to start dreaming of a future

My journey of self-discovery

BY THE TIME I REACHED 21 I HAD REALLY STARTED TO HATE MY LIFE and wanted out of this lonely existence. I feared I had caused so much pain and heartache that my family would never accept me, and certainly not the society I had wreaked havoc in. My family had always stood by me and even my local community knew I wasn't a bad person, just a troubled soul.

I was due in court again and expecting a custodial sentence, so I decided to give rehab a try once more. It was a beautiful August Monday morning in 1988. I was already into my third day of withdrawal when my mum and dad took me up to Phoenix House. They had bought me all new things in the hope that this time it would work. Of course I promised them this time would be good, but internally I was still unsure if I was ever able to be a 'normal person'. I kept thinking 'I am damaged goods and deserve no better'.

As I walked into this Georgian house, I felt overwhelmed, as I knew this was day when there was no hiding place. I had to meet the person I looked at each morning in the mirror, but she was a stranger that I had to confront, accept and make peace with.

I noticed this guy standing at the bottom of the stairs; his eyes twinkled like emeralds, so handsome. He came over and introduced himself as Francis – funny 'cos that's my dad's name too – and his voice gave me tingles all up my spine. I was totally transfixed by his presence. I hadn't had feelings like this before, but he put me at ease and reassured my mum and dad that he would look after me and I would be OK.

Alone and unsure what my future held, I had dreams and hopes of being a mum, with a few children and a husband who would love me in the same way I would love him. I'd have a garden and decent jobs – nothing too extraordinary – but normality had evaded me for so long. Would I ever be privy to the life most people take for granted?

The following few days, Francis and I sat talking. It was like I was in a movie; he accepted me and I was totally head over heels in love with him. We had connected on a plane that I never imagined possible, and I had never felt such love.

I learnt all about his traumatic life and how he was a single dad of a little boy, Francis junior, who was four and a half. I was in awe of him. We spent every moment possible together and I could be honest in a way I had never been.

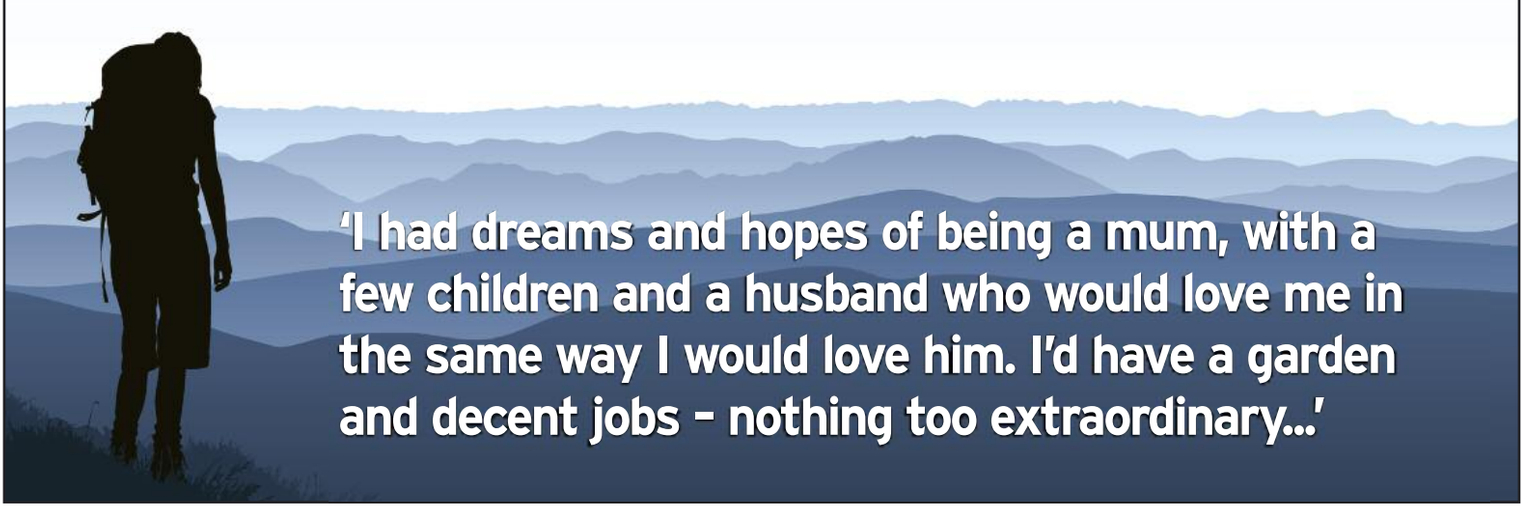
On Saturday morning the house was a buzz of residents excitedly preparing to meet their families, with all the girls swapping clothes and make-up. I felt a bit sad as I was not going to see my family, but something else brought smiles into my day; I had seen photos of Francis junior and today I was going to meet him.

The sun was shining, the birds were singing in the trees and the sky was blue with soft weightless clouds. It was like a fairytale with the sound of laughter and the serene, tranquil atmosphere. I was sitting in the back garden when the most amazingly cute little boy walked in and ran over to his daddy to give him the biggest cuddle in the world.

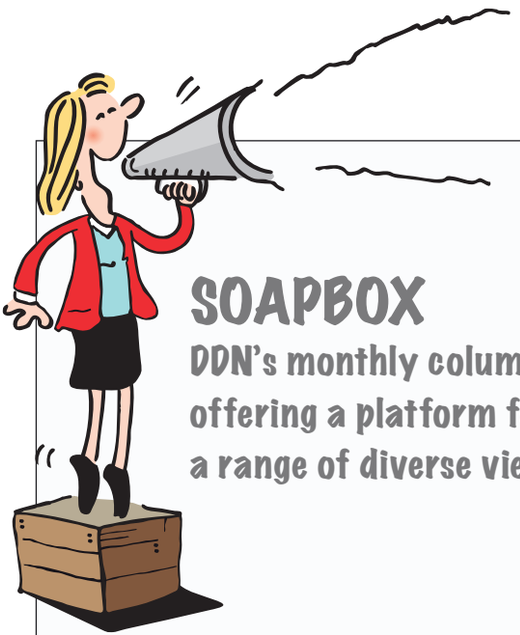
I watched as Francis spun him around. The sun's rays were illuminating his innocent chubby little face, the same emerald eyes twinkling with innocence and wonderment, in his denim dungarees and little denim jacket with his spiky gelled-up hair. I was in love – I knew that very instant I was going to be his mummy. He came over and shook my hand and as we played in garden and chatted away.

I felt so at ease, a moment I experienced again twice in my life when Chloe and Joseph were born – that same feeling of unconditional love and acceptance for your child. There in front of me were the fairytales I had been telling my keyworker only a few weeks ago.

Next issue: Can Marie make a go of a new life?



'I had dreams and hopes of being a mum, with a few children and a husband who would love me in the same way I would love him. I'd have a garden and decent jobs – nothing too extraordinary...'



SOAPBOX

DDN's monthly column offering a platform for a range of diverse views.

GET WITH THE PROGRAMME

Evidence-based prevention and education initiatives are vital to the future of our young people, says **Yasmin Batliwala**

THE NTA'S LATEST STATISTICS ON YOUNG PEOPLE SHOW A STEADY DECREASE IN THE NUMBER OF UNDER-18S ACCESSING TREATMENT FOR DRUG AND ALCOHOL PROBLEMS. Substance misuse among young people: 2011-12 reveals that fewer young people are being treated for class A drugs and that the vast majority (92 per cent) receive support for problems with cannabis and alcohol. The figures also show that most young people accessing drug and alcohol specialist support services present a range of other problems, which demonstrates that 'substance misuse is seldom an isolated issue'.

While we welcome the news that the number of young people entering treatment has decreased over the years – reflecting a decrease in the number of under-18s using drugs – underage alcohol consumption is still higher in the UK than in most other EU countries. With a third of alcohol related A&E admissions for under-18s, we call on the government and local commissioning bodies to ensure a continued commitment to treatment services for young people, as well as further investment in prevention programmes and early interventions.

WDP believes that there is a clear and defined role for structured drug and alcohol support for young people, and that investing in drug and alcohol treatment for this group has clear cost benefits to society. According to a Department for Education study published in February 2011, for every £1 spent on young person's treatment, between £5 and £8 is saved by the NHS and other agencies.

It's also clear that there are opportunities to build on the provision of specific family-focused services within substance misuse specialist agencies. This provides a unique opportunity to tackle the issues of drug or alcohol use within a family unit – a 'whole family' approach to substance misuse treatment is an effective way of dealing with drug and alcohol issues early on and breaking the cycle of intergenerational problems.

In line with the government's drug strategy, which states that 'the focus for all activity with young drug or alcohol misusers should be preventing the escalation of use and harm, including stopping young people from becoming drug or alcohol dependent adults', WDP believes that help needs to be available to young people and their families before the problems become too serious.

If society wants to prevent more young people from becoming dependent on drugs and alcohol then it's essential that we to take steps to reduce the stigma and taboo around drugs. Stigma can make it more difficult for parents to talk to their children about drugs. It also makes it harder for children to learn about the risks of substance misuse and harder for people experiencing problems to seek and receive help. It is absolutely crucial to provide understandable information and meaningful drug and alcohol education for everyone, including children, parents and teachers.

We believe that prevention programmes should focus on all drugs, including alcohol, as all drugs can have a negative impact on people's lives. There is also a clear need to increase awareness campaigns on the harms that alcohol can cause, aimed at both adults and young people. A recent report by 4Children shows that too many parents are unaware of the negative effects their drinking can have on their parenting. Honesty about drugs and alcohol, their different properties and the circumstances in which they can be harmful, increases knowledge and increases confidence in the truth of the information. It encourages people to take responsibility for their actions.

The NTA reports that 76 per cent of young people who access drug treatment present a range of vulnerabilities, so it's clear that young people accessing drug and alcohol treatment will need a range of support and that the substance use should not be looked at in isolation. Similarly, prevention work should look at the issues that cause substance use, and not just focus on the drugs. Any prevention programmes should also be tailored according to age group, and the range of difficulties that age group faces.

The most powerful way to prevent young people from misusing drugs or alcohol is for society as a whole to create ambition for all our young people to learn, participate, achieve and enjoy life, enabling them create a positive environment for themselves away from drugs and alcohol.

We are asking the government and the recently established health and wellbeing boards to not lose sight of the clear benefits of investing in evidence-based drug and alcohol prevention and education programmes for all. We are also calling on local decision makers to focus on investment in young people's treatment services, as well as to commit to providing early intervention programmes and adopting a 'whole family' approach to all those entering treatment for substance misuse.

Substance misuse among young people: 2011-12 available at www.nta.nhs.uk

Yasmin Batliwala is chair of Westminster Drug Project (WDP).

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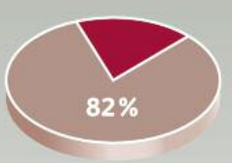
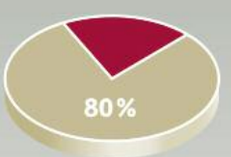
of those staying longer than seven days have improved psychological wellbeing



are abstinent or show improvement after six months



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1 Outcomes based on standard metrics across all Priory hospitals for service users with an addiction who could be contacted after six and 12 months 2011

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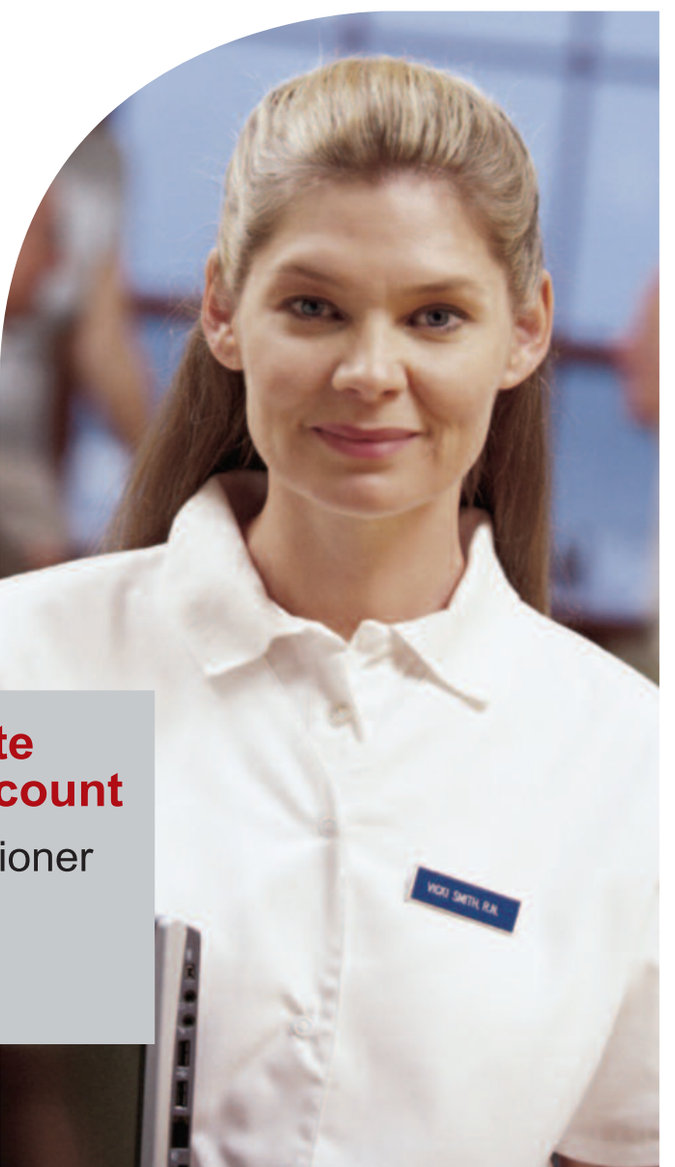

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