MERRY CHRISTMAS TO ALL OUR READERS

DDN
Drink and Drugs News

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'I'm standing here because my family was affected by drug use... I didn't know for a long time. There was odd behaviour from my daughter and I knew something wasn't right.'

WHAT ABOUT ME?

THE FIRST ADFAM/DDN CONFERENCE FOR FAMILIES URGES CARERS TO MAKE THEIR VOICES HEARD

NEWS FOCUS
Is Scotland closer to a consensus on drug treatment? p6

CHRISTMAS CARDS
Organisations from across the sector wish you a very merry Christmas p18

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Police Federation principal officer, George Gallimore, on PCCs and drug treatment p20

Painting by Martina Schapiro

WOMEN

AFFECTED BY DRUG & ALCOHOL ISSUES CONFERENCE

Day Conference: 9.30am – 5.00pm

Evening Session, 'The Big Debate': 6.00pm – 7.30pm

CARDIFF CITY FOOTBALL CLUB – 20th MARCH 2013

DAY CONFERENCE

The day conference will include keynote speakers and workshops and will cover areas and issues synonymous with women affected by drug and alcohol use, including:
• Breaking the Cycle • Families • The impact of the Criminal Justice-System on Women • Domestic Violence • Recovery Capital

Speakers include: **Pam Webb** Head of Zurich Community Trust, **Dr Gail Gilchrist** Principle Research Fellow of University of Greenwich, **Rebecca Daddow** RSA Senior Researcher, **Jenny Earle** OBE Director, Prisoner Programme to Reduce Women's Imprisonment, **Julia Lyon** CBE Director Prisoner Reform Trust and **Dr Bernadette Hard** Kaleidoscope Doctor. Chaired by **Amanda Davies** CEO Seren.

Lunch and evening refreshments included. Parking available.
Tickets £75.00
Booking forms available from: thevoicegwent@gmail.com
Tel: 01633 246196

EVENING SESSION – THE BIG DEBATE

The evening session will be a chance for our leading politicians and business leaders to debate the direction that society needs to go in to support women affected by substance misuse.

From disadvantage, to being a successful Woman in Wales: **Kirsty Williams** AM, **Suzy Davies** AM, **Jocelyn Davies** AM, **Adele Blakebrough** CEO Social Business Trust, **Niamh Eastwood**, Executive Director of Release. Chaired by **Mary Riddel** of *THE DAILY TELEGRAPH*.

Tickets: Donations Only.
Booking forms available from: thevoicegwent@gmail.com
Tel: 01633 246196

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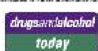

Editorial – Claire Brown

Listen and lobby

Get interactive, get involved!

The *Families First* conference was our big chance to listen and learn from families (page 8), but it also gave an opportunity for carers to make themselves heard and influence Adfam's future work programme. 'Be vocal, get lobbying,' said Paul Hayes. 'Help me to make my colleagues better at listening,' said Dr Steve Brinksman.

This issue of *DDN* is full of opinion on what works (and doesn't). George Gallimore comments on the risk of fragmentation after police and crime commissioner elections (page 20). Amar Lodhia criticises lack of support for entrepreneurs from disadvantaged backgrounds (page 17). And hosting its final conference, the UKDPC's chair Dame Ruth Runciman says 'We need a new conversation about drugs'. If ever there was a time to have that conversation – about drugs, alcohol, public health, family support – it's now, as we head towards a new year of policy change for the field. As Public Health England chief exec Duncan Selbie says (page 11): 'We need to ensure services are designed around the best available knowledge of what works.'

We wish you a healthy and happy Christmas and New Year – tweet us @ddnmagazine until we return in January. Many thanks to those of you who bought Christmas cards, displayed on our centre pages – you helped to make this issue possible. There's still time to have a *DDN* e-card – please get in touch!

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NEWS IN BRIEF

EASTERN EUROPE HIV INCREASE CONTINUES

Eastern Europe and Central Asia have seen a 20 per cent increase in new HIV infections among young people, says UNAIDS, despite a more than 50 per cent drop in new HIV infections across 25 low- and middle-income countries, mainly in Africa. 'The majority of young people who are acquiring HIV are those who inject drugs, very few of whom have access to evidence-informed HIV prevention and treatment services,' says *UNAIDS world AIDS day report 2012*. 'We need to do more to reach key populations with crucial HIV services," said UNAIDS executive director Michel Sidibé. *www.unaids.org*

HEP B INFECTIONS DOWN

One in six people who inject drugs has been infected with the hepatitis B virus, according to the Health Protection Agency (HPA), although the numbers have fallen over the last decade (see Soapbox, page 27). The decline is likely to reflect the 'marked increase' in the uptake of the hepatitis B vaccine, says *Shooting up: infections among people who inject drugs in the UK 2011. An update: November 2012*. Targeting vaccines to injecting drug users needs to be maintained, urges the document, if low levels of new infections are to be maintained. Needle and syringe sharing is also lower than a decade ago, although around a sixth of people who inject drugs continue to share, while a third of injectors reported a symptom of bacterial infection such as a sore or abscess. *Available at www.hpa.org.uk*

ADDICTION CARE

Day care treatment centre Addiction Care has opened in Guildford, offering a range of programmes supported by a comprehensive aftercare service for clients and families. 'Everyone deserves the chance to achieve a healthy, fulfilling and meaningful life away from the grip of addictive behaviour,' said founder Peter J Davies. *www.addictioncare.co.uk*

AFGHAN OPIUM CULTIVATION UP

Afghan opium poppy cultivation was 18 per cent higher in 2012 than the previous year, according to UNODC, largely driven by high prices. Crop damage, however, caused by plant disease and bad weather means there will be a 36 per cent fall in potential opium production. *2012 Afghanistan opium survey at www.unodc.org*

Government consults on 45p minimum price

The Home Office has launched a consultation on a minimum price of 45p per unit of alcohol, one of a range of measures to 'cut crime, save lives and reduce alcohol consumption' alongside a ban on multi-buy promotions, a review of the mandatory licensing conditions and a new health-related objective for alcohol licensing. The consultation will run for ten weeks.

'The evidence is clear – the availability of cheap alcohol contributes to harmful levels of drinking,' said policing minister Damian Green. 'It can't be right that it is possible to purchase a can of beer for as little as 20p.' The proposals were first set out in the government's alcohol strategy, published earlier this year (*DDN*, April, page 4).

According to the consultation, a 45p minimum price would mean a reduction in overall alcohol consumption of more than 3 per cent and save more than 700 lives and nearly 25,000 hospital admissions each year. Harmful drinkers would see their annual spending on alcohol increase by £118, hazardous drinkers by £49 and moderate drinkers by £7.

While the consultation has been welcomed by health campaigners, many want to see the price set at 50p, as in Scotland's Alcohol Minimum Pricing Bill which was passed in May, albeit with a 'sunset clause' allowing the provision to expire after six years if considered ineffective (*DDN*, June, page 4). 'It is vital that such a significant step is taken based on the best available evidence of what works,' said vice president of the Faculty of Public Health, Dr John Middleton, while Alcohol Concern said a minimum price of 50p would save around 3,000 lives per year.

A report from NICE, Alcohol Concern and Balance, issued for Alcohol Awareness Week, said minimum pricing would 'protect young people from the dangers of excessive drinking'. Chief executive of the Wine and Spirit Trade Association, Miles Beale, however, said that minimum pricing and promotion restrictions were 'wholly untargeted' and would 'unfairly punish millions of consumers' while failing to tackle the root causes of alcohol misuse.

Chief medical officer Professor Dame Sally Davies' first annual report, meanwhile, states that deaths from chronic liver disease and cirrhosis in the under 65s rose by around 20 per cent in England between 2000 and 2009, at the same time as falling by roughly the same amount in most EU countries.

Consultation at www.homeoffice.gov.uk until 6 February
Chief medical officer's report at www.dh.gov.uk

Iran and Saudi Arabia step up drug offence executions

Executions for drugs offences have increased in Iran and Saudi Arabia despite a global trend towards abolition, according to a new report from Harm Reduction International (HRI).

More than 540 people were executed for drugs in Iran in 2011, says *The death penalty for drug offences, global overview 2012: tipping the scales for abolition*, a five-fold increase since 2008. At least 16 people were also executed for drugs in Saudi Arabia in the first six months of 2012, compared to just one in the previous year, and Pakistan has tripled the number of death sentences imposed since 2009.

While data for executions in China – widely considered to execute more people than any other country – and Vietnam remain a state secret, many countries in South East Asia are demonstrating 'declining political will' to enforce their own capital sentences for drugs crimes, says the document, with no executions in Indonesia or Thailand since 2008. Malaysia and Singapore have also been reviewing their mandatory death penalties, and while 33 states or territories retain the death penalty for drug offences, fewer than ten actually carried them out in 2011-12, confirming the international movement away from the practice, says the report.

'Politically, governments seem increasingly uncomfortable with the death penalty for drug offences,' said chair of the All Party Parliamentary Group on the Abolition of the Death Penalty, Baroness Vivien Stern. 'Even Malaysia, which many see as a very repressive state on drug laws, is currently debating whether to remove the mandatory death penalty, and has placed a moratorium on executions until that decision has been made.'

Although there was cause for optimism on some fronts, behind the statistics was a 'truly horrifying picture of inhumane drug enforcement', said HRI executive director Rick Lines. 'The identities of many of those sentenced to die or executed are rarely made public but in those few instances when the details are revealed, the same pattern emerges – the condemned are very often poor, disadvantaged and desperate.'

Some death penalty states, including Iran, are also in receipt of drug enforcement aid funding, states the report, helping to 'legitimise' the executions and potentially facilitating the capture of people who are then sentenced to death. 'Donors and the UN Office on Drugs and Crime are effectively legitimising the death penalty at a crucial time when every effort is needed to move towards abolition,' stated Lines.

Available at www.ihra.net

Europe: 'new era' of declining heroin use and complex stimulant market

Europe could be moving into a 'new era' in which heroin plays a 'less central role' in the drug problem, according the annual report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), while the stimulants market becomes ever more complex and volatile.

'New recruitment' into heroin is falling, along with availability of the drug in many countries, says the report. Although opioids were cited as the primary drug by more than 200,000 treatment clients across the EU and Norway, the number of people entering treatment for the first time for heroin fell from 61,000 to 46,000 between 2007 and 2010. Overall injecting rates are also continuing to decline, along with the numbers of newly reported HIV cases – particularly when compared to countries like Russia and Ukraine. In Greece, however, where harm reduction services have fallen victim to austerity measures, infection rates increased from less than 20 per year before 2010 to 241 in 2011, the result of 'a local, but large' epidemic among injectors in Athens.

'The difficult financial situation in Europe, which forms the backdrop of our reporting, means that resources for addressing health and social problems are in short supply,' said EMCDDA director Wolfgang Götz. 'Ensuring the highest treatment quality and best treatment outcome for the lowest possible cost are therefore priorities in the current climate. It is essential to ensure that the available funds are invested in well-targeted activities of proven effectiveness.'

The report also highlights 'an increasingly complex' stimulant market with a 'wide variety of powders and pills', and where cocaine, amphetamines and ecstasy increasingly compete with new synthetic drugs. These continue to be reported at the rate of around one per week, with more than 50 already detected via the EU's early-warning system this year, in addition to the 49 in 2011 and 41 in 2010. The agency has also identified nearly 700 online 'legal high' retailers, compared to 170 two years ago.

To many consumers, the new drugs are effectively 'interchangeable', says EMCDDA, creating a 'volatile market' influenced by price and purity, with 'obscure chemical groups' being reported alongside increasing numbers of products containing multiple psychoactive substances, both controlled and uncontrolled. Better forensic and toxicological analysis is vital, says the agency, as is the need to 'proactively engage with those most at risk'.

Cocaine use has continued to fall in 'high prevalence' countries like the UK, Italy and Spain, possibly influenced by low levels of purity, with the EMCDDA's index of average purity in the EU falling by 22 per cent between 2005 and 2010. However the document reports increasing rates of methamphetamine use – historically limited to parts of Eastern Europe – in Scandinavia and elsewhere on the continent.

Meanwhile, a report from the NTA reveals that more people in England are seeking treatment for 'club drugs' like mephedrone, methamphetamine, ketamine and GHB/GBL. Around 6,500 people – 2,000 of whom were under 18 – were treated for a club drug last year, compared to around 4,600 in 2005/06, says *Club drugs: emerging trends and risks*.

While the numbers remain low compared to those needing treatment for heroin or crack they are further evidence of shifting patterns of use (*DDN*, November, page 5). Club drug users make up around 10 per cent of young people in specialist services, and 2 per cent of adults, and 'stand a strong chance of benefitting from treatment as they tend to have the personal resources to recover from their problems', says the agency.

There were 751 presentations for ketamine treatment this year compared to 114 six years ago, and 900 for mephedrone. Ecstasy remains the most commonly treated club drug in the UK, but the numbers of new adults seeking treatment has halved to just over 1,000 in the last six years. 'With new substances arriving on the drugs market all the time, treatment services need to remain vigilant to new trends and adapt their treatment approaches accordingly,' says the report. DrugScope's latest street drugs trends survey also found evidence of increasing numbers of people injecting mephedrone, often in a 'compulsive' manner throughout the day.

'Whilst overall the drug treatment system has made tremendous gains in recent years, particularly in tackling heroin and crack, newer club drug use is a significant challenge and we are still learning the full extent of the resulting harms,' said founder of Chelsea and Westminster hospital's club drugs clinic, Dr Owen Bowden Jones.

In the meantime, the government has announced that the 'legal high' methoxetamine – known as 'mexxy' – and its related compounds will become illegal class B drugs, along with synthetic cannabinoids such as those sold as 'black mamba'. The decision follows a recommendation by the Advisory Council on the Misuse of Drugs (ACMD). Methoxetamine – which was being sold as a 'safe' alternative to ketamine – has been subject to a temporary class drug order (TCDO) since March (*DDN*, April, page 4).

Annual report 2012: the state of the drugs problem in Europe at www.emcdda.europa.eu

Club drugs: emerging trends and risks at www.nta.nhs.uk

NEWS IN BRIEF

FIFTH ANTHRAX CASE FOR UK

An injecting drug user in Oxford has been diagnosed with an anthrax infection, according to the Health Protection Agency (HPA), bringing the number of UK infections in 2012 to five. There have been three confirmed cases in England, two of which – in Blackpool – were fatal (*DDN*, October, page 5) and one each in Scotland and Wales. A total of 12 cases have been identified across Europe since June, with the others in Germany, Denmark and France.

HPA has advised DAATs to talk to service users about the risks of infection, said director of its Thames Valley Health Protection Unit, Dr Éamonn O'Moore. 'Injecting drug users often experience skin infection but we strongly advise them not to ignore signs such as redness or excessive swelling around injection sites, or other symptoms of general illness such as a high temperature, chills, severe headaches or breathing difficulties. They should seek medical advice quickly in such circumstances generally, but particularly now because we have concerns that some batches of heroin in circulation in Oxfordshire and the wider Thames Valley may be contaminated with anthrax. Early treatment with antibiotics is essential for a successful recovery.'

GRAYLING ANNOUNCES 'MENTOR' PLANS

Mentors will 'meet criminals at the prison gates on release and help them turn away from crime', said justice secretary Chris Grayling, as he outlined the next steps in the 'rehabilitation revolution' in a speech last month. He wanted people to have 'a place to live sorted out' and 'training or rehab lined up', he stated, while payment by results would 'open up the provision of post-prison services to a whole host of new participants in a way that forces anyone who wants to be involved to be excellent at what they do'. Further details will be published soon, says the Ministry of Justice.

Speech at www.justice.gov.uk

IS SCOTLAND CLOSER TO A CONSENSUS ON DRUG TREATMENT?

Scotland's latest set of drug death statistics made for grim reading and triggered a war of words in parliament and the press. But could the opposing sides now be reaching an agreement, asks **DDN**

WHEN NATIONAL RECORDS FOR SCOTLAND REPORTED that more drug-related deaths had been registered in 2011 than ever before, and had increased by 20 per cent since the previous year (*DDN*, September, page 4), it was clearly going to be a big story. What really hit the headlines, however, was that methadone had been 'implicated in, or potentially contributed to' 47 per cent of them.

Although it was not known how many of those who died had been prescribed methadone and how many had obtained it on the black market – as the information is not recorded in the death registration process or on pathologists' questionnaires – leader of the Scottish Conservatives, Ruth Davidson, promptly issued a statement calling the country's methadone programme a 'human disaster', adding that it seemed 'the more you spend on methadone, the more people it kills'.

This was followed by sections of the Scottish press, particularly the *Daily Record*, calling for a parliamentary enquiry and running negative methadone stories, particularly the *Record*'s articles on 'methadone barons' – those who profit from the 'massive payouts for prescribing the drug'. Alex MacKinnon, the Royal Pharmaceutical Society's director for Scotland, felt compelled to state that 'pharmacists dispensing methadone are doing a difficult job and play an important role' in helping people beat their addiction. 'It's important to recognise that pharmacists are only carrying out their duties to the NHS by dispensing methadone,' he said.

In October, the Scottish Government announced that it was commissioning an independent expert group, chaired by chief medical officer Harry Burns, to consider the evidence supporting the role of opiate replacement therapy and make recommendations to the government in spring 2013. This was followed by the country's drug strategy, *Road to recovery* (*DDN*, 2 June 2008, page 4), being debated in the Scottish Parliament last month.

Described as 'thoughtful and measured' by the Scottish Drugs Forum (SDF) – and as 'clashes over methadone treatment' by the *Scotsman* – the debate culminated in the passing of a motion that included recognition of the value of replacement therapies as part of a wide range of treatment options, with Conservative MSP Annabel Goldie stating that 'polarising' the issue was unhelpful, as were 'sensationalist articles in tabloid newspapers'.

So does this mean that consensus is looking more likely than in recent months and that there's something approaching cross-party support for the drug strategy? 'I think broadly, yes,' says SDF director David Liddell. 'Political cross-party support has been restored for the moment, but in the choppy political waters leading up to the referendum [on Scottish independence, expected to be held in autumn 2014] it wouldn't be safe to assume that this can easily be maintained.'

How much was the decision to commission the independent expert group in the first place media-driven – particularly by the *Daily Record*? 'Clearly the wish of the government and the sector as a whole is to try and retain political consensus,' he says. 'We've seen many countries in Europe lurch from one drug policy direction to another and my view is that this costly, unhelpful and should be avoided. I certainly wouldn't say it was media driven, but rather by the fact that some of the political parties believed that there were easy political points to be scored by attacking the approach being adopted – in particular, methadone.'

The SDF has previously called for politicians to think more deeply about the issue of methadone, instead of using it as a political football or as a simplistic argument that the drug strategy isn't working. Could the debate be seen as evidence that they've started to do that? 'I think what we saw was a degree of posturing, which the debate usefully flushed out, and it exposed simplistic arguments – for example the attack on pharmacists as "methadone millionaires". There will always be those who see solutions in more simplistic ways. A key part of our briefing to MSPs was to highlight one of the key planks of the *Road to recovery* strategy, that for too long the debate in Scotland has centred on whether the primary aim of treatment for people who use drugs should be harm reduction or abstinence.'

So if a truce has been called in parliament for now, are the press likely to lose interest in their anti-methadone campaign? 'Clearly the high level of drug-related deaths and in the number potentially involving methadone continue to be important issues which need to be addressed, but an expert group is a far better way to do this than trial by the media. Such a campaign is also not likely to sell papers, and therefore would probably be difficult to sustain.' **DDN**

Wsdouglas

Conservative MSP Annabel Goldie: Polarising the issue is unhelpful, as are 'sensationalist articles in tabloid newspapers'.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

If you deliberately and openly injured yourself, for instance by breaking your own fingers, and made yourself unfit for work, would you seriously expect the taxpayer to keep you? Of course not. In that case, why are millions of pounds of my money and yours being spent on benefit payments to so-called 'alcoholics' and 'drug addicts'?... Nobody forces anyone to start drinking too much, and it takes quite a lot of effort to become a habitual heroin user. Even assuming it was true (which it isn't) that such people cannot stop if they want to, why would they want to stop if they are told by society that their gross appetites are a disease, and they are paid unearned money because of their alleged sickness?
Peter Hitchens, *Mail on Sunday*, 11 November

Britain simply cannot afford to allow anyone who finds working for a living psychologically draining to opt for a life on premium-rate benefits. Somebody needs to look out for the interest of taxpayers too.
Express editorial, 10 November

The [police and crime commissioner] reforms are poorly conceived. They give too much power to individuals, barely restrained by panels of worthies. The regions for which each PCC will be responsible are too big for genuinely local concerns to emerge easily: one commissioner must reflect the priorities of bucolic Somerset as well as Bristol's mean streets. The government insists the new system will not cost more than the old one, but the multi-layered edifice will certainly not be cheaper, even before counting national elections every four years.
Economist editorial, 10 November

David Cameron's promise to get tougher while rehabilitating more ex-prisoners is fatally flawed. Mr Cameron has bet the house on payment by results, under which private providers and charities get rewarded only for success. As Andrew Neilson, of the Howard League, has pointed out, chaotic people who slip in and out of trouble with the law are not amenable to the tick-box tests on which payment will depend. Nor has the system that government has made central to its rehabilitation policy been properly tested anywhere in the world... Thursday's PCC elections are the stunted offspring of a gung-ho government and an opposition that has not dared to say that tough talk and craven solutions (of which Labour governments have been equally guilty) have led to chaos.
Mary Riddell, *Telegraph*, 13 November

Their [people who have held high public office] fall from grace and humiliation can be assessed to have had such a startling impact upon their mental state that they are considered 'too ill' to be banged up. Imagine that you are a skagheaded member of the *untermensch* up before the courts on a charge of aggravated burglary amounting to, let's say, £50. Do you think that your brief would be able to tell His Lordship: 'Such is the disgrace that this crime has brought upon himself, my client is in a deeply distressed state and mentally unfit therefore to be sent to prison. He can hardly look his sister, who is also his wife, in the face as they queue for their methadone each week.'
Rod Liddle, *Spectator*, 15 November

Post-its from Practice

Beyond a script

Actively bringing patients closer to services could mean a paradigm shift for hepatitis C treatment, says Dr Steve Brinksman

Good quality shared care has always meant a lot more than just the provision of a prescription for opioid substitution treatment (OST). To help facilitate this our practice has developed a template that allows any of the doctors, nurses and key workers to update and review the situation with respect to a number of health outcome parameters for any client they are working with.

One of our longer registered clients, Danny, recently saw one of our GP registrars who, diligently checking the notes, realised that despite some years in treatment with us we had no record of his blood-borne virus status. A discussion ensued and Danny agreed to have this checked but he said, 'no one can get my blood' and of course he was right – despite years of experience our phlebotomist was unable to obtain a sample.

A few days later I was discussing this with the registrar during one of his regular supervision sessions and he told me that Danny had offered to get his own blood sample, but the registrar had felt that was inappropriate. The opportunity to explain the need for pragmatism in working with this group wasn't missed and Danny was duly invited in.

After being provided with sterile equipment Danny proceeded with a very proficient femoral stab and we soon had the sample we needed. We booked a follow up appointment to discuss the results, as it is our policy to always give BBV results in person, whether positive or negative. The results came back showing he was hepatitis C antibody and PCR positive and it was a genotype 1 infection.

As part of the suite of training resources available to GPs, the RCGP has a part 1 and a part 2 course in viral hepatitis. The former is designed as a general introduction to the subject and is invaluable for those working in shared care to be able to give patients with hepatitis C the information they need about the illness and treatment options. The part 2 course was only launched this summer and is much more intensive. I was lucky enough to be in the first cohort to complete it and over the course of the six liver outpatient clinics I attended, have built a good working relationship with our local hepatologist.

I was able to reassure Danny that the fact he was receiving a methadone script was not going to prevent him accessing treatment and in fact addressing his daily alcohol consumption of three cans of strong lager was much more significant. I was able to explain that alcohol not only accelerated the progress of viral hepatitis, but that it could reduce the efficacy of anti-viral treatment. He decided to think about it and when I saw him a month later he had reduced his alcohol and was keen to be referred.

Having undertaken the RCGP part 2 course I now believe that there is a developing expertise within primary care, which could help facilitate community-based treatment programmes for hepatitis C. A huge barrier to accessing treatment for substance users is the difficulty in frequent hospital outpatient attendances – something far more easily addressed in primary care.

A move towards making shared care more outcome focused should encompass the impact of viral hepatitis, and by looking to increase the provision of services by taking the process closer to patients we can support those many thousands to whom treatment services currently seem an impractical option.

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.

'WHAT ABOUT ME?'

The first Adfam/DDN conference for families affected by drug and alcohol use urged carers from all over the country to make their voices heard. **DDN** reports

'You know how much stigma gets in the way of your lives. It's that stigma we have to challenge,'

said Vivienne Evans, Adfam chief executive, opening the inaugural *Families First* conference. 'This annual event is the start of a movement for family members,' she said, before handing over to the first speaker, a mother asked to give her personal perspective.

'I'm standing here because my family was affected by drug use,' said Christine Tebano. 'I'm a mum of four and I didn't know for a long time. There was odd behaviour from my daughter and I knew something wasn't right. It hit home when she didn't sit her final exam. We found drugs in her handbag, had calls from her school and then the police started arriving at our door. We didn't know what to do.'

Working in social care, Tebano thought she knew where to go for help; but at that time, nearly 20 years ago, she found nothing. One day she responded to an article in the newspaper about how drugs could affect a family. Her letter became front-page news and there was a torrent of heartfelt response, forwarded to her by the paper, from people in a similar situation.

This demonstration of local need prompted her to set up a group, Parent Support Link (PSL), around her kitchen table. 'We needed someone to listen, not judge, but understand,' she said. The catalyst was word of mouth and the group soon developed a varied skill set among its members, including legal knowledge, giving it the confidence to become a charity. Passion and personal commitment were vital in the small organisation's mission to provide non-judgemental support.

Most importantly, said Tebano, 'we didn't say "this is what we do; here's a menu". We asked what we could do to help.' With a telephone support line in place from the outset, the group responded to the need for face-to-face meetings with others, eventually settling on a monthly group meeting. Finding the right venue also took time and the group realised it had to work up a set of guidelines so people got the right idea about the group from the outset and understood that it was for support, rather than a campaign group.

With one-to-one support making up the other important element of the group, PSL has become a much-valued part of the community and has developed a clear, outcome-based relationship with funders. Feedback from group members speaks for itself, said Tebano, quoting a selection of comments.

'It's a place where I can think – my home is full of stress where it seems like a dead end,' said one. 'The group is my sanctuary, a place of protection,' said another, while another group member said: 'There's a bond around us as we begin to realise the meaning of the journey we are undertaking.'

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Next to take the platform was the NTA's chief executive, Paul Hayes, who told his audience, 'As the man from the government, I've been asked to give you things as straight as possible. You can work out the challenges and threats in that.'

He explained that despite local authority budgets being cut by a third, more money – about £2bn a year – would be ring-fenced for public health in England. But it was as yet unclear how much of this would be available to spend on drug and alcohol treatment. With the NHS Commissioning Board giving local decision-making to GP clinical commissioning groups, the challenge for families was to make themselves heard, he said – an opportunity that would be enhanced by the new health and wellbeing boards, involving local communities.

'You need to find ways of harnessing energy and passion in a way that supports you and your family member,' said Hayes. 'Be vocal, get lobbying. Stir up concern to make sure the system is listening… you can exert a lot of influence through local radio, television and politicians. You need to persuade people and build allies.'

Later in the day Dr Steve Brinksman reassured the audience that GPs were well placed to take this lead in commissioning local health services, as they had families' interests firmly at heart.

'We work with whole families – there's continuity,' he said. 'I've been in my

Alex Copello (opposite), Christine Tebano (above right), Swanswell's yarn bombers (centre), Jennifer Upperdine (far left) and workshops

practice for 26 years now and the roots go deep. I don't discharge people and there are no "treatment completions".'

His message for family members was: 'Complain if you're treated badly. We need to push awareness to GPs. Empathy's important, and to be listened to makes a huge difference… I need your help in making my colleagues better at this.'

This could be done in many ways, said Si Parry from the Southampton service user group Morph – a speaker asked to give his perspective as a son who had used drugs, and who had since become a father. His experiences had led him to become involved in drawing up core competencies for GPs, directly influencing their response to, and treatment of, drug use in the family.

More practical advice came from Release solicitor Niki Durosaro, who gave reassurance on families' legal rights. A common fear was that families would become liable for debts. 'This isn't the case,' she said. 'Debts are personal and addresses can't be blacklisted.'

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For many members of the audience, the main mission of the event was to find more effective ways to cope as a carer – either for themselves, or for their clients in family support services.

Alex Copello, a consultant clinical psychologist, gave a snapshot of the impact of substance use on the family, with a view to developing coping strategies. People living with someone with a drug or alcohol problem were found to use primary care services a lot more, he said. They frequently felt stigmatised and often did not know where to get support – or even how to talk about the problem with their own family.

The three ways that family members responded to their relative's behaviour tended to be putting up with it, standing up to it, or withdrawing from it – or a combination of all of them.

'There's no evidence to show one's better than another because it's all so complicated,' said Copello. But the 'five-step' method had been shown to be helpful, whatever the reaction. This involved listening and reassuring, giving relevant information on treatment and support, exploring coping responses, discussing social support, and looking at further support needs. Families who had received the 'five steps' in primary care had been shown to develop a calmer and more assertive approach to their relative, while at the same time refocusing on their own life and needs.

'A little support can have wide positive consequences,' he said, stressing that it was important to see family members as partners in the treatment journey.

So what else could families and carers do to help themselves and strengthen their resilience?

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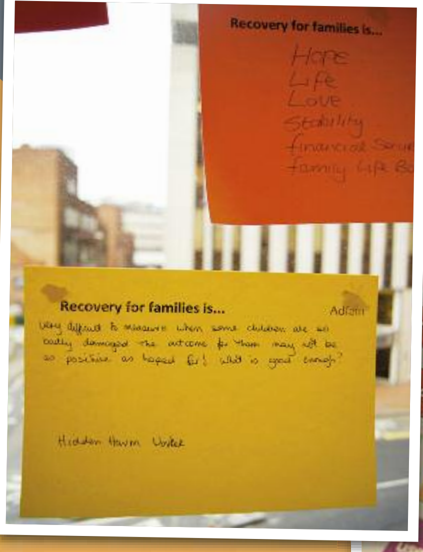
Through her workshop, Jennifer Upperdine of Swanswell's carer support service gave a lesson on 'tough love' – one of the most difficult, yet beneficial, skills a carer could practice.

The aim was to empower the carer by giving them a support network, so that they had the strength to realise that they could influence the choices of the service user – sometimes by standing up to them, she said.

Upperdine explained how, through six sessions of one-to-one support, the service switched the carer's focus back onto their own life, helping them rebuild their confidence and put themselves first.

The big lesson was for the carer to be able to support their relative without it affecting their own physical and mental wellbeing, and the service used an 'outcome star' to map improvements. Alongside their self-esteem work, carers learned what to expect from supporting someone through treatment, including the possibility of relapse, and the stresses accompanying detox.

With improved self-confidence and understanding of the situation, carers were in a position to be firmer. 'Tough love means there are certain things you no longer do,' said Upperdine, including offering financial support to the service user. The



Llinos Merriman gives a therapeutic massage to a family member in the therapy room; messages of recovery from delegates and services

service also prepared the carer for the outcomes of tough decisions like no longer offering a home to a problem substance user who refused to seek help.

In a workshop on the impact of alcohol use on family members, Richard McVey from Aquarius highlighted that support groups should make themselves as accessible as possible by running meetings in homes, cafes, supermarkets – 'wherever people are comfortable using them'.

'Give them something, such as lunch or pampering days, where people can talk without identifying themselves as having problems,' he said. 'Make support as flexible as possible. Lots of families don't want to go through a lengthy referral route – they just want to find a group.' Sharing experiences was one of the most valuable methods of support and encouragement – demonstrated by the workshop, which encouraged participants to share their experiences of what worked.

'When I was 60 I was suicidal, as my son was an alcoholic,' said one woman. 'But he's in a good place now and he says that me putting in boundaries made all the difference.'

Karen Biggs, chief executive of Phoenix Futures, had the unenviable task of summing up a packed day. She kept the message clear and simple, using feedback from her clients to emphasise why treatment providers should think about families: 'because I want to do all I can to help my loved one get better'; 'because I need to know that someone recognises my pain'; 'because I need some practical help with coping with the chaos addiction has brought to my life.'

'Successful recovery requires support for the family as well as the person with addiction,' she added. 'Most carers are mums and the reality of the world is that most mums don't say "what about me?" I've found that staff don't do enough for families not because they don't care, but because they fear overstepping the mark, and that has to change.'

See Adfam's record of the day, with photos, presentations, and tweets, on Storify – click the 'Families First Conference' tab on our website, www.drinkanddrugsnews.com

FAMILY MATTERS

RECOVERY IS...

The Families First conference gave Adfam the opportunity to ask family members what recovery means to them, says **Joss Smith**

WE WERE SO PLEASED to be running our inaugural *Families First* conference in partnership with *DDN* last week in Birmingham and very excited about the turnout and the opportunity to promote the needs of families. The conference drew together both professionals and family members to hear from leading practitioners and organisations in the field. It gave us a real opportunity to have wide-ranging conversations on how best to promote the idea of families' recovery.

We have been very interested in what recovery means for families for some time, and saw the conference as an ideal way to ask families and professionals what recovery means for them. Attendees were asked to consider the question and we received some very interesting and insightful responses, including:

Recovery for families is...

'A journey towards sustainable physical and mental health and wellbeing – a life without fear. No more walking on eggshells.'

'Teaching them to seek support for themselves, including how and when to then support the user.'

'Having a family become whole again. Having the circle reconnected.'

'Independence, having my own life.'

'A good night's sleep.'

'The chance to be whole again.'

These are just a few of the many responses we received, and show not only the significant impact on families' lives that a drug or alcohol user can have, but also the long, individual and sometimes painful process recovery can be for them. We think it is really important that families receive recognition for their own recovery journey and have support and places to turn when that journey is hard. One of the most significant challenges is the continuing lack of services and professionals out there that recognise their needs.

Over the next few months we will be asking families and professionals what they think 'recovery for families is...' so that we can gather some form of consensus and understanding at both a local and a national level.

So what do you think? Send your *Recovery for families is...* comments to policy@adfam.org.uk or tweet us @AdfamUK.

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

HEALTH CHECK

Public Health England chief executive Duncan Selbie describes how his organisation will work with the treatment sector, and promises that it will deliver 'a marked improvement' in the public's health within three to five years

PUBLIC HEALTH ENGLAND takes over the functions of the NTA next year, when decisions about local drug and alcohol services will become the responsibility of regional directors of public health.

The chief executive of the organisation, Duncan Selbie, has spent more than 30 years working in the NHS and Department of Health, including stints as chief executive of a mental health trust, a strategic health authority and, most recently, Brighton and Sussex University Hospitals. He tells *DDN* about how the new body will work with the treatment sector, and how services will need to adapt.

DDN: What's your vision for the new organisation?

Duncan Selbie: This is the opportunity of a lifetime to make health and prevention everyone's business. It's important to emphasise that our commitment to local action led by local government is absolute, and our objective in Public Health England is to support this in every way we can. The new leadership for local public health is political, supported by professional public health specialists.

Public Health England will be an authoritative national voice. We will provide national and local services, advocacy and practical know-how, bringing together for the first time the full range of public health expertise that currently sit across many organisations. We exist to improve the public's health and will be held accountable for this by the public and by government. I believe we can show a marked improvement within three to five years and that we will have learned as a nation how to make this irreversible within ten years.

How's it looking with recruitment for the senior posts – when is the team likely to be in place?

DS: We have completed the appointments to the national team and expect to have the remaining senior people in place regionally and locally by January.

How closely will the organisation be working with other bodies – such as housing, employment, training, criminal justice – to address the underlying issues of substance misuse?

DS: The new legal duty on local government to improve the health of their communities is, in my view, the most significant change of all the recent health and care reforms. In giving local government these new responsibilities we are very much recognising that public health is 'coming home'. The factors that promote health – access to jobs, stable homes, education opportunities and community support – are all very familiar to local government and they are in the best position to join this all up.

No single part of the system can on its own deliver the improvements we need to see, including for people with a drug and alcohol problem – but together we can.

Many in the treatment sector are concerned that, with so many competing demands, drug and alcohol issues won't be seen as a priority by some directors of public health. What would you say to them?

DS: There has always been, and will always be, competing demands for resources in public health, as in all aspects of public service. Action on alcohol and drugs is not limited to addressing problems of dependence. Local authorities have a responsibility to address the wide range of issues resulting from alcohol and drug misuse and it will be Public Health England's role to support them in this.

> **'We need to ensure services are designed around the best available knowledge of what works. Services will need to evolve and adapt to this and to local circumstances and priorities.'**
>
> DUNCAN SELBIE

Some people are also worried that the move to Public Health England – alongside the introduction of Payment by Results and ongoing budgetary concerns – just adds to the general uncertainty over the future of service provision. Are you able to reassure them?

DS: If treatment systems are to deliver the best health improvements for their populations, they need to be built on evidence of what works. Public Health England will work with local government and providers to ensure that treatment systems continue to be resourced, supported and led to achieve the best possible outcomes for service users.

The system reforms that we're still all feeling our way through create understandable uncertainty. But our ambition is to make further significant inroads into drug and alcohol harm, and to always emphasise recovery. We need to ensure services are designed around the best available knowledge of what works. Services will need to evolve and adapt to this and to local circumstances and priorities. **DDN**

Adapt and thr

The drug and alcohol treatment sector was in a period of profound change, DrugScope's director of policy, Marcus Roberts, told delegates at the organisation's *A question of balance: delivering an inclusive treatment and recovery system* conference. DrugScope had been broadly supportive of the notion of 'recovery', he said, in terms of individually-focused journeys and community support, 'but I wonder if the high tide of recovery as an organising definition for our times has already been passed, as we find ourselves in this new environment'.

Issues of crime prevention were already moving rapidly up the agenda, he told the conference. 'While that's certainly a lever for investment, how does it balance with the more positive message of recovery?' The sector was now in a position of having to 'talk to different audiences' locally – directors of public health and police and crime commissioners – and there was also the question of how the vision of recovery set out in the *Drug strategy 2010* translated into local action. 'The broader message from government is that it's not in the business of providing guidance, as that goes against localism.'

Many decisions would now be made in town halls, he said, and while several of the functions of the NTA might live on in Public Health England (PHE), most of the money would go to directors of public health. 'Responsibility for treatment systems, and the chronic and acute health issues of drug and alcohol problems, are passing from the NHS to local authorities, which raises crucial questions around clinical governance. If this was happening with diabetes or mental health, for example, I think we'd be hearing a lot more about it.'

The national policy debate was still very much focused on problem drug users, he continued, particularly those dependent on heroin, despite the numbers of 18 to 24-year-olds needing treatment for class A drugs falling dramatically (*DDN*, November, page 5). The sector was increasingly working with people who had problems with other kinds of substances, he said – skunk, GBL, ketamine and alcohol – as well as particular populations like the LGBT community and victims of domestic violence. 'At a policy level I just don't think we're grasping the potential for a qualitative shift. That's not to suggest we lose the focus on the problem drug users who often have the most entrenched needs, but move to a broader scope that speaks more to the public health environment. We're in a period where careful navigation will be needed.'

Although April 2013 had come to assume the status of a 'canonical date' in the sector, it was very likely that many changes would 'start to bite' later, he said, for example when police and crime commissioners took responsibility for spending Drug Intervention Programme (DIP) funding. 'It's important that you don't drop your guard,' he told delegates. The 'constant talk' – by vested interests – that drug policy was failing was also potentially damaging, he stressed. 'It's not true. But if you're a new commissioner, for example, that's going to be influencing your views. We need to get out and make the case locally.'

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While approaches to treatment did need to adapt to changing needs, said public health minister Anna Soubry, 'we are making inroads and there's much to be proud of. If someone wanted to stop using drugs ten years ago they'd have had to wait weeks – now it's five days. Although I don't like jargon, we've got to work together to make sure recovery is what it says in the drug strategy – an "individual, people-centred journey".'

The government wanted to see more people abstinent and leading productive lives, she stated. 'I don't apologise for that, but I do recognise the role methadone can play in some people's lives.' While there would be 'few that would disagree' that methadone had been inappropriately used – with people 'parked' on the substitute medication – the government had endorsed the *Medications in recovery* report by Professor John Strang's expert group (*DDN*, August, page 5) and there was agreement 'across government' about the role of methadone in treatment.

'Although I don't like jargon, we've got to work together to make sure recovery is what it says in the drug strategy – an "individual, people-centred journey".'

ANNA SOUBRY (pictured with Martin Barnes)

On the subject of payment by results (PbR), she had met with representatives of the eight pilot areas and been 'blown away', she told the conference. 'I'm not saying there aren't difficulties, but there was a real enthusiasm for the work they were doing.' The government intended to learn from the pilots, she said, including how to improve and coordinate support from housing, education and criminal justice departments. Questioned on whether PbR would be rolled out across the country, she said that the government 'genuinely' had an open mind. 'If it's going to be rolled out, we have to do it properly and it has to be properly modelled. It's still early days. It's not an ideological matter – I'm not saying "we're only going to do payment by results". We're going to do what's best, but, so far, so good.'

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The issue was balancing a more aspirational approach with 'some caution', so that what people were expected to achieve was realistic, said Professor Strang, head of King's College London's addictions department. 'We've been inappropriately preoccupied with retention in treatment per se, and my worry is

DrugScope's recent conference focused on how the sector could deliver high quality services in uncertain times. *DDN* reports

that we'll now move on to just focusing on exit from treatment without considering the benefit from treatment.'

He was concerned about people reading things into the drug strategy that weren't there, he said. 'Retention in treatment is not recovery, and neither is abstinence – it might be part of how you achieve it. There will be times when medication helps with recovery, or is even crucial to it, and times when it will be irrelevant.'

This was not an issue unique to substance misuse, he continued. 'In mental health, there are occasions when medication is appropriate and occasions when it's inappropriate. We need to do a lot more thinking about this – if there are exciting things coming down the line like vaccinations to neutralise the effects of cocaine, for example, or long-lasting versions of buprenorphine, then how do these fit in? We need to be skilled practitioners in knowing what's right for people.' It was about 'moving towards something more aspirational', he stressed. 'But you can't just encourage people to go down that riskier aspirational pathway without knowing how you'll deal with it if it doesn't work out.

'In my view we have a lot of substandard treatment in this country,' he told delegates. 'The intensity and quality of the support we provide is not as good as it could be, or as in other countries.' Part of the reason was 'institutional inertia', he said, as well as an 'obscene pursuit' of cheapness. 'Value for money is what purchasers should be pursuing, not cheapness. It's a challenging call.'

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On the question of whether NHS services were needed in the new landscape, strategic director of addiction and offender care for CNWL NHS Foundation Trust, Annette Dale-Perera, told the conference that the NHS was no longer a single entity but rather a range of commissioning groups and provider bodies. A survey of tenders and retendering carried out by the Royal College of Psychiatrists had found that 'if you're the provider you're less likely to win than a new organisation – the grass is always greener – and you're even less likely to win if you're an NHS incumbent', she said. NHS organisations tended to be more expensive, and there was also a perception that they were not 'recovery-focused' enough and too slow to change. 'So it's an ever-shrinking number of NHS providers and we're losing that skill set, losing NHS staff trained in addiction.'

The result, combined with the ongoing split between drug and alcohol treatment, was that the sector was failing to 'future-proof' itself. 'The rhetoric coming out centrally is that drug use is down, but I think seeing drugs as separate from alcohol is becoming more and more outmoded,' she said, with a 40 per cent increase in primary diagnosis alcohol-related hospital admissions since 2002/03.

'Substance use is not necessarily going down if you look at the whole picture, and we have to provide culturally appropriate services to address that. The people who come through our doors are poly-substance users, and that includes alcohol. If you look at the figures, methadone use is up, along with methamphetamine, ketamine, GBL and GHB, BZP, Spice and mephedrone – we've seen young people who've been on mephedrone binges having two-day psychotic episodes. And those are just the drugs they measure – the British Crime Survey, the school surveys and so on, don't measure a lot of the stuff that's being used.'

The move to public health meant a policy shift towards behaviour change at population level, she said, 'so there's a whole new language to be learned, and the NHS needs to be involved. If we ignore that, we do so at our peril.'

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The residential rehab sector, meanwhile, was facing its own particular challenges, said Phoenix Futures chief executive Karen Biggs, including an ageing treatment population, increased running costs and reductions in both public spending and average lengths of stay. While residential services were more expensive than others, this didn't mean they were less value for money, she stressed, and alongside the challenges of evidencing outcomes and PbR, specialist services could 'really struggle' within a localism framework.

'When we look at the value for money argument, the easiest case to make is that residential services provide the expertise and experience to address really entrenched problems,' she told delegates. 'We also need to be able to map our services to provide better matching of clients and evidence the wider "recovery agenda" work we do. We're not a homogenous group – we deliver very different types of services, and I think we're at a time when we can think of residential services as part of an integrated system.'

The programme offered by the Ley Community in Oxfordshire was a year long and highly structured, in a 'safe and enabling environment', said its chief

MESSAGE IN A BOTTLE

'The thing about government alcohol policy, when it comes to interventions and treatment, is that they don't really have one,' said independent consultant Trevor McCarthy at the conference's panel debate on alcohol. PbR was also 'building a postcode lottery' into provision, he said.

While the government had committed to minimum pricing in its alcohol strategy, and would be consulting on it imminently, the most important thing, according to Diageo GB's head of alcohol policy, Mark Baird, was 'evidence-based policy rather than policy-based evidence'. Minimum pricing 'very much fell into the latter category', he said. While the University of Sheffield's minimum pricing studies and other models should inform public debate, 'we shouldn't have policy that's based on modelling'. There was also no evidence that banning quality discounts had any impact, he maintained, or that advertising restrictions along the lines of France's 'Loi Evin' (*DDN*, June 2011, page 21) would have any effect.

'Anybody who comes up with the notion that large private sector organisations spend lots of money on advertising because it has no impact are either stupid or they're lying,' said McCarthy. 'No one has ever said that advertising makes no difference,' countered Baird. 'We're ridiculed all the time for saying that we advertise in order to get people to switch brands, but it happens to be true. This is also one of the most heavily regulated countries in the world when it comes to alcohol advertising, and if we're accused of advertising to get more young people to drink then we're failing miserably, because their consumption has been falling since 2003.'

Alcohol Concern was not advocating for an advertising ban, stressed its director of fundraising and campaigns, Emily Robinson, just 'stricter controls for under-18s'. Policy had been slow to catch up with developments, such as social media, that had made TV advertising a far less relevant issue, she pointed out. 'If we're going to be looking at a new model of regulation then we should be asking young people what they think.'

'Substance use is not necessarily going down if you look at the whole picture, and we have to provide culturally appropriate services to address that.'

ANNETTE DALE-PERERA

executive Wendy Dawson. 'But increasingly I have commissioners saying "can I just purchase an aspect of your intervention?" Well no, because it's a progression. We don't just deal with drugs and alcohol. We deal with issues, and support residents to learn new skills.'

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Just 0.55 per cent of people requiring treatment in the NHS system got a residential place, said Nelson Trust chief executive Steve Cooke, with a quarter of residential treatment centres closing between 2003 and 2010. 'Not everybody needs residential rehab. There are fantastic prescribing services – very few are just dishing out methadone like in the old days – but the sad fact is that residential treatment centres are closing, and when people are in residential they get the time and space to build relationships, build a therapeutic alliance and address the issues that got them there in the first place.'

What mattered ultimately was evidence, UKDPC chief executive Roger Howard told the conference. 'We've spent an awful lot of time beating ourselves up in this sector. If there's one DNA thread running through our *Fresh approach to drugs* report (*DDN*, November, page 4) it's the importance of evidence. We don't evidence properly – many programmes are not evaluated.'

One of the biggest obstacles was cultural, he stressed. 'We struggle against the killer anecdote – "my mate got off drugs this way", or "this is how it was done in this place, so this is how it should be done everywhere". Policy and practice needed to be evidence-imbued rather than evidence-based or informed, he said, with negative evidence seen as learning rather than failure.

It was also vital to extend the debate into the broader social policy arena and issues of inequality, he said, with Child Poverty Action Group chief executive Alison Garnham telling delegates that her organisation had 'a serious problem with the current narrative about how we tackle poverty', such as the troubled families agenda. 'These are not the "neighbours from hell". We have to respond to the urgent circumstances of the children affected by parental drug and alcohol misuse, but we need to respond to that and not the rhetoric.'

Although the sector was undoubtedly going through very challenging times, it had 'never shirked a challenge', DrugScope chief executive Martin Barnes told the conference. 'We do have the passion, savvy and maturity to respond. We've just got to hold our nerve.'

'There's a duty on all of us to demonstrate value for money to taxpayers in austere times,' said Roger Howard. 'But it's even more important to deliver the optimal care.' **DDN**

POLICY SCOPE

How will the core vision of recovery fare as the transition to localism begins in earnest, asks Marcus Roberts

TURNING TIDE?

'While elements of recovery may well flourish there are potential grounds for concern about the core vision.'

Has the high tide of 'recovery' as the organising principle for drug and alcohol services started to recede? There is certainly a question mark about how recovery will fare as the transition to 'localism' gets underway in earnest – with the election of police and crime commissioners (outside London) a few weeks ago, the abolition of the National Treatment Agency in April 2013 and the transfer of most of the drug and alcohol budget to directors of public health employed by local authorities.

While elements of recovery may well flourish in the transition to localism (for example, recovery-themed events, the development of recovery champions and a greater profile for mutual aid), there are potential grounds for concern about the core vision; that is, the understanding of drug treatment as 'an individual person-centred journey' and the focus on 'social capital' and barriers to social inclusion.

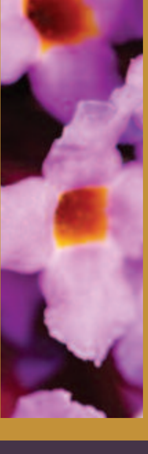
While many providers are embedding recovery in their practice, the impact of this will be limited unless local systems are designed and commissioned to support recovery (for example, integrating substance misuse services with mental health, youth services, housing and employment support).

New local structures will provide some real opportunities for 'joined up' commissioning – for example, health and wellbeing boards – but will local commissioners (such as directors of public health) be adequately supported to design recovery systems, particularly with limited budgets? Not so long ago we were told that there would be a 'road map' for new commissioners to replace *Models of care* and support them in the practical business of 'building recovery in communities'. No proper map to help them to navigate a new and challenging terrain has ever materialised.

There is also a question about how we sell our sector to local decision-makers and communities in tough times. There is a lot to be said for emphasising the impact of drug services on crime – the crime reduction benefit is substantial, well evidenced, delivers a genuine good and speaks directly to community priorities. But representing drug service users mainly as prolific offenders, while it may lever investment, is to rely on a 'politics of fear', and not the message of hope – and the appeal to social justice – that is embodied in the recovery vision.

This is not to counsel despair, nor to be naive about the need for compromise and accommodation (or, in the vernacular, 'ducking and diving'). It is to stress, however, that if we are committed to the recovery ambition we need to be proactively championing it at local level in the months ahead.

Marcus Roberts is director of policy and membership at DrugScope, the national membership organisation for the drugs field, www.drugscope.org.uk



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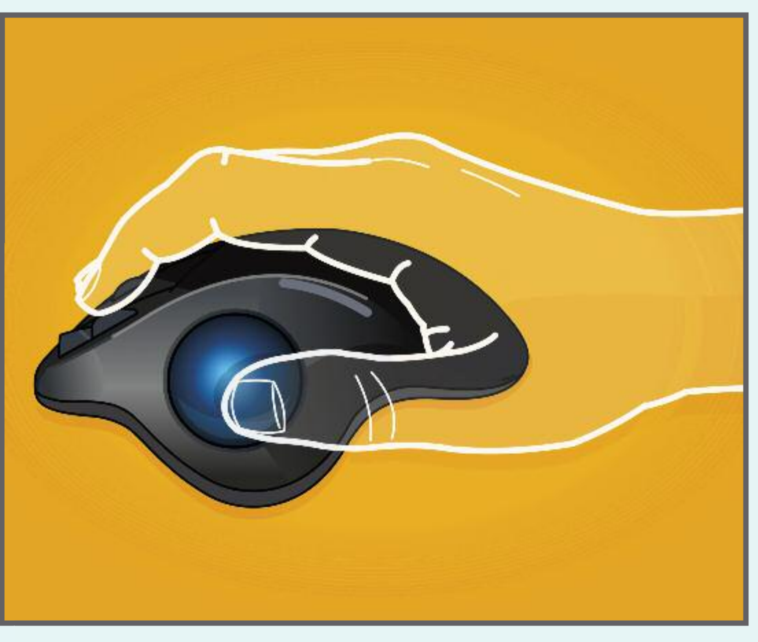


'In an age when research, and research reporting, is beset with controversy around drug-company involvement, undisclosed interests, "ghost writing" and suppression of negative findings, it is important we all are vigilant as to how data is presented and used.'

LACK OF VIGILANCE

I wonder if your editorial team wittingly sanctioned such a flagrant piece of product placement as that exhibited by 'The road less travelled'? (*DDN*, November, page 16).

The authors, McKeganey et al, are discussing the active ingredient buprenorphine and the active ingredient methadone, but one would be forgiven for thinking otherwise. They consistently refer to one by its trade name (Suboxone) the other by its pharmacological name (methadone) and then go on to equate buprenorphine with the buprenorphine-naloxone product as if there is equivalence, or in this case, superiority.

This 'sleight of tongue' renders the European monitoring data quoted meaningless. The penetration of Suboxone as a new product in these European countries is primarily of relevance to the drug company. Comparative prescribing of buprenorphine generally, however, may be a story. The research reported (small numbers, uncontrolled, open-label, not statistically relevant, drug-company funded) is similarly meaningless, seeming to function primarily as product placement. The article is then dressed up more portentously with a quote from Robert Frost and a strap line suggesting we have all got it wrong.

If one means to compare buprenorphine with methadone, do so. If one wants to look at the superiority of a newer product (Suboxone) over buprenorphine then this is not the study, nor would this be the journal to report the findings.

It is acknowledged that the research is supported by the manufacturer of Suboxone, but the authors do not disclose their conflicts of interests.

In an age when research, and research reporting, is beset with controversy around drug-company involvement, undisclosed interests, 'ghost writing' and suppression of negative findings, it is important we all are vigilant as to how data is presented and used.

Dr Ron Alcorn, by email

WRONG FAN CLUB

Is Paul Hayes getting his mum to write letters to *DDN* (November, page 14)? 'I don't wish to hail Mr Hayes as a great visionary' said the letter-writer in the last issue of *DDN*, before going on to spend over six paragraphs doing exactly that.

The argument seemed to be that all the people who campaigned for years to challenge stigma and have people addicted to drugs and alcohol viewed with compassion and caring, and their chronic condition treated as a debilitating illness, have inadvertently managed to dramatically reduce the available funding for treatment. Apparently this well-meaning campaign was in vain, and we should have taken a 'pragmatic approach', continued to let it be a social and criminal justice issue and quietly taken the money. Taking this argument to its logical conclusion, presumably drug users should have just increased their criminality every time they wanted a rise in funding.

I would like to tell your letter-writer, and Mr Hayes, that to me and all of the people I have met in the treatment system over the last 20 years, changing public attitudes towards drug and alcohol problems from one of hostility to support of people's condition is the most important battle that we are fighting. If this can be achieved, drug treatment would not be losing out by competing against perceived worthier health needs like old people's services or child welfare, but would be viewed as an equally deserving health issue.

This is not an attack on Mr Hayes, or the NTA, who have done a great deal of good improving access to treatment over the last ten years, but your letter-writer should put the pompoms and Paul Hayes fan club stickers back in their box, and put their efforts into campaigning to have drug treatment seen as a health issue deserving of proper funding.

N White, by email

TREATMENT TREAT

I would just like to congratulate *DDN* on their recent residential treatment directory (*DDN*, November, centre section). My colleagues and I find it a very useful resource and wondered if it was available in any other formats, and how often it was updated.

R Glover, by email

DDN replies: *We are glad you find the directory useful. We work to make it as comprehensive a resource as possible and update the printed version twice a year. The residential directory and our training and service user group directories are available in the resources section of the new look DDN website. All directories can be viewed as virtual magazines and downloaded as PDFs to print.*

We are working on revamping the layouts of our directories in 2013 to include as many features as we can that will be useful to readers. We are already considering adding map views so that organisations can be searched for geographically as well as alphabetically, but if anyone has any suggestions for improvements please email them to directories@cjwellings.com

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.

ENTERPRISE CORNER

BLINKERS OFF!

Great talent can come from anywhere. If only the government would see it, says **Amar Lodhia**

Last month I wrote about the government's 'out of touch' policies in driving reintegration of those with multiple social disadvantage. I was specifically referring to the Department of Work and Pensions (DWP)'s social justice strategy and the flaws in the new enterprise allowance (NEA) scheme.

On 20 November, I received a letter from the minister for employment, Mark Hoban MP, saying 'I was pleased to learn about the success of your organisation in assisting those in the community who face the greatest challenges in securing employment and training opportunities'. The minister then went on to say that the government 'continues to develop provision which will help unemployed clients with drug and alcohol dependency move closer to the labour market... By 2013, it is hoped that the new enterprise allowance (NEA) scheme will have helped up to 40,000 unemployed people start a business.'

Currently the scheme is eligible to anyone over 18 and who is on jobseeker's allowance, but not those on incapacity benefits or employment and support allowance (ESA) – which marginalises a large portion of drug and alcohol service users and those accessing our self-employment programme. The minister, who declined to meet with me, evidently needs to go back and understand how the NEA scheme is marginalising those who would provide the most mutual benefit from being able to access it.

We have other serious reservations about the NEA scheme, which is estimated to cost the taxpayer £50m. Firstly, this figure implies that the investment per head is just £1,274 and secondly, if the full 40,000 new enterprises are launched under the scheme, it only represents an increase of 0.83 per cent from Britain's existing small-to-medium sized enterprise (SME) population – an insignificant rise for a scheme costing that much.

My suspicion of this government's inability to promote self-employment among disadvantaged social groups was further fuelled when I read chapter 3 of the *Social Justice Strategy*, which states that in 'the welfare system this Government inherited... too many people had been written off on incapacity benefits because they have a health condition or impairment, without support to move towards work...' It is obvious this hypocritical government continues to blame its predecessor, but to me the responsibility of what is happening now is not an inherited problem.

So what should the government do to enable great talent to come from anywhere? Firstly, they need to open up the new enterprise allowance scheme to those on incapacity or ESA benefits. For example, in London and Leicestershire, this could be made available to those who have completed our self-employment programme, E=MC2. Secondly, they should increase the amount invested to at least £5,000 per head.

Thirdly, you will recall me writing about our successful trial of *Breaking the cycle* last year, a scheme which enables those furthest removed from the labour market to gain a work trial within the growing SME sector, and also training SME employers on how to make it a 'value-add' to their business. Despite numerous visits to Downing Street, meetings with DWP and other department officials – and demonstrating results of our successful pilot – the government couldn't allocate £500k to support the scheme.

I'd be interested in hearing your views. Contact me at ceo@tsbccic.org.uk and follow on Twitter @amarlodhia or @tsbclondon using the tag #DDNews.

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

LEGAL LINE

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

DO I REALLY HAVE TO MOVE HOME?

READER'S QUESTION:

I made a homeless application to my local council and they said that I have been accepted but have offered me temporary accommodation in a completely different city, as they have nothing available. I'm really worried about moving away from my friends, family and drug treatment services. It would also mean my daughter having to move schools, disrupting her education when she is in the last year of her GCSEs. Is there anything I can do to stay in my home town?

KIRSTIE SAYS:

You are able to refuse an offer of a property on the basis that it isn't suitable, but many councils will have a policy not to make a further offer if the first is refused.

You can ask the council to review the suitability of the accommodation offered, but you would have to accept the offer and then go through the review process. You would need to live in the property during this time. It is sometimes possible to get legal aid for a housing solicitor to take on these cases.

The suitability of a property can be reviewed on various grounds including the impact that moving to a new area would have on your health, your daughter's schooling, and any other aspects of your life (including if another individual would be negatively affected, for instance if you act as a carer for a family member). It is advisable to provide the council with as much supporting evidence as you can for the arguments you make. This will include letters and reports from your GP, drugs worker, daughter's school and any other relevant people or organisations about how relocation is likely to affect your family.

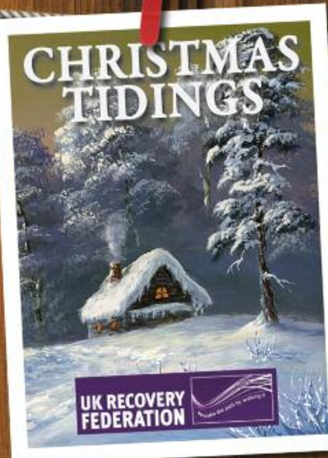
However, it may be that while the council agree that you need accommodation within the local area, that they simply do not have any available. This is unfortunately becoming more common as demand for housing is high and availability of affordable properties low. The council must also consider the cost of accommodation when making an offer of housing, so they could not place you in a home where you could not afford to pay the rent (whether this is directly or through housing benefit). If there is no affordable housing locally they will use this to justify out-of-area placements. It may be possible to challenge the council's failure to have sufficient housing stock via a judicial review. Again, a solicitor may be able to undertake this for you for free.

It is possible to get housed locally, as councils have a list of people placed outside of the local area, but who are considered in need of local accommodation. People are given a priority status (based on individual circumstances) for transfer as properties become available.

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.

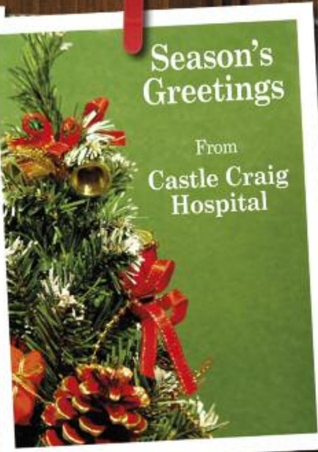
For more information on this issue call the Release helpline on 0845 4500 215.

SEASON'S GREETINGS
Frontier Medical Group

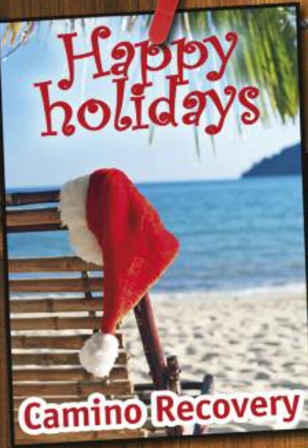


Merry Christmas
and a
Happy New Year

From the NTA
Building recovery in communities



Season's greetings from all at Swanswell
www.swanswell.org



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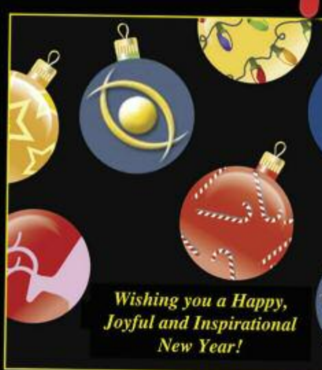
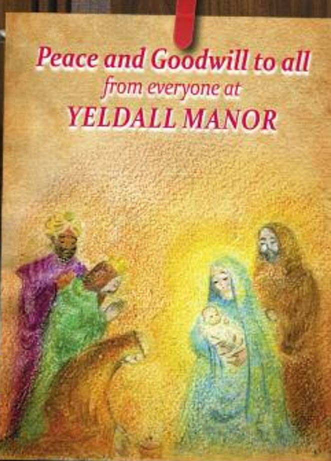
Happy Christmas
Blithe Computer Systems

Christmas Greetings
Action on Addiction





Man of pri

Principal officer at the Police Federation, George Gallimore, talks to **David Gilliver** about how PCCs could affect the relationship between the criminal justice and treatment sectors

The election of police and crime commissioners (PCCs) across England and Wales last month was met with overwhelming public indifference. But the record low turnouts have led to fears that the new commissioners' agendas will be dominated by the local concerns of the fewer than 15 per cent of voters who engaged with the process.

A police officer for 33 years, George Gallimore is principal officer at the Police Federation, and speaks on its behalf on drugs and harm reduction issues. 'The electorate will worry about lower level anti-social behaviour, dog fouling, litter and the minor things that you worry about when you live in an area,' he says. 'People don't generally worry about drugs, because it doesn't affect them directly – that's why it never gets anywhere. Drugs has never been top of police priorities, but I fear the pressure is going to be dealing with the neighbourhood stuff that attracts voters to the polls.'

Gallimore has been involved in drug enforcement policing since the early 1980s, but it was in the mid '90s, he says, that things really started to change, with much more partnership work. 'We can do little alone and I think most people and organisations have come round to that,' he states. 'The biggest challenge will come with the PCC era, and I think that will affect the partnerships more than the police, to be honest.'

The PCCs will have control of the community safety fund and the Home Office portion of the Drug Intervention Programme (DIP) budget, and will inevitably be a major influence on commissioning and how partnerships address local issues. In terms of changes on the ground, however, it's important to remember that the police are also facing a 20 per cent funding cut, Gallimore stresses.

'We'll have far fewer resources – you can't take off 20 per cent and not expect something to give. They've told us that the service won't be harmed, but the fact is that you're now bringing in a political appointment – and most of them will be on a party ticket – to be given oversight and some control of local policing and the police budget. They'll provide all the funding for the community safety partnership and any other group, so DAATs will have to get their funds from someone else. You can only expect your police to do so much with less – if it's not pressing for you, you don't deal with it.'

While there's concern that some directors of public health won't necessarily see drugs and alcohol as important, none of the DIP money or community safety fund will be ring-fenced for drugs and alcohol either. Are drug and alcohol teams right to be concerned they might not be high on the list of priorities?

'I think they are, to be honest. If something else becomes flavour of the month they might well say, "We don't need funding for that DAAT", and the current fondness for payment by results may not assist either. It's difficult in the substance misuse world to say, "There's the result" – long term is the only success you can look at, and nobody wants to wait for the long term. It will be, "I'm not going to be here in four years' time, why should I worry about that? I need to do something that gets me noticed now". We'll still have to deliver national policing objectives or someone will jump in, but if you're not delivering local drug and alcohol schemes who's going to come and shout for that?'

The official line is that the new system will actually improve partnership working, however. 'We'll see,' he says. 'If it works as it's supposed to do it will be great, but there are tensions there and someone needs to take an overview. Tension is good in some respects, because if you don't challenge each other it gets too comfortable. The problem is that chief constables are the best people to do operational policing, but the PCCs will want to impose more of their will.'

Visible evidence of change will be limited in the short term, he says, with the PCCs likely to go with what's worked previously. 'But I think in two years' time you'll see the impact – the PCC might say, "What we're doing now is this" and no one can do anything about it. You can't get rid of them until election time. The Independent Police Complaints Commission, the police and crime panels – none of them have the power to get rid of them. They'll become quite powerful locally.'

The Home Office is adamant, though, that the PCCs will have more of a

nciple

democratic mandate and be more accountable locally. 'But will they?' he says. 'Police authorities were made up of local councillors, across political parties, and magistrates, so there was a level of independence because they all countered each other's arguments. But if one person decides, one person decides. The question locally is what they'll direct us to do. The chief officers will have to take account of national matters – major public disorder and major events like the Olympics and so on – but after that it's what the PCC wants to the chief to do.'

*****

Even the best practice worldwide remains dependent on the whims of elected officials, he states. 'You see good stuff internationally, like safe injection rooms, but all it takes is for someone to come along and say, "I don't fancy that." You need that buy in.' One example here is custody suite-based drug workers, something that took a long time to embed in the police culture – could they be at risk? 'Absolutely,' he says. 'I don't think anyone's safe, and if you work in the margins where you don't see immediate stuff like the crime figures coming down, then you're in danger of them funding something that gives them that instead.'

The combination of the advent of PCCs and move to Public Health England means the risk of fragmentation is real, he warns, with the new landscape representing the 'biggest change since the Police Federation began' in 1919. 'We've always kept up with change – if you ask us to do things differently we will, and we'd really like the PCCs to be a success, but we have concerns that some things might get lost. The public needs to keep on the case of their elected PCC.'

*****

Following a brief spell as a civil servant, he's been a police officer since 1979 – 'I found a job I liked,' he says – and one of the major changes in that time has been the growing call for decriminalisation. 'Not that I concur fully with Peter Hitchens, but I flicked through his latest book and he's right, there is no drugs war – all we do is skirmish around the edges. But on a personal basis, I think we're missing a trick. I'm in broad support of looking at anything that reduces the crime aspect and the damage to society. If you could do it properly, why not? The world lives on drugs – legitimate drugs – so the issue is criminality. Most of the criminals involved in it don't take drugs, they make money.'

In the old days his officers would 'put away two street dealers every week', he says. 'They went to jail in the morning and someone else had taken over their patch by the afternoon. I think we've moved away from criminalising users. I wouldn't punish users – I've never been into that – it's the people who make money from it and cause suffering to other people that we should be looking at.

'I'm a family man who lives in society – I'm no different, I just have the power of force on behalf of the state. I'm just someone who lives in this society and enjoys trying to keep it on a straight line.' **DDN**

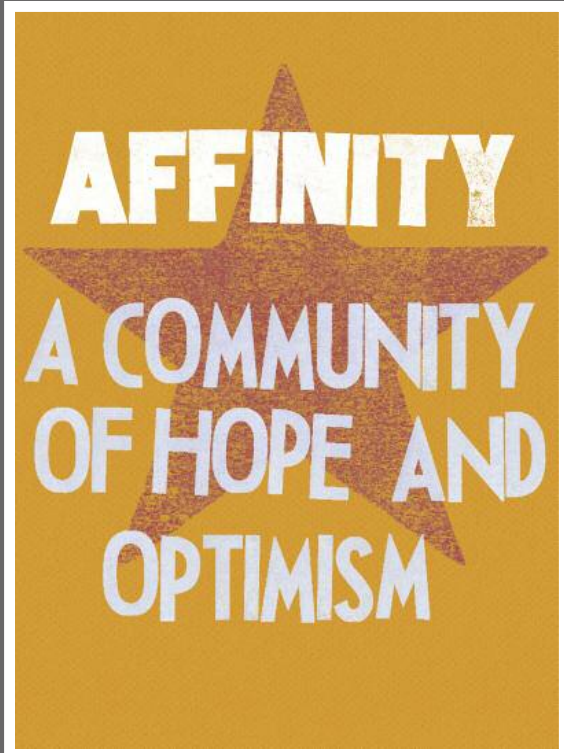
'We'll still have to deliver national policing objectives or someone will jump in, but if you're not delivering local drug and alcohol schemes who's going to come over and shout for that?'

George Gallimore

VOICES OF RECOVERY

PEOPLE POWER

The last year has seen dramatic change in bringing small and disparate recovery communities together in Lancashire, say **Alistair Sinclair** and **James Attwood**



COMMUNITY-LED RECOVERY IS BECOMING MORE AND MORE VISIBLE WITHIN LANCASHIRE THESE DAYS. For many recovery activists here it feels like new, diverse and creative communities of recovery are growing, becoming more confident, making new links and becoming stronger.

The Lancashire User Forum has launched its recovery barge (the LUF boat), the Red Rose Recovery Choir is finding its voice, Recovery Radio has taken to the airwaves and at the beginning of November more than 200 people turned out on a rainy Saturday afternoon to support the launch of The Well. Every Saturday afternoon since then has seen the Dallas Road boys' and girls' club in Lancaster transform into a social club, run by and for people in recovery, which, as one of the launch participants put it, 'brings people together to share stories, support each other and build recovery'.

Described by Dave Higham, a local recovery activist who worked tirelessly with a few others to pull the social club together, as 'a source of strength, a place where people can come to power up', The Well is a place where people in recovery and family and friends can come together to play some sport and games, paint faces, drink tea, chat, make new friends and have fun; a safe place in the community where people can connect and build on their strengths.

Not just a social centre, The Well is also the base for a 'Warrior Down' (*DDN*, November, page 20) support network which will offer peer support in the community to people who are struggling. It intends to be self-sufficient and independent, reflecting a desire to develop community recovery and, judging by the diversity in the room at the launch (local social enterprises, faith groups, fellowship members, political activists, the UKRF, the mayor) it's on the way.

Here's what people had to say at the launch: 'The Well makes recovery visible in the community, it's about building a space where people in recovery can come together and grow their recovery through the building of friendships' (Lesley); 'We want to empower people to support their own recovery. What's unique is we're bringing family members and people in recovery together to build new relationships because its relationships that sustain recovery' (Dave Higham); and 'Projects like these are the future, the future is about communities coming together to sort things out for themselves' (Hayden Duncan NTA).

A week after the launch of The Well, the editorial team of the Lancashire *Affinity* newsletter met at the social club to plan their second edition. Launched in October this newsletter is produced for free by volunteers from the Lancashire recovery community and distributed free to anyone who wants it. The newsletter focuses on celebrating recovery and making visible what supports the 'five ways to wellbeing' in Lancashire. It connects people, advertises activities, encourages reflection, supports people in taking notice of the good stuff around them, encourages learning and provides opportunities for people to give within their communities.

Hosted on the UK Recovery Federation website, the newsletter is also available to everyone to download for free. It's early days but by producing it in this way it's been demonstrated that when people with passion come together and map their assets (a process that started at a Lancaster UKRF recovery seminar in November last year) it can be surprising – to some – just how much they can do for themselves without funding and without services' involvement.

If people want a print copy of the *Affinity* newsletter they can print it off themselves and if services want to distribute it then the cost is theirs. Through doing it this way the *Affinity* group has maintained its independence. It's a way of working that can be reproduced anywhere by anyone who has the will to do it. The *Affinity* newsletter has the potential to be a voice that connects and celebrates the recovery community in Lancashire. It can help to make recovery visible and it could support the growth of stronger networks based on an 'affinity' – a commitment to promote the 'five ways to wellbeing' for all and a desire to support recovery in its widest sense within communities.

While there have been small recovery communities in Lancashire for quite a while (the fellowship and friends from rehabs supporting each other) they've often been invisible to those who didn't know where to look, and the various recovery pockets were disparate and unconnected. The last year or so has seen this change dramatically. Communities of recovery have started to come out into the light and, as they've done so, they've begun to articulate a message of solidarity, hope and optimism. In becoming visible, new connections and friendships have been made and stigma challenged in real and concrete ways. The Well has just begun and it'll be a while before we see an Affinity network in Lancashire. But it's a good start and there are plenty of people in Lancashire who are committed (as we say in the UKRF) to making the path as we walk it. *James Attwood and Alistair Sinclair are UKRF* directors.

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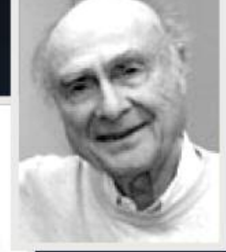

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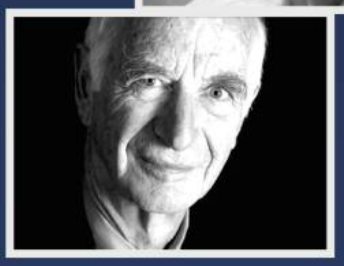

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Body of evidence

The UKDPC's final conference saw politicians, policymakers, commentators and media representatives gather to discuss where next for drug policy. *DDN* reports

'We need a new conversation about drugs,' UK Drug Policy Commission (UKDPC) chair Dame Ruth Runciman told delegates at the commission's final conference, *New generation, new problems, new drugs*, last month. The UKDPC had been set up in 2007 to 'provide objective analysis of the evidence for drug policy and practice and improve public understanding', she said, publishing its final report in October (*DDN*, November, page 4). 'The wider social and economic issues around drug use are at least as important, if not more so, than polarities around the legal status of drugs,' she told delegates.

Policy had not worked over recent decades, chair of the all-party group on drug policy reform, Baroness Meacher, told the conference. 'In 1971, when the Misuse of Drugs Act was passed, the government of the time believed that the drug problem would have been solved by 2010, but there has been a phenomenal increase in drug use over that time. The situation is out of control, and all the money is going to terrorists and drug barons.'

It was important to abandon the assumption that there would ever be a drug-free world, she said, along with beliefs that emerging substances could be dealt with through the classification system or that banning a drug had any real effect. 'This needs to be looked at properly, because we don't have a logical system.'

Education was a vital tool, she stressed. 'We're beginning to learn about preventative policies that work. It's not about a didactic approach of just telling them in the classroom not to take drugs, but interactive teaching, building resilience and confidence and the ability to withstand peer pressure, hearing from people who've experienced drug use. We know what works in schools, and that's what we should be spending the money on.'

Evidence needed to be 'treated properly', said Liberal Democrat federal executive member Dr Evan Harris. 'Policymakers need to be able to understand what is stronger and weaker evidence – randomised control trials, for example, are stronger than anecdotal evidence. There's a hierarchy of strength of evidence – it's not all subjective. Policymakers need to have a broad understanding of this.'

The argument that drug policy should be guided by evidence and not ideology made 'no sense', however, argued director of the Institute of Ideas Claire Fox, and the assumption that 'better evidence and science' would solve the problem was 'false'. Politicians surrounded themselves with experts and advisors through lack of confidence in their own beliefs and ability to convince the public, she said – 'that's why evidence is given the last word'.

The 'obsession' with evidence was also the reason that the focus of so much drug policy was on harm and safety, she said. 'There's nothing about indulging in personally risky behaviour that merits state intervention. It's up to people to decide how to live their lives.'

'One of the saddest things is that we've gone backwards,' said chair of the Independent Scientific Committee on Drugs, Professor David Nutt, 'from the introduction of needle exchange, which was not desired politically but which led to the UK having one of the lowest rates of HIV among drug users, to a point where politicians are interested, not in evidence but in pieces of data that support their decision.' Foreign examples such as the moves by US states to legalise cannabis, however, could demonstrate to politicians that 'it didn't always end in tears'.

Drugs were an issue about which the media, the public and, to a lesser extent, politicians were able to hold conflicting views simultaneously, said chief executive of Ipsos MORI, Ben Page. While drugs came below things like anti-social behaviour and litter in terms of public anxiety in MORI polls, at the top of the list of where people got their information from was the media.

People's priorities were drug supply, he said – which put them in line with policing priorities – while 'providing long-term treatment, care and support' for drug users came bottom of the list. The media were 'not always coherent', he said, but they were extremely influential.

'The power of the media is not as great as you think,' responded writer and broadcaster Vivienne Parry. 'It disturbs me the way we talk of the public as fools with no independent opinion. Newspapers are mirrors – we choose the newspaper that reflects our opinions.' Newspapers engaged with their readers through online comments and letters pages and knew their views, she stressed. 'If you have someone talking about the death of their child from drugs, for example, that's extremely emotive. And the public's response tends to be "something must be done".'

Honesty and transparency are crucial: 'We can have these arguments, but in a democracy we need to have them in a way that we can carry the public with us.' David Blunkett

Presenting complex information and arguments in a tabloid context was difficult, she continued, and the press also feared alienating its readers at a time of declining circulations. 'If they present an evidence-based argument, such as free needles, what they get back is a wave of anger, especially from people who have medical conditions themselves. But should the media be held accountable for what they write? Yes.' One effective way of doing this was to 'subject editors to a constant stream of short, concise letters saying "you've got this wrong",' she pointed out.

Proper analysis was 'tough stuff to sell in a 24/7 communications world', said broadcaster Roger Graef. 'Journalists are in default mode these days and they'll get their stuff off press releases or the wires, because solving the drug problem is a hard issue to think through with those pressures of time.' The 'catastrophic' effects of welfare cuts were also something that editors tended not to engage with, said former home secretary David Blunkett MP, as they rarely had family that were affected by them.

One of the dangers of policy was that there was 'no shared starting point', said Liberal Democrat MP Julian Huppert. 'There needs to be much more clarity about what we're trying to achieve before we talk about how to achieve it, and if you're going to experiment with things, then the penalty paid in the media has to be lower. It has to be a less politically painful process, and we need to be able to scale things up quickly when they do work.'

It was vital to take account of all the evidence, even when that evidence was 'inconvenient,' said former chief inspector of constabulary, Sir Denis O'Connor. 'There's a split between elites and the way they talk about drugs and ordinary folk who don't read all the reports – policy has to make sense locally as well as nationally.' Persuading people took a lot of effort but it could be done, he stressed. 'Arguments need to be set out coherently and honestly, we should have pilots, and they should be properly reported on.'

'If we can't agree on basic statistics, we can't learn from other parts of the world or what's been happening here,' said David Blunkett. 'If we can agree on what's made some difference – even if not enough – then we can agree on what can be scaled up.' Honesty and transparency were crucial, he said. 'We can have these arguments, but in a democracy we need to have them in a way that we can carry the public with us.'

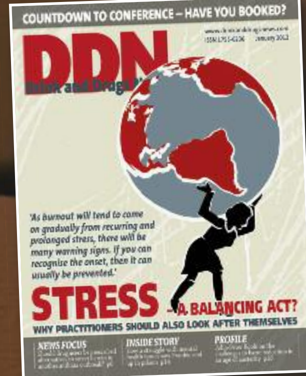
There was a view that 'if only politicians were brave and said what they really thought it would all be all right', he said. 'But it's about creating a wave – as with the Make Poverty History campaign – on which those politicians who are convinceable can ride. It involves a degree of leadership, but if you don't have people behind you then you won't pull it off.' **DDN**

Next issue: Roger Howard sums up the work of the UKDPC

SHIFTING

2012 ACCORDING TO DDN

While the frequently hot-tempered harm reduction/ abstinence debate that had characterised previous years finally appeared to be morphing into something more measured, 2012 still saw the sector negotiating upheaval on all sides and dramatic shifts in patterns of drug use.



JANUARY

Perhaps fittingly for early January, 2012 begins with a call from the cross-party science and technology committee to review the government's sensible drinking guidelines, including a recommendation for at least two alcohol-free days a week. The government launches its controversial 'troubled families' agenda and, in what is to become one of the year's defining characteristics for policy debates – celebrity endorsements – Sir Richard Branson writes in the *Telegraph* that it's time to end the 'failed drug war'.

FEBRUARY

The UK has reached an 'alcohol death tipping point', warns the Royal College of Physicians' special advisor on alcohol, Professor Sir Ian Gilmore, with the next 20 years potentially seeing more than 200,000 avoidable deaths. Meanwhile, the fifth national service user conference, *Together we stand*, sees another day of vibrant debate and vital networking at its brand new venue, Birmingham's NEC.

MARCH

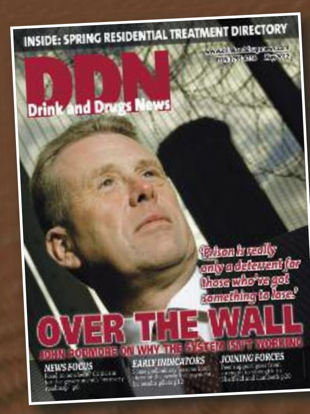
The government launches its long-awaited alcohol strategy, which contains something many people thought they'd never see – a commitment to a minimum price per unit of alcohol – while north of the border the Alcohol Minimum Pricing Bill passes its first stage in the Scottish Parliament, although Labour abstains. Methoxetamine, the 'legal high' sold as a 'safe' version of ketamine, becomes the first substance to be banned under a temporary class drug order (TCDO), the NTA publishes research showing that the number of crimes committed by drug-dependent offenders fell by almost half after successful completion of treatment, and the Home Office publishes its 'recovery roadmap', *Putting full recovery first*.

APRIL

Putting public health first, a statement signed by around 40 organisations and individuals, attacks the 'recovery roadmap' for ignoring 'decades of evidence' and potentially putting the wellbeing of clients at risk, while the Obama administration publishes a drug strategy stating that 'outdated policies like the mass incarceration of nonviolent drug offenders are relics of the past that ignore the need for a balanced public health and safety approach'. A new synthetic drug is being detected in the EU at the rate of roughly one per week, says a report from EMCDDA and Europol – a 'global phenomenon developing at an unprecedented pace'.

MAY

'The government has spent £3bn on moving the deckchairs around the Titanic,' is how RCGP chair Clare Gerada describes the health service reforms at the organisation's *Managing drug and alcohol problems in primary care* conference, while work and pensions secretary Iain Duncan Smith hints at plans to cut the benefits of people with drug and alcohol problems who refuse to enter treatment. Ex-governor of Brixton and Belmarsh prisons, John Podmore, meanwhile, tells *DDN* that, 'We know, but we won't accept, that we use remand to deal with social problems' – locking up people with substance and mental health problems to get them off the streets. 'The least we can do is provide that in some form of supported housing, not a prison.' The Scots finally pass their Alcohol Minimum Pricing Bill, declaring that 'cut-price alcohol will become a thing of the past' and prompting threats of legal action from the industry.



JUNE

UNODC predicts 300m drug users globally by the end of the century and, in what may be a taste of things to come, a bitter row breaks out over the transfer of drug services from the NHS to the charity sector in Manchester.

G SANDS

Meanwhile, the war of words over the government's welfare reforms continues in the press, with the liberal media calling for an end to the 'invidious moral crusade against the poor' while other papers continue to act as cheerleaders with articles about 'junkies' and 'scroungers'. 'The government caricatures poor people in terms of the worst cases they can find,' writes Polly Toynbee in the *Guardian*. 'So far they have won the argument.'

JULY

Two years on from the largest UK 'common source' anthrax outbreak in humans for half a century, NHS Lanarkshire issues a chilling confirmation of an anthrax infection in an injecting drug user, and EMCDDA reports cases in Germany, Denmark and France. Meanwhile, Professor John Strang's expert group delivers its final report, rejecting the idea of time limits for treatment but recommending that substitute prescriptions be regularly reviewed and more priority given to 'the desire of individuals to overcome their dependence on drugs'. The government's focus on binge drinking risks sidelining public health in alcohol policy, warns the House of Commons health committee, while a UNAIDS report states that, despite a 20 per cent reduction in new HIV infections worldwide between 2001 and 2011, Eastern Europe saw 170,000 new infections in 2011 alone, largely the result of contaminated injecting equipment.

AUGUST

'I believe we are approaching the point where we can achieve a genuine consensus that will be of benefit to practitioners and patients,' Professor Strang writes in *DDN* of the harm reduction versus recovery debate, adding that 'well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys'. A fatal anthrax infection in Blackpool brings the number of cases across Europe to eight, and Scotland records its highest ever number of drug-related deaths, with the number of cases potentially involving methadone leading to calls in the press for a parliamentary inquiry. 'We throw away £36m every year doling out more and more methadone in the face of less and less evidence that it achieves anything but line the pockets of those involved with dispensing it,' thunders the *Daily Record*.

SEPTEMBER

Blackpool sees a second fatal anthrax case, and Public Health Wales confirms a case in Gwynedd. As a new report reveals that rates of premature death from liver disease are higher in the North West than anywhere in England – and have doubled since 1995 – British Liver Trust chief executive Andrew Langford tells *DDN* that 'we really do have to educate the health and wellbeing boards, and particularly the directors of public health', about the importance of investing in treatment.

OCTOBER

UKDPC calls for a wholesale review of the Misuse of Drugs Act and the classification system in its *Fresh approach to drugs* document, while the NTA reports that the number of young adults needing treatment for heroin or crack has plummeted to the lowest recorded level, making the over-40s the only group whose numbers in treatment are increasing. 'Young people are savvier about heroin and crack than they were in the '80s,' says chief executive Paul Hayes. The Scottish Government commissions an independent expert group to look at the evidence for opiate replacement therapies and new Public Health England chief executive Duncan Selbie tells the *City health 2012 conference* that relocating public health in local government is a 'stroke of genius', pledging that his organisation will make sure drug treatment is 'evidence-led'.

NOVEMBER

The EMCDDA reports that Europe may be entering a 'new era', with declining heroin use but a bewildering and ever-growing array of new synthetic drugs, while the American states of Colorado and Washington vote to legalise and regulate marijuana, although the drug remains illegal at federal level. Area manager of Islington Community Alcohol Service Hazel Jordan writes in *DDN* that swamped alcohol services are 'only scratching the surface of need', while Neil McKeganey and colleagues call for a reevaluation of Suboxone, currently prescribed to only a fraction of the number of people who are prescribed methadone.

DECEMBER

The sector prepares for the year when all the talk, and Public Health England, becomes a reality. As DrugScope chief executive Martin Barnes tells conference delegates, the sector has 'the passion, savvy and maturity' to respond to challenging times. 'We've just got to hold our nerve.'

In the fourth part of her story, **Marie Tolman** gets her first real taste of family life – but will it last?

My journey of self-discovery

A week after I met Francis we left Phoenix house prematurely. Staff and residents advised me to stay, but I insisted I was in love and was going to be with him. Two hours behind Francis, I walked down the path and there he was sitting waiting on the bench, our whole lives ahead of us. We were on a journey and unsure where to, but we knew for sure it was together.

I did get a custodial sentence. When I came home we lived with my parents for a bit, and then Francis's mum. Francis junior also moved back with us full time and it was so exciting, taking him to school each day, waiting outside for him to come out, playing in the park, and having purpose. We had no expectations of each other – we just enjoyed every moment as it came.

This was soon to be overshadowed by the fact that, upon my release from prison, we somehow had to test each other and see who would go to extremes with drugs and criminality. We messed up and within weeks were out of our depth. We came to realise that this wasn't the life we wanted – our love for each other and Francis was too precious.

It took four long months before we got back into the treatment system. Every day we would do the minimum to get by and it was horrible. People would say we had a choice and we could have just stopped, but addiction doesn't work like that.

One day Francis junior and I were going to town on the number 17 bus, the best of mates. Never had his dad or I ever said 'this is your new mum' – I was just Marie. But suddenly he looked at me and said 'mum'. This amazing little boy had unconditionally accepted me – a thief and a smackhead – as good enough to be his mummy. To this day he has never called me anything else and we have a unique and special bond.

Methadone brought stability and we got a new house in Wallasey. It was a dive, but all I could see was our new home. We spent weeks cleaning it and friends and family were so generous in giving us bits and pieces – we turned it into a beautiful family home. Our lives felt full and happy, and another precious gift came our way when I found out I was four months pregnant. Francis junior was so excited that I took him to all my scans.

I panicked and cut down my prescription medication to just 10mls and then 5mls. Chloe was breach, so I had to have a Caesarean section, and the experience I had in hospital was appalling. I was heavily judged. The first surgeon refused to operate and when they finally did, they were all wearing what looked like space suits. Chloe was treated as if she was on a higher level of medication (and I must take responsibility for that, by not being honest) and looked to me as though she was also being treated like a second-class citizen. She was an innocent little baby who deserved none of this.

I was treated like a leper. One particular midwife, whom I had asked to be discreet about my medication, came in and announced my methadone in front of all the other mums. Later that day I explained that nobody would choose to be an addict and she told me that nurses had had their handbags stolen, and they had caught women taking drugs in the toilets. But after that she accepted and supported me, seeing past the label to the person underneath – Marie, a women who was already feeling guilty and frightened.

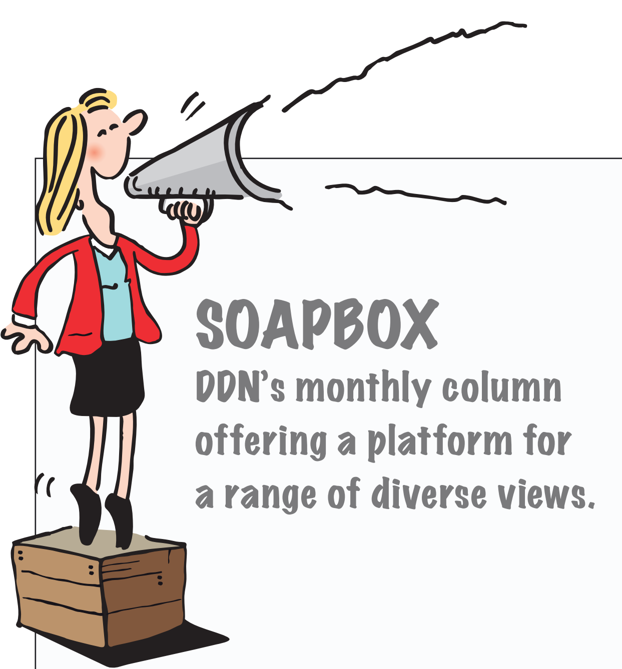
Francis's mum passed away, which seemed so unjust as we so wanted her to be part of our lives. Then my dad passed away, actually dying the day we set the date to get married. We'd just got money through from sale of Francis's mum's house and were able to pay some money back out of the huge amounts we owed him; I always say it was the shock of us paying him back that gave him a heart attack.

We got married in the same church where the funeral had taken place only weeks earlier. It was a magical day and when Joseph was born two years later, my experience was very different. The midwives had more knowledge of addictions and care of babies and mums.

To the outside world we were the perfect family – beautiful family home, fantastic children, family days out, jobs and a car. But behind closed doors lurked insecurities, I think brought on by postnatal depression. Once again drugs found their way back into our lives.

Next issue: Can Marie survive her latest crisis with the family intact?

'Methadone brought stability and we got a new house in Wallasey. It was a dive, but all I could see was our new home.'



ENTRY POINT

Harm reduction services are the door to recovery and must be protected, says Michelle Judge

A NATIONWIDE NETWORK OF NEEDLE EXCHANGES has been a feature of drug treatment in England since the late 1980s, when the Advisory Council on the Misuse of Drugs' (ACMD) 1988 report warned that 'HIV is a greater threat to public and individual health than drug misuse'.

The Conservative government of the day responded swiftly to the report by establishing needle exchanges, and successive governments have invested in improving the quality and availability of treatment, including harm reduction services. As a result, despite having one of the largest populations of heroin and crack users in the western world, England has one of the lowest rates of HIV among injectors – 1.3 per cent in 2011, compared to 3 per cent in Germany, 12 per cent in Italy, 16 per cent in the USA and 37 per cent in Russia.

We know that drug users come into treatment wanting to overcome addiction, and this is the aim of all drug treatment. At the same time, it is vitally important to keep people safe as they recover. Taking action to minimise the risks that go with drug dependence, such as drug-related death and contracting blood-borne viruses, can be an important first step, especially for those who have been dependent on drugs for some time. Providers of these services are an important link to other treatment and recovery services, such as mutual aid.

Treatment services and needle exchanges work to change individuals' behaviour via a number of step changes that initially emphasise the importance of using sterile equipment and not sharing, then encourage the shift to non-injecting use and, ultimately, to overcoming addiction.

This approach has not just kept HIV rates low. The number of injectors has also fallen, from 137,000 in 2004-05 to 103,000 in 2009-10, while sharing has declined, almost halving from 33 per cent of injectors in 2001 to 17 per cent in 2011. Fewer people injecting drugs is one of the best protections against drug-related harm.

Drug injectors are vulnerable to a wide range of viral and bacterial infections, which often lead to illness and death. Hepatitis C, which can cause liver disease, poses the biggest risk, and is much more prevalent in England than HIV. Around 45 per cent of injecting drug users currently carry the virus, although this figure has been broadly stable since 2002 and is still lower than in many other European countries (for example, Netherlands at 65 per cent or Sweden at 84 per cent) according to the Health Protection Agency (HPA).

One in six drug injectors has been infected with hepatitis B at some point in their lives, down significantly from 2001 when it was more than one in four. This fall is likely the result of targeted hepatitis B vaccination programmes, including in prisons, which saw vaccination rates among drug injectors leap from 37 per cent in 2001 to 76 per cent in 2011. There is no equivalent hepatitis C vaccination and, of the total 12,642 hepatitis C infections diagnosed in the UK during 2011, around nine in ten were a result of injecting drugs.

Recent UK research estimates that removing substitution treatment and needle exchanges could lead to a 25 per cent rise in hepatitis C among drug injectors. To bring down hepatitis C prevalence, treatment needs continued investment. Evidence shows current injectors can achieve similar treatment outcomes to non-injectors, while NICE guidance says that treating injectors is also cost-effective.

Injectors also run a much higher risk of premature death. Drug-related deaths escalated rapidly in the 1990s, from 1,025 in 1995 to 1,697 in 2001. Since then the number has stabilised at around 1,500 a year, with a spike of 1,800 in 2008 but falling back to 1,461 in 2011. We know that heroin and crack users in treatment are less likely to die than those not receiving treatment – the escalation of drug-related deaths slowed from 2001 as the treatment system expanded.

The current situations in Greece and Romania show that disinvestment threatens public health. Injectors are now the population most affected by HIV in Greece, following significant disinvestment from drug treatment and harm reduction services as a result of the economic crisis. Injectors represented 41 per cent of all new infections in 2012, compared to 2-3 per cent in 2006-2010, while in Romania, significant downsizing of harm reduction services has seen HIV prevalence among injectors increase from 1.1 per cent in 2008 to 52.5 per cent in 2012.

For the moment, blood-borne virus figures for drug injectors remain comparatively low in England, and drug-related deaths have stabilised. But if we are to see these numbers fall further, maintaining needle exchanges and other harm reduction services is vital. Responsibility for commissioning harm reduction services shifts to local authorities from April. The cost-effectiveness of these services is self-evident, the consequences of disinvestment clear.

More positively, harm reduction services integrated within the treatment system provide the entry door to recovery. The more we reduce the harm caused by injecting, the more people will be around to recover.

Michelle Judge is programme officer at the NTA

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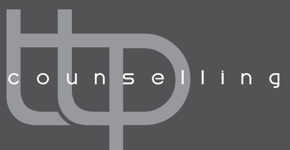

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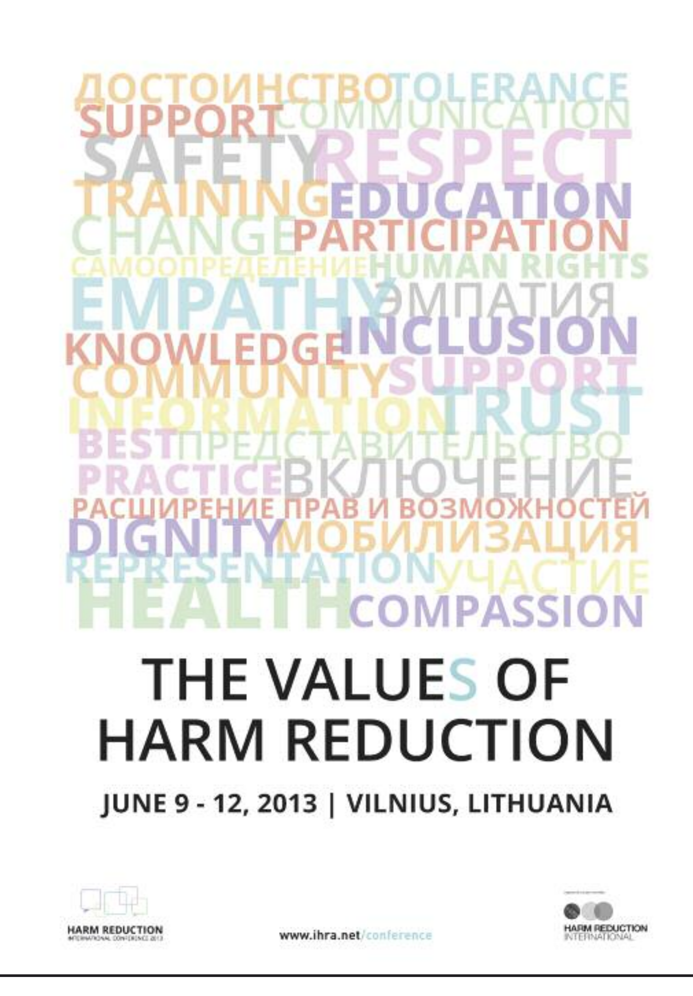

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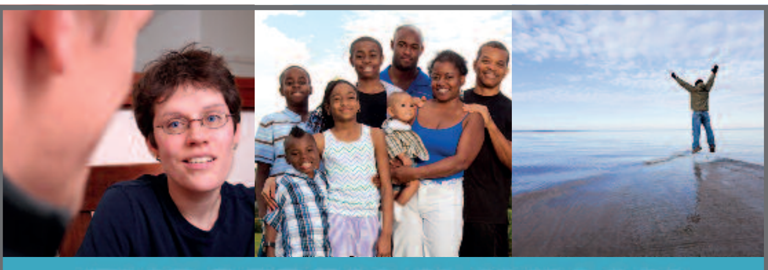

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Brief solution focused therapy	*4 & 5 June*
Controlled drinking programme	*20 & 21 June*
Training for trainers	*25 & 26 June*
Effective leadership	*12 & 13 November**
Working with concerned others	*14 & 15 November*

**Effective leadership £275 (+VAT)*

Online booking available

INVITATION FOR EXPRESSIONS OF INTEREST FOR THE PROVISION OF SUNDERLAND INTEGRATED SUBSTANCE MISUSE SERVICE

Sunderland City are seeking expressions of interest from suitably qualified and experienced providers who can deliver high quality substance misuse treatment services in the Sunderland area.

It is expected that the Framework will commence on 10 July 2013 for a period of two years with an option to extend for a maximum of a further twelve months at the sole discretion of the Council.

The Framework will consist of:

- **Lot 1 – Recovery Pathway**
- **Lot 2 – Clinical Interventions**
- **Lot 3 – Specialist Harm Reduction Service**
- **Lot 4 – Psychosocial Interventions**

Please note, this is an electronic tender process.

All organisations interested in this tender process should register an expression of interest against this contract (NEPO reference: QTLE-8WSHJJ) online at www.qtegov.com from, 04 December 2012.

The Council will be using the Restricted Procurement Procedure to select potential tenderers.

An Information Session will be held for Providers on:

Date: 12 December 2012
Time: 14:00
Venue: Committee Room 2, Sunderland Civic Centre

Please ensure that you confirm your attendance at the Information Session by contracting Chris Cummings, as detailed below.

If you have any questions in relation to the tender process, please contact Chris Cummings, Category Manager – Social Care, Corporate Procurement Team, telephone 0191 561 2377 or email chris.cummings@sunderland.gov.uk

Alcohol Concern
Making Sense of Alcohol

Our new phone number is 020 7566 9800

As a result of internal promotion within the Service, Early Break, a high profile young people's Drug and Alcohol Service, is looking to recruit for the following managerial posts:

AREA BUSINESS MANAGER £36,183 - £43,550

As part of the Senior Management Team, you will support the organisational management of Early Break, ensuring the highest standards of business and charitable governance. This will be achieved by leading and managing finance, administration, practice and service delivery to young people and their families in Bury and Rochdale.

A relevant degree and/or equivalent relevant professional qualification, will be complemented by managerial experience in a young people's service setting, ideally substance misuse, and management training/qualifications.

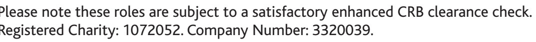
AREA OPERATIONAL MANAGER £29,132 - £32,680

Providing day-to-day support to the Area Business Manager to ensure the highest standards in clinical service delivery to our clients, you will line manage colleagues to ensure all fulfil their professional requirements.

Degree qualified or qualified by experience, you will hold a Level 3 Substance Misuse Practitioners Certificate and have experience of working in a young people's substance misuse service. Management training would be desirable.

For an application pack, please email Barbara Hampson, PA to the Chief Executive bhampson@earlybreak.co.uk or telephone 0161 723 3880, stating the role you wish to apply for.

Closing date: Noon on Wednesday, 19th December 2012.
Interview dates: Tuesday, 15th January 2013 (Area Business Manager).
Wednesday,16th January 2013 (Area Operational Manager).



Please note these roles are subject to a satisfactory enhanced CRB clearance check.
Registered Charity: 1072052. Company Number: 3320039.

CAN is an established and thriving agency, providing a range of drug, alcohol and homelessness services throughout Northamptonshire and Bedfordshire

We have a range of exciting full and part time opportunities within our Substance Misuse CAN Partnership service delivering a range of recovery focussed open access specialist services to residents of Bedfordshire.

- **Volunteer and Mentor Coordinator – Countywide Bedfordshire**
- **Recovery Practitioners – Bedford and Dunstable**
- **Family Support / Recovery Practitioners – Dunstable**
- **Recovery / Intensive Family Support Service Practitioner – Bedford**
- **Community Recovery Practitioners – Bedford**
- **House Project Facilitator – Bedford**
- **Employment Training & Education Worker – Bedford**

For full details visit our website www.can.org.uk

CAN offers competitive salaries, 24 days annual leave plus statutory days, Pension Scheme and development opportunities. **Closing date for returned applications is, Sunday 16th December 2012**

Alternatively you can email recruitment@can.org.uk, fax 01604 635679, or write to the Administrator, 8 Billing Road, Northampton, NN1 5AW giving your full name and address to request an application pack.

Sunday Times 100 Best Non Profit Organisations to work for 2012
Equal opportunities matter at CAN

Merry Christmas
and
Happy New Year
to all our readers.

The next
DDN
will be out on
14 January

BE THE CHANGE

'You must be the change you want to see in the world.'

Mahatma Gandhi

Join us for this year's service user involvement conference – our sixth annual national event to make sure the service user's voice is heard loud and clear. Once again we will host the field's number one networking event while bringing crucial issues to the table – and then to politicians and policymakers. Bring your voice, your concerns and your passion for change and help us form the service users' agenda for 2013 – more crucial than ever in the changing landscape of drug and alcohol treatment becoming part of public health.

This year's programme will feature:

- The best new peer inspiration from service user group colleagues around the country
- Discussion session on how we fit into Public Health England
- Back to work and entrepreneurial skills
- Practical workshops teaching essential skills and knowledge
- Health advice and harm reduction
- Recovery inspiration • Exhibition showcasing service user groups
- Open mic 'soapbox' • Plenty of opportunity to network with colleagues

Issues from the day will be recorded in a special issue of DDN to make sure your key issues and concerns are taken forward.

Your involvement makes this conference special every year.

Join us and make it one to remember!

Early bird delegate rate: £135 + Vat for professionals or £80 + Vat for service users.

Includes FREE entry to the Motorcycle Museum after 4pm

There will be an additional £10 per person charge for all places booked after 31 December 2012.

For details on sponsorship and exhibition opportunities contact ian@cjwellings.com

For full programme and online booking:

www.drinkanddrugsnews.com

14 FEBRUARY 2013

The National Motorcycle Museum Birmingham

THE SIXTH NATIONAL SERVICE USER INVOLVEMENT CONFERENCE

DDN
Drink and Drugs News