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DDN
Drink and Drugs News

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'Despite media interest and a growing evidence base around PIEDs in the sports arena, very little is known about PIED use in the general population...'

THE PERFECT IMAGE

PERFORMANCE AND IMAGE ENHANCING DRUGS – A GROWING PROBLEM

Ignorance isn't bliss...

- Five out of every six people with chronic hepatitis C are unaware of their infection
  Hepatitis C Action Plan for England
- All injecting drug users and their partners should be offered testing for hepatitis
  Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007

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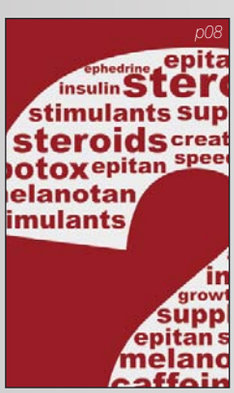
Off the wall?

Fighting social networking is a losing game

TRYING TO LIMIT THE ALCOHOL INDUSTRY'S SPREAD across social media networks is an ambitious aim (*news*, page 4; *news focus*, page 6). A look at any leading booze brand's Facebook page will show hundreds of thousands of followers – the Jack Daniel's page, for instance, has an almighty 2,225,733 'likes' (rising as I write) and their 'wall' shows a collage of faces, young and old. In all the fun of the virtual booze-up is a caution – 'Your friends at Jack Daniel's remind you to drink responsibly'. Click on the 'responsibility' button and there's a statement that 'any posts of pics that are irresponsible or inappropriate will be removed'. The pictures that remain demonstrate the widely different perceptions of 'responsible marketing' held by the drinks industry and public health charities.

The industry is operating around ASA's rules by not targeting alcohol at young people, nor linking it with social or sexual success. But the Facebook page is in itself an environment for bonhomie, rendering the notion of 'responsible posting' pretty meaningless. The industry has very little to worry about, which must help them to humour the 'health and responsibility' dialogue – with an army of Facebook users posting up their boozy holiday snaps, their marketing's already in hand and out of anyone's control.

This issue



FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

News in Brief

BE AWARE

Drinkaware has launched £3m worth of outdoor advertising as part of its 'Why let good times go bad?' campaign, which is designed to challenge attitudes to drinking among young people. The campaign, which involves around 60 drinks companies, will see new posters and billboards across the UK. Maximising investment was 'only possible with the active support of Drinkaware-funding companies who will amplify the campaign through their own communications', said chief executive Chris Sorek. Alcohol Concern, however, has warned that the drinks industry has become too influential on public health policy, especially through its increased presence on the Government and Partners Alcohol Working Group. The government must decide if it wants to get to grips with the UK's levels of alcohol harm, or 'stick with the status quo of allowing the drinks industry to call the shots', said chief executive Don Shenker. 'It can't have it both ways.'

LAY MEMBERS WANTED

The National Institute for Health and Clinical Excellence's (NICE) expert group developing a quality standard on drug use disorders is looking for applications from service users and carers to become lay members, to make sure their views inform the standard and recommendations to the NHS. All group members will have equal status, says NICE. Application details at *www.nice.org.uk/getinvolved/joinnwc/MemberDrugUseDisorderTEG.jsp*. Closing date 16 September

GET COMMITTED

The Association of Nurses in Substance Abuse (ANSA) is to hold an Extraordinary AGM in London on 8 September, following the collective resignation of its executive committee. A new committee needs to be elected as the previous one were no longer able to give their time voluntarily, says ANSA. Details at www.ansauk.org

LLOYDS LOLLY

WDP has been given a grant from the Lloyds TSB Foundation to help support people with dual diagnosis in the London boroughs of Croydon, Hackney, Waltham Forest and Wandsworth, with around 120 people set to benefit over a three-year period. 'We have been given a great opportunity to provide additional support to our service users who present with these issues,' said operations manager Rich Luck. 'We will be looking at ways to take what we learn from this project and extend it into as many WDP areas as possible.'

Banish drink marketing from social networking, says charity

Official alcohol marketing should not be allowed on internet social networking sites because of their 'strong appeal' to young people, says a new report from Alcohol Concern.

The charity is also calling on site administrators and drinks firms to stop the unauthorised use of drinks logos and advertising images on social media.

Social networking and video sharing sites like Facebook, Twitter and YouTube have become increasingly important means of promotion for drinks companies, says *New media, new problem?* while online age verification mechanisms to prevent under-18s from accessing content aimed at adults remain 'inadequate'.

Many young people also post pictures of themselves drinking with their friends, helping to 'normalise' drinking behaviour, says the charity, with 37 per cent of 13 to 15-year-olds claiming to have seen images of their friends drunk on social networking sites. Despite a minimum age limit of 13 for most sites, 27 per cent of 8 to 11-year-olds aware of such sites said they had already set up a user profile, the report states.

Until better ways can be found of restricting young people's access to alcohol-related content, alcohol brand websites should limit themselves to 'straightforward factual' product information, the report says. It also urges health organisations to counter alcohol marketing and 'pro-drinking messages' by making full use of new media themselves.

'Most of the leading drinks companies have a presence on Facebook or Twitter, plus their own websites which often contain content likely to be attractive to young people, such as games and videos, competitions and prizes,' said Alcohol Concern chief executive Don Shenker. 'There's a real danger of children and young people being exposed to alcohol marketing on such sites, particularly given that age verification mechanisms are largely ineffective. This is especially worrying given that research shows that alcohol advertising and marketing have a significant impact on young people's decisions about alcohol.

'It's also increasingly common for young people to use sites like Facebook and YouTube to document their parties and nights out, posting details of their heavy drinking and discussing their favourite drinks,' he continued. 'Many Facebook groups about drinks also mirror official drinks industry advertising and make use of official drinks logos. Much of this can be easily accessed by users of any age. The sharing of pro-drinking messages in this way fuels the normalisation of alcohol – the more people are regularly exposed to images and descriptions of excessive consumption, the more normal and acceptable this behaviour appears.'

Alcohol industry body the Portman Group, however, said the suggestion that marketing was being targeted at those under 18 was 'entirely misleading' and that online marketing was 'strictly and proportionately' regulated. 'The UK already has some of the strictest rules in place around digital media to prevent alcohol being marketed to children, or in a way that might appeal to them,' said head of external affairs Sarah Hanratty. 'It is perfectly legitimate for drinks companies to use social media to market their products to adult consumers provided there are clear safeguards in place – which there are.'

The report's findings, however, appear to be backed up by new US research from the National Center on Addiction and Substance Abuse at Columbia University. A survey of 12 to 17-year-olds found that those who spent time on social networking sites were three times more likely to drink and twice as likely to use marijuana as those who did not. Forty per cent had seen 'pictures of kids getting drunk, passed out or using drugs', the report says – half when they were 13 or younger.

Meanwhile a private member's bill to safeguard children from exposure to alcohol marketing (*DDN*, June, page 21) is scheduled for its second reading in the House of Commons on 9 September. The bill, proposed by Totnes MP Dr Sarah Wollaston, is based on the French 'Loi Évan' legislation which bans marketing disguised as games, and to mobile phones, among other measures.

New media, new problem? at www.alcoholconcern.org.uk
Portman Group digital marketing guidelines at www.portmangroup.org.uk
National survey of American attitudes on substance abuse: teens and parents at www.casacolumbia.org
See news focus, page 6

'STAFELL FYW CAERDYDD LIVING ROOM CARDIFF

ROOM FOR RECOVERY: Living Room Cardiff, which opens this week, is a community-based centre offering a non-judgemental space for peer-based individual and group support, set up by the Welsh Council on Alcohol and Other Drugs (WCAOD). 'Sometime after I started on the road to recovery, I resolved to set up a recovery and day-care centre so that people, like me, who needed to abstain from drink and drugs, while confronting the burden of being human, could receive the support they needed on their doorstep,' said WCAOD chief executive Wynford Ellis Owen, who will run the facility. Cardiff is also host city for the annual recovery summit on Friday 9 September, and third UK recovery walk on Saturday 10 September.

Poor parenting 'increases' binge drinking risk for children

Parenting style is one of the most significant influences on whether children will go on to drink responsibly, according to a new report from the Demos think tank.

A study of more than 15,000 children found that parenting that combined 'consistent warmth and discipline' – or 'tough love' parenting – was the most effective way to prevent children developing an unhealthy relationship with alcohol. Less effective parenting styles were identified as 'laissez faire', 'disengaged' and 'authoritarian'.

Bad parenting at age 16 made a child more than eight times more likely to drink excessively, says *Under the influence*, and more than twice as likely to drink excessively at age 34, while bad parenting at age 10 made a child twice as likely to drink excessively at age 34. An important element of the 'tough love' approach is making sure teenagers do not have access to alcohol in the home, it continues, and parents should also take care not to be drunk around their children.

The research – which was funded by brewers SABMiller – says policies to tackle Britain's binge drinking culture need the active involvement of parents, and it calls on the government to prioritise alcohol education projects that involve parents in the forthcoming alcohol strategy.

'The enduring impact of parenting on a child's future relationship with alcohol cannot be ignored,' said lead author Jamie Bartlett. 'This is good for parents – those difficult moments of enforcing tough rules really do make a difference, even if it doesn't always feel like that at the time.'

Meanwhile, new figures from NHS Scotland show that alcohol sales in Scotland are now 23 per cent higher than in England and Wales, with an average of 2.2 more litres of pure alcohol per adult sold in Scotland last year. Health and wellbeing secretary Nicola Sturgeon reasserted the Scottish Government's commitment to minimum pricing as a means of tackling the country's alcohol problems, and said that a bill would be introduced as a priority in the autumn.

'For too long Scotland's unhealthy relationship with alcohol has gone unaddressed,' she said. 'These shock statistics show that the difference between alcohol consumption in Scotland and England and Wales is now at its highest rate for 17 years. This is a situation that must be tackled head on. Minimum pricing can and will help us to redress the balance.'

A new quality standard for alcohol treatment has also been published by NICE. *Alcohol dependence and harmful alcohol use* is designed for use in all NHS-funded settings and will 'help healthcare practitioners and commissioners of care services to deliver the best possible, high-quality care to patients', said programme director at NICE's centre for clinical practice, Christine Carson.

Under the influence will be published on 12 September and available at www.demos.co.uk
Scottish alcohol figures at www.scotland.gov.uk
Quality standard at www.nice.org.uk

Poison deaths drop by five per cent

There was a five per cent fall in drug poisoning deaths in 2010, compared with the previous year, according to figures from the Office for National Statistics (ONS).

There were 2,747 deaths from drug poisoning in 2010, nearly 70 per cent of which were in males. While heroin accounted for the vast majority, poisoning deaths involving cocaine also fell by 29 per cent to 144. The total number of drug misuse deaths also fell slightly compared to 2009.

The fall reflected 'encouraging trends' in declining demand for treatment, particularly among the under 30s, said NTA chief executive Paul Hayes. Adfam also welcomed the figures but said that it was vital that the needs of bereaved families were not forgotten. 'Adfam hears many cases of the families of drug and alcohol users not being afforded the same level of respect, attention and sympathy that would be given to others dealing with the untimely death of a loved one,' the charity stated, with families often 'stuck between agencies'.

The number of people in England using heroin and crack has also fallen, according to research from Glasgow University's Centre for Drug Misuse Research published by the NTA today (Monday). Researchers estimate that there were 306,150 heroin and/or crack users in 2009-10, down from more than 321,000 the previous year, and around 25,000 fewer than in 2005-07.

The number of drug-related deaths in Scotland has also fallen for the second year in a row, according to figures released by the registrar general. There were 485 drug-related deaths last year, 11 per cent lower than 2009 and 16 per cent lower than 2008. However, the number of deaths has risen in six of the past ten years so it is unclear whether the upward trend has 'definitely changed', says the registrar. Heroin, morphine and methadone were implicated in, or potentially contributed to, 88 per cent of the deaths, and benzodiazepines to 25 per cent.

The figures were 'very encouraging', said director of the Scottish Drugs Forum, David Liddell. 'However, as the report itself makes clear, it's too early to say if this is a long-term trend – figures published next year will shed more light on that. The biggest issue, however, is that Scotland's death toll from drug problems remains unacceptably high. If you look at the rate of drug-related deaths among the drug using population, Scotland has similar rates to our European neighbours. But if you look at the rate of drug-related deaths compared to the overall population, Scottish people are seven times more likely to die from a drug-related death than their European counterparts.'

It was vital that people had swift access to high quality treatment, he stressed, while the government needed to 'invest in the kind of social, educational and employment opportunities which help to stem the flow of new recruits – our most vulnerable young people – into damaging drug use'.

See the next DDN for a feature on the problems faced by bereaved families, and page 14 for our feature on the growing problem of benzodiazepine use
www.ons.gov.uk; www.gro-scotland.gov.uk; www.nta.nhs.uk

News in Brief

PRISON PRIORITY

PCTs need to 'plug the yawning gap' between the alcohol treatment available in UK prisons and actual levels of addiction, says RAPt (Rehabilitation for Addicted Prisoners Trust). Just three intensive treatment programmes in the entire prison system are expected to cope with the 34 per cent of prisoners assessed as severely dependent on alcohol, the organisation points out. 'Alcohol addiction is a huge unmet need in prisons,' said chief executive Mike Trace.

DESIGNER GUIDE

The London Drug and Alcohol Policy Forum has produced new guidance for licensed premises in partnership with the police and nighttime economy organisation NOCTIS. *Drugs at the door* covers issues like amnesty bins and the wide range of new designer drugs. Email *ldapf@cityoflondon.gov.uk* for a copy.

DEVELOPMENT GRANT

Harm Reduction International (HRI), the International Drug Policy Consortium (IDPC) and the International Network of People Who Use Drugs (INPUD) have been awarded a major joint grant from the Department for International Development (DFID) to help improve HIV/Aids prevention and treatment among injecting drug users. Meanwhile, a new book edited by HRI's Damon Barrett, *Children of the drug war*, looks at the impact of worldwide drug policies on young people and families. Available at *www.childrenofthedrugwar.org*

FOILED AGAIN

The Cell Drinks range of vodka-based drinks in foil pouches have been found not to be in breach of the Portman Group's Independent Complaints Panel's code, following a complaint that they looked like soft drinks. 'Pouch-style packaging is still relatively new to the alcoholic drinks market and companies need to be extremely careful in their design and marketing to make sure products are clearly recognisable as containing alcohol and do not appeal to children,' said chief executive David Poley.

CUTS CARNAGE

According to the government's own figures, charities are facing nearly £3bn worth of cuts between now and 2015, says the National Council for Voluntary Organisations (NCVO). The amount was arrived at by analysing figures released by the Office for Budget Responsibility, while responses to Freedom of Information requests show that half of all local authorities are making major cuts to the voluntary sector.

IS THE ALCOHOL INDUSTRY USING SOCIAL MEDIA TO FLOUT MARKETING GUIDELINES?

Alcohol Concern thinks so, a claim refuted by the industry. ***DDN*** finds out what the regulators think

'THE DRINKS INDUSTRY SEEKS TO ENSURE THAT ITS MARKETING COMMUNICATIONS ARE TARGETED AT OVER-18S,' states The Portman Group's *Responsible marketing of alcoholic drinks in digital media* guidelines. As well as being socially responsible, it says, this makes commercial sense 'as the perception that it has an under-18s following is likely to damage the value of a brand'.

Alcohol Concern, however, is not convinced. According to a new report from the charity, not only are Facebook and YouTube awash with images that young people have posted of themselves drinking heavily – therefore normalising the behaviour – drinks manufacturers are also 'very effectively' taking advantage of online technology to promote their products, luring young people with things like competitions, videos and interactive games.

Not only did the volume of UK online alcohol adverts nearly double between 2007 and 2008, and the online alcohol advertising spend reportedly overtake TV spending the following year, says *New media, new problem? Alcohol, young people and the internet*, the industry was also quick to recognise the potential for reaching consumers through social media, with many leading brands launching interactive websites and establishing a presence on Twitter and Facebook. Alcohol Concern is firmly of the view that, because of the strong appeal of social networking sites to the young, official alcohol advertising should not be allowed (see news story, page 4).

Since March, however, alcohol marketing communications – including those in 'third party space' such as Facebook pages – have had to adhere to the Advertising Standards Authority's (ASA) Committee of Advertising Practice code on non-broadcast advertising. But is it effective?

'Social networking is subject to the advertising codes, and there are strict rules in there about marketing to children – you can't do it,' an ASA spokesperson told *DDN*. 'Alcohol advertising can't appeal to children, it can't feature anyone who is, or appears, under-25, it can't link alcohol with social and sexual success. There are strict rules in place, and we think that those rules are robust and appropriate, so we don't feel that there needs to be any strengthening of them in terms of a ban on advertising on social networking sites.'

Increasingly sophisticated viral marketing techniques, however, along with the sheer volume of user-generated content, are rendering the boundaries of what constitutes official marketing increasingly blurred. Many drinks companies will have an official Facebook page, but there are countless more user-generated pages with members effectively becoming 'unofficial ambassadors' for drinks brands, whether intentionally or not. Surely this renders the codes largely useless?

'What we would say is that we extended our remit in March of this year to address the issue of social networking sites and other websites not being subject to the advertising rules, so that was a huge step forward in terms of bringing those websites and social networks under a regulatory umbrella,' says the ASA. 'The rules are there, they are robust, and they are strictly enforced. We feel the situation is very much in-hand.'

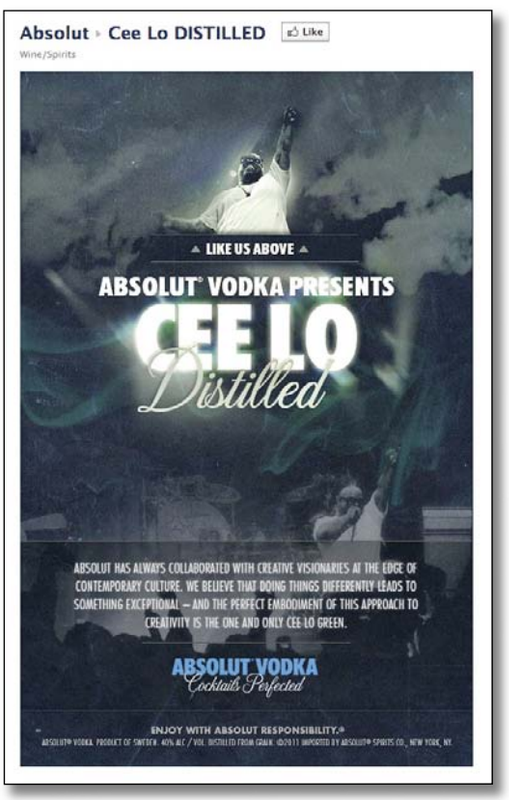
The authority also rejects Alcohol Concern's call for drinks manufacturers' official sites to restrict themselves to 'straightforward factual information about products' until better ways are found to bar access to those under 18. 'We take each case on its merits, but there are very strict content rules about what they can and can't do on their websites – anything that we felt would appeal to children would not be acceptable.'

However strict the guidelines are – or are not – Alcohol Concern's report also points out that popular alcohol adverts from the past that would never meet current regulatory standards are easily available for anyone to see on sites like YouTube. Is that something that worries the ASA? 'If it's not something that's being used in a contemporary marketing campaign, it's not something we would look at, especially if it's content that's been put online by a private individual,' says their spokesperson. 'If a marketer was to take an historic ad and use it in a new campaign, that is something we'd look at, but if someone just uploaded it because they thought it was interesting, that's up to them.'

According to Alcohol Concern, however, there is now such a huge amount of user-generated pro-alcohol and 'pro-drunkenness' images online that the conversation needs to go way beyond whether the regulations are restrictive enough, or are being adhered to. 'There is a much broader issue regarding the sheer volume of pro-drinking images and messages that are regularly uploaded to these sites, and viewed by people often below the legal drinking age', it says.

It's urging health organisations to fight back by making full use of new media themselves, although this may be something of one-sided fight. The Department of Health's *Men's Units Add Up* advert has clocked up nearly 5,000 views on YouTube – not bad for a public information film, you might think. *The Ultimate Drunk People Compilation Video Ever!*, meanwhile, is currently edging towards its 45 millionth….

Report available at www.alcoholconcern.org.uk



'The industry was... quick to recognise the potential for reaching consumers through social media, with many leading brands launching interactive websites and establishing a presence on Twitter and Facebook.'

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

So now the chickens have well and truly come home terrifyingly to roost. The violent anarchy that has taken hold of British cities is the all-too-predictable outcome of a three-decade liberal experiment which tore up virtually every basic social value... The married two-parent family, educational meritocracy, punishment of criminals, national identity, enforcement of the drugs laws and many more fundamental conventions were all smashed by a liberal intelligentsia hell-bent on a revolutionary transformation of society... Of course these parents know their children are out on the streets. Of course they see them staggering back with what they have looted. But either they are too drunk or drugged or otherwise out of it to care, or else they are helping themselves to the proceeds, too.
Melanie Phillips, *Daily Mail, 11 August*

Working at street level in London, over a number of years, many of us have been concerned about large groups of young adults creating their own parallel antisocial communities with different rules... The drug economy facilitates a parallel subculture with the drug dealer producing more fiscally efficient solutions than the social care agencies who are too under-resourced to compete.
Camila Batmanghelidjh, *The Independent, 10 August*

The people who wrecked swathes of property, burned vehicles and terrorised communities have no moral compass to make them susceptible to guilt or shame... They respond only to instinctive animal impulses – to eat and drink, have sex, seize or destroy the accessible property of others. Their behaviour on the streets resembled that of the polar bear which attacked a Norwegian tourist camp last week. They were doing what came naturally and, unlike the bear, no one even shot them for it... They have their being only in video games and street fights, casual drug use and crime.
Max Hastings, *Daily Mail, 10 August*

Much of the long term welfare problem and related criminality is really about drugs and dependency. The DWP estimated a few years ago that there are about 300,000 severe drug users on benefits. Many more will be alcoholics. We could learn some big lessons from the 'Hope' project in Hawaii. Drug addicted offenders in the community were tested every day. Failure to comply meant an immediate prison sentence. The sentence they received was actually shorter than the traditional length, but it was always and immediately applied, not on the sixth such breach. It improved compliance and cut relapsing so radically that it saved money and freed up prison spaces.
Neil O'Brien, *The Telegraph, 18 August*

Nine out of ten incapacity benefit claimants have been found fit to work after being made to undergo medical examination... because so many people have been miraculously 'cured' of their afflictions since being called in for tests, the Glasgow office of the DSS is now known as 'Lourdes'.
Richard Littlejohn, *Daily Mail, 2 August*

Post-its from Practice

Fighting fallacy on hep C

Some doctors misinform, says Dr Chris Ford

Yesterday Gill came into my room with a long face and said, 'You're going to say I told you so.' Two years ago, she found out she was HCV and PCR positive, and genotype 3. That hadn't been the right time for her to start treatment as she was working full time, drinking above safe limits and not settled on opiate substitution therapy (OST). Just last week she went for her first appointment in over two years at the local hepatology clinic.

Over that period we have worked hard together. These efforts have meant Gill has completely stopped drinking and become stable on a methadone mixture. She has informed her work that she needs treatment and they have been completely supportive. We have also undertaken all the baseline tests, which were good, and completed a mental health assessment as she had experienced a bout of depression five years ago. She understood the evidence and decided not to restart antidepressants, but said she would choose to if her mood worsened on treatment.

Before referral we had discussed treatment options and the choice of hospitals. Gill was very optimistic about her chances of clearing as she has genotype 3 and decided to go back to the hospital she had previously attended, which was also closest to where she lived. I encouraged her to go to a different hospital given that we have had a much better response there, especially to active drug users. One patient in a very similar situation to Gill had started treatment there two weeks after my referral and was now in her third month of doing really well.

Soon the reason for her opening comment above became clear. On arrival the consultant insisted that she would need to stop using methadone before hepatitis C treatment could begin. He added that they would not even consider treatment without a formal mental health assessment by a psychiatrist. When Gill replied that her GP had said almost the opposite about the methadone, he implied that I knew nothing. I won't print what Gill replied in my defence!

It worries me that a consultant working in hepatology believes that methadone affects hepatitis C treatment and does not know that it is quite safe for the liver. It is true that treatment side effects can mimic opioid withdrawal, so the patient may feel like he/she needs more methadone to be stable and comfortable. As such, clinical monitoring for methadone withdrawal symptoms is recommended as maintenance therapy may need to be adjusted in some patients.

We know that active drug users and patients on substitution maintenance treatment do not differ from past users in terms of SVR and compliance to hepatitis C treatment. Patients currently using drugs or on OST with chronic hepatitis C infection should therefore not be excluded from treatment. This is supported by NICE guidelines.

I cannot help but wonder how much of this consultant's comments relate to a certain prejudice towards people who use drugs. It worries me that perhaps he hasn't heard that we try to practice evidence-based, rather than opinion-based, medicine!

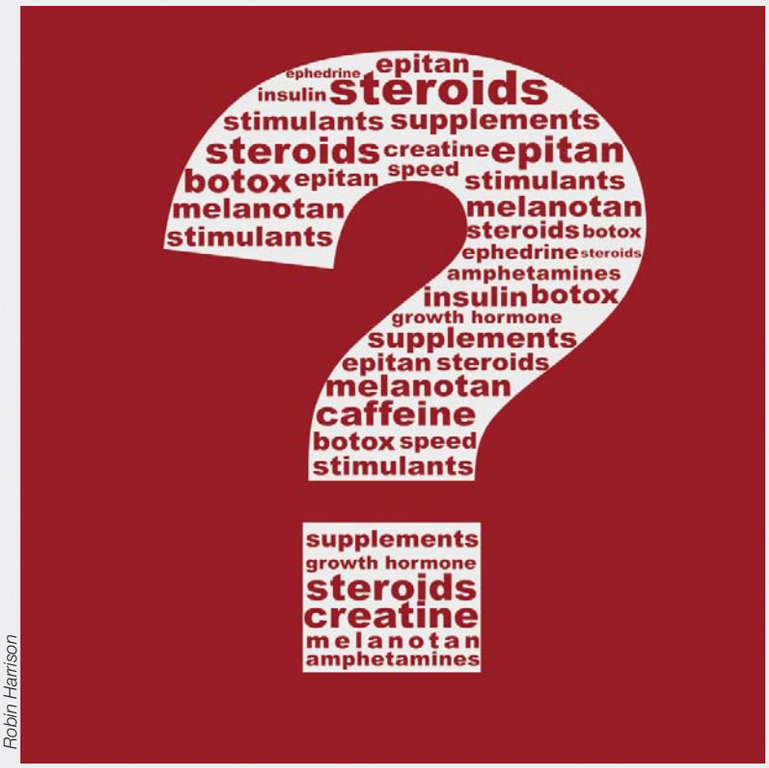
Gill has gone away to reflect on how to move forward. As she does this I am writing this Post-it, before I challenge the hospital again. Misinformation and/or prejudice are not acceptable.

The GMC states: 'You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views [including your views about a patient's lifestyle] to adversely affect your professional relationship with them or the treatment you provide or arrange.'

Perhaps I will recommend he completes our excellent new 'RCGP Certificate in the detection, diagnosis and management of hepatitis B and C in primary care'. I would also recommend this to you all because it is a great way to increase knowledge about this important subject – you can find more information about it on the SMMGP website.

Will he change? I remain optimistic that he might, especially once he hears from me again – and perhaps reads this article!

Dr Chris Ford is a GP at Lonsdale Medical Centre, clinical director for IDHDP and a member of the board of SMMGP, www.smmgp.org.uk



Robin Harrison

A growing PROBLEM

Increasing demand for equipment to inject substances such as steroids and human growth hormone at the East Riding of Yorkshire's needle exchanges prompted a survey of local PIED use. Tom Hall **and** Tony Margetts **share the findings**

Performance and image enhancing drugs (PIEDs) are often associated purely with competitive elite sport, but the use of PIEDs in the general population is an issue that is gaining prominence. Both the NTA and the ACMD have recognised the problem and called for more information and research on PIED use. The main areas of concern are around access to, and availability of, PIEDs, the harms they cause and their use in the general population.

PIEDs are a range of substances that can be used to improve or enhance an individual's physique, looks or image, and include anabolic steroids, human growth hormone (HGH), erythropoietin (EPO), beta blockers, melanotan, Botox and weight loss substances.

A lot of PIEDs have a complicated legal status – some are obtainable by prescription or illegal means, while others are marketed as supplements, vitamins or minerals. This has led to reports of online purchasing, or purchasing without a clear understanding of the substance or how to use it. For example, anabolic steroids are controlled as class C substances under the Misuse of Drugs Act, both as named compounds (of which there are currently 69) and using a generic definition, while steroids remain a prescription-only medicine. If they are intended for personal use as a medicinal product then it is legal to import, export and posses them unless there is an intention to supply, but this quasi-legal status has not stopped a proliferation of websites and mail order companies supplying real and counterfeit steroids into the UK.

Another example is the potential use of injectable melanocyte-stimulating hormone drugs to improve skin tanning. Melanotan is an unlicensed medicine marketed online as an injectable tan – it underwent testing in Australia, America and Europe but did not meet regulatory standards because of side effects which ranged from rashes, depression, nausea and headaches to increased risk of skin cancer.

Use of PIEDs – particularly steroids – is associated with a range of physical and psychological effects including cardiovascular problems, dermatological issues, injecting site infections, blood-borne viruses, endocrine problems, hepatic problems (such as jaundice), musculoskeletal damage, neurological effects, reproductive problems, mental health problems and psychological changes such as aggression and mood swings.

Steroid misusers usually take very high doses in cycles lasting between six and 14 weeks. The doses can consist of daily oral steroids, in addition to weekly or monthly intramuscular injections, and the high-volume use of multiple PIEDs makes it ethically difficult to replicate the use of PIEDs in a controlled research environment. The evidence on the harms of PIEDs, therefore, mainly comes from case studies/series and observational research.

This observational research is accompanied by media reporting of alleged PIED use in elite athletes, with high-profile cases including cyclist Marco Pantani, who died of cerebral and pulmonary oedema aged 34, and American sprinter Florence Griffith Joyner who died from a heart seizure at the age of 38.

But despite media interest and a growing evidence base around PIEDs in the sports arena, very little is known about PIED use in the general population – with the only surveillance data on PIEDs being the steroid use figures collected as part of the British Crime Survey (BCS) – or about the needs of the PIED-using population group.

In the East Riding of Yorkshire we knew that the BCS prevalence estimate for anabolic steroid users (0.2 per cent) equated to approximately 400 local PIED users. From August 2008 to December 2010, East Riding needle exchanges dispensed 1,264 packs containing ten green needle heads with 2ml barrels, the standard equipment for injecting steroid drugs. These are quite large needles as steroids are oil based and injected intra-muscularly – opiate and stimulant users would normally use smaller needles, and the steroid injectors' pack does not contain citric acid. This demand for green needles equates to around 9 per cent of all needles dispensed in the East Riding.

The needle exchange data was indicative of a small, but not insignificant, steroid using population, and the Safe Communities team pulled together a small working group to discuss the issue. The working group was led by the DAAT with representatives from public health, sport and leisure and local prisons, as well as a local body builder and physical trainer. The group decided to gather more information before attempting to make service developments.

A survey was launched in November 2010, both online and in a paper format, with the aim of gathering local knowledge/evidence to improve access to information, advice and services for PIED users. Posters and promotional materials were produced to direct people to the online survey, which was publicised in the local press, on online discussion forums, and by mailouts to 270 sport, leisure, security, health, fitness, beauty, tanning, and educational organisations.

East Riding Council's leisure services also promoted the survey through their leisure centre and gym network, and press releases were sent to local media.

Meanwhile, hard copies of the survey were distributed through East Riding's pharmacy needle exchange network and through the prison health network. The survey was anonymous and did not request any personally identifiable data.

Despite all this, however, only 38 completed surveys were received – four were from respondents outside the East Riding and four were inappropriately completed, leaving 30. The sample size of the survey was disappointingly small, a situation that could have been improved if there was an incentive to complete the survey. This makes it very difficult to generalise the results of the survey, but the responses we did receive painted a fascinating picture of PIED use.

Of the respondents, 93 per cent were male and the majority were aged 21-34 years. Some things, however, were surprising. A large proportion of people responding were prisoners – 73 per cent of respondents were serving a prison sentence and 13 per cent were in full-time employment, while two respondents were in full-time education, one unemployed, and one in part-time employment.

The level of poly-substance use was high, with the two most commonly reported substances being steroids and nutritional supplements. Seventeen respondents (57 per cent) reported using one substance, six (20 per cent) reported using two substances and a further six reported using three or more substances. This was combined with recreational drugs – mainly alcohol, cannabis and cocaine – in a number of cases, but the majority (57 per cent) reported no recreational drug use at all. Over half reported one or more side effect from their PIED use, with the most common being aggression – a key point, given that the majority of respondents were prisoners.

Respondents reported accessing health information mainly from a GP, but also from the internet, magazines and the gym. In answer to the question, 'What help and information would you like to see for people who use PIEDs?' all responses were about providing credible, evidence-based information on side effects. These were split between those who were angry about what they viewed as misinformation on PIEDs and those who just wanted more information to be available. Respondents wanted to see advice provided in gyms by credible experts – for example, people who had suffered side-effects themselves – posters with 'picture proof', and improved understanding and knowledge among GPs, alongside information in leaflets and on the internet.

There were a number of additional questions for people who admitted injecting their substances. In total, 18 reported injecting, 83 per cent of whom got needles from pharmacy needle exchange – only one person reported not knowing about specialist and pharmacy needle exchange. Another positive finding was that 89 per cent had not reused injecting equipment and no respondents reported sharing needles.

Not only will the survey inform future service developments, it has also been a useful process itself – bringing together key stakeholders, necessitating an exploration of published research and starting a dialogue with other parts of the region and the country.

In County Durham, 50 per cent of needle exchange transactions are now for PIED users and more than 40 per cent of all new harm reduction registration is for PIED use. Glasgow Addiction Services, meanwhile, reported that between 25-50 per cent of new clients were PIED users, but that just 2 per cent of all needle exchanges were for PIEDs.

What is not clear from the survey, and from reports from other areas of the UK, is whether PIEDs are the most important issue for the individuals reporting problems. The reports of poly-drug use, high-risk sexual practices and the link with mental health problems may mean that PIED use is merely associated with other important health risks. This group of substance users were difficult to engage despite a large amount of effort, which may make targeting health improvement messages problematic.

'A lot of PIEDs have a complicated legal status... This leads to a lot of online purchasing, or purchasing without a clear understanding of the substance or how to use it.'

However, PIED users do want clear, evidence-based, and credible information – respondents highlighted that PIED users do not think that current reported harms of PIED use are evidence-based. This misinformation may be a real concern given the lack of research on PIED harms and the very high doses of multiple substances reportedly used.

While County Durham, Glasgow and Bradford's dedicated PIED clinics appear to have been well received and well used by clients, no research has been published to establish if these clinics have led to a reduction in risky behaviours or harmful outcomes.

There is still more good quality research to be done until a clear strategy for tackling this issue is developed.

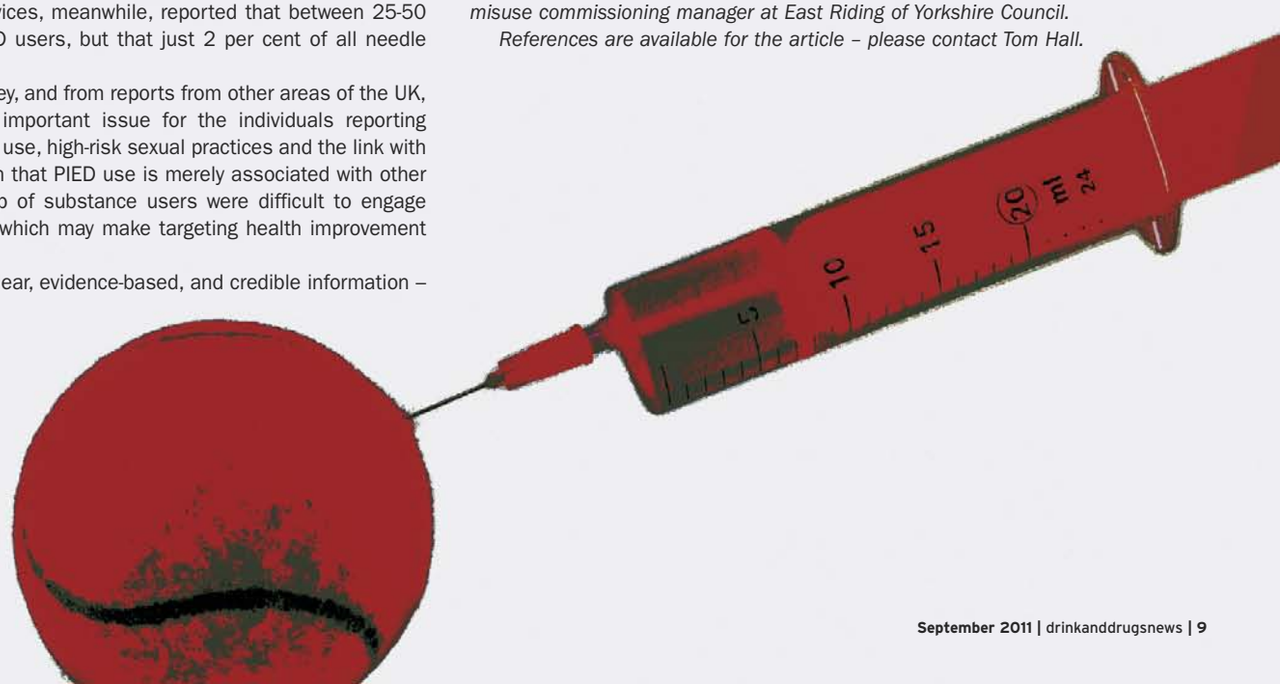
Based on the results of the survey and from published research and information, we made the following recommendations:

- *PIEDs should become a standing agenda item for the DAAT, and continual monitoring of the distribution of needle packs could be a data source included in the Joint Strategic Needs Assessment*
- *The fact that needle exchange services provide needles for PIED use should be promoted. The nature of this promotion should be pre-tested with a user group, but could be based on a peer-to-peer model.*
- *Credible evidence-based information for use online and in gyms should be developed through work with a focus group of PIED users*
- *The use of PIEDs in the prison population should be further investigated – specifically, what proportion of substance misuse in prisons is PIED use*
- *The possibility of working more closely with general practice, the probation service and the police on PIED use needs to be explored.*

Our work on PIEDs has been an illuminating experience. We're keen to hear if other areas are starting to do more work on PIEDs or more specifically on steroids. Please feel free to respond to this article or contact us directly: tomhall@nhs.net **DDN**

Tom Hall is a specialty registrar in public health at NHS North Yorkshire and York (formerly with NHS East Riding of Yorkshire) and Tony Margetts is a substance misuse commissioning manager at East Riding of Yorkshire Council.

References are available for the article – please contact Tom Hall.



LETTERS

'It is ironic that in these times off widespread atheism, religious practice dominates so much of today's view of the world.'

RECOVERY REVELATIONS

Alex Boyt's article *Higher Powered* (*DDN*, August, page 12) provides a good insight into what is perceived as the faults with the 12-step programme. However I think his concentration on the religious aspect misses the point.

Far from being outdated, I think that (sadly) the AA/NA approach is well in-tune with much of today's thinking. One need only look at the comparisons between environmentalism and the bible: the end of the world as a result of global warming shares the same defeatism as the idea of the apocalypse, as mentioned in the Book of Revelation. It suggests that there is nothing mankind can do about it. It is ironic that in these times of widespread atheism, religious practice dominates so much of today's view of the world.

Alex mentioned the American 12 steppers (were there no British ones?) putting their beliefs across as fact, and I don't doubt that that was the case. But again the environmentalists use the same approach, some wanting to go as far as to make climate change denial a criminal offence. Whilst I don't approve of the state of what passes for debate these days, it is hard to condemn the chief executive of the Betty Ford Clinic for using the same methods that work in other discussions.

The idea that AA/NA's approach needs updating suggests that it worked at one time, and the idea that the AA/NA is a cult is rather disingenuous towards the millions of people who attend meetings. It also gives credence to the idea of self-will as a negative force.

Perhaps we should be asking ourselves why we pour so much time, energy and money into getting people to stop drinking or taking drugs. It is, at the end of the day, their choice. Telling people that they have an illness negates their responsibility and is, ultimately, dehumanising. I like to think better of my fellow man. That we are not animals, prone to obeying instincts, may strike some, in today's cynical and misanthropic times, as naïve. And whilst I concede that there could be a genetic factor in a very few cases, as human beings we are quite capable of rising above such things.

Millions of people around the world attend fellowship meetings and are convinced by what they see and hear in those meetings. So what? Equally, millions of people lead 'unhealthy' lifestyles (whatever that means), and again: so what? As long as those choices do not impose on society then what is the harm? When they do, then the person should be treated as a human being and not as an alcoholic or an addict, or any other convenient label, and be made to account for themselves.

Denis Joe, by email

WHITE-KNUCKLE RIDE

DDN reflects many facets of recovery and freedom of speech, and the article by Alex Boyt needs to be respected in this context. However, I am struck by the 'white-knuckling-it' sense of expression communicated by the article and the active denial reflected, which makes me concerned on Alex's behalf.

Alex seems to be setting himself up for a relapse, and wants to give himself permission to use so as not to be tormented by internal/unconscious conflict, of which he has perhaps had similar experience on previous occasions.

My more serious and sincere concern is for those who are reasonably new to recovery within the abstinence-based framework represented by the 12-step fellowships, who might read Alex's article and become confused as a result.

I do not feel that the integrity of the 12-step framework is compromised by Alex's viewpoint, just that newcomers to abstinence-based recovery within 12-step treatment settings, and those working the steps with their sponsor, may have doubt cast into their minds by someone who is trying to subjectively convince himself that he can do without the support of the recovery fellowships.

Alex's viewpoint is at best unbalanced, irresponsible and logically flawed, with clear evidence of subjectively setting the ground for a lapse. Indeed, his article is a live example of the expression of someone who is desperately white-knuckling it.

John Graham, therapeutic counsellor

FOETAL FACTS

I should like to raise awareness of foetal alcohol syndrome (FAS), as so many of our clients who start to get healthier as they get their drug use under control tend to increase their use of alcohol.

We have seen an increase in clients' ability to get pregnant as they control their drug use, but after years of sexual activity without pregnancy, they often believe they are infertile so they do not necessarily think about using birth control. For many women in early recovery, they are simply not yet taking full responsibility for their life choices, as they struggle to function day to day – with the very high risk of having an unplanned pregnancy while drinking. This leads to a range of unalterable developmental deficits in the foetus – and the child, and the adult – as a direct result of alcohol use.

Even a short binge, or a Friday night drinking session, can lead to a part of the foetus's brain or body not developing correctly. FAS is visible and measurable but other alcohol related neurodevelopmental disabilities (ARND) and alcohol related developmental disabilities (ARDD) cause problems that show up as behaviour or learning problems later on.

By educating our clients and the general public, we can ensure every child is born as healthy as possible. There seems to be a hesitance about speaking out unequivocally about the need to stop drinking if one is planning to get pregnant, and if not wanting to get pregnant, to ensure birth control. It is as though nobody wants to upset women, but by keeping silent we are facilitating women unknowingly causing unchangeable serious brain damage to their unborn children.

This issue does not seem to have really been incorporated into the public consciousness here, but it is well documented in Canada and the US and several European countries, which have well presented studies and teaching models that could be introduced in Britain. In the 1970s and '80s Canada and the US became particularly aware of the link between drinking and foetal changes because they have distinct populations with well documented alcohol problems.

This problem is preventable, and it is an issue that our clients and staff deserve to know more about so they can make educated decisions in their own lives.

Gwen Moncrieff, by email

NALOXONE SAVES LIVES

I used to volunteer with SURF Bradford and I did the naloxone course (*DDN*, August, page 14). I carry it around with me and I know it's there if anything happens to me or my partner.

I think that if someone has an addict in the family who visits them or lives with them they should be able to do this course. It also tells you basic cardiopulmonary resuscitation (CPR).

I thought the training was great and it's a few hours out of your day – it will save a life!

Sarah Smith, by email

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.

The Families Plus course, *Thinking beyond the individual*, promotes vital skills for working with families and carers. Cinzia Altobelli **shares her training diary alongside** Michael Rawlinson's **practitioner's diary.**

It is rare to have the opportunity to allocate time to reflect and observe our practice from different perspectives, and to return to work with renewed enthusiasm as a result. But Families Plus' training, *Thinking beyond the individual*, provides an opportunity to understand addiction and its impact on families and children from a systemic perspective, translate relevant theory and research into evidence-based effective interventions, get valuable feedback and take back a new awareness and a range of tools to the workplace.

The course can be taken as an accredited training by Bath University or unaccredited, and to give you a taste of what to expect, here's my diary of a training week.

I would like to thank Michael who kindly shared his experience of the training.

Michael Rawlinson is a counsellor at Cloud's House. Cinzia Altobelli is leader of therapeutic services at Action on Addiction – Families Plus. If you are interested in this training or forthcoming 'reflective practice days' please contact Debby.Williamson@actiononaddiction.org.uk or Sheila.Thomas@actiononaddiction.org.uk Tel. 01747832015

group

Cinzia (trainer)

DAY ONE

I have been delivering this training for a while but it never ceases to surprise me how different it can be each time, so it's with a bit of apprehension and much excitement that we begin the week. At this stage it's hard to predict how the week will go, as each group is so unique. It can take a while to break the ice and for the group to feel at ease enough to gel or form subgroups.

It's an intense week where anxiety can be high at first – it's unusual to come away from work and daily routine and be immersed into a week of leaning and sharing. When I put myself in the shoes of practitioners attending the week I forget about my own 'first day' anxiety and focus on how we can create a safe and relaxing environment where we can maximise learning from each other.

Sharing our hopes for the week and some warm up discussions helped us to get to know each other a little, setting the foundations and breaking the ice. Trainers need to be able to attune to the needs of the students – we need to provide structure but be open to change course in response to what emerges. I'm aware that the practitioners we have on the current training are all highly competent, so my initial anxiety is forgotten and I'm excited about the possibilities of such a high quality learning exchange during the week.

In the afternoon we had the research lecture. We're very fortunate to have highly regarded researchers like Professor Alex Copello and Lorna Templeton, who present relevant research and are available for questions. Practitioners looked tired at the end of the day, but they've gelled quickly as a group. This is not usual and it's great when it happens!

DAY TWO

I particularly like today's training content as we explore family roles theoretically and experientially. We view family roles as creative adaptations to surviving unmanageable situations – in the long term these strategies, if fixed, can reduce choice and we explore the 'pay off' of each role.

Each time I facilitate a 'family sculpting' I never know what shape it's going to take and what story is going to be co-created, but I know that it is going to be a powerful visual and sensory experience for the group. This exercise needs to be treated with care and respect, and it never ceases to surprise me how much the practitioners and I learn each time we do it. The group seemed quite thoughtful, and 'embodying' the experience of each role certainly had an impact.

A really important, lively and open debate also took place about the language used around family members, such as 'co-dependency' and 'enabling'. I have to admit I dislike these terms, as they are simplistic, don't tell the 'whole story' adequately and can imply blame or, worse, pathology. On the other hand, I'm also aware that these same terms have been useful to clients and practitioners in the same way that I've heard patients say it has helped to finally have a 'label' to make sense of what was happening to them.

DAY THREE

We revisited motivational interviewing (MI) in the context of family work, and the day focused on practicing MI skills in a recorded role-play, which is part of the assignment if you undertake the accreditation.

This is an opportunity to practice your skills working with family scenarios 'live' in small groups, and receive feedback. The group was very motivated and embraced the task with determination, energy and a bit of apprehension, which was soon dispelled as their curiosity and desire to learn from each other took over. They recorded their 'live' session in the afternoon and seemed to enjoy it!

DAY FOUR

Matt (trainer) did a genogram (pictorial display of a person's family relationships) demonstration with the group, which resulted in co-creating a very 'interesting' family. We wanted practitioners to experience the power of using genograms, which are a creative and therapeutic way of working systemically with individuals, couples and families.

Again the group reported how much of an impact the exercise had had, and how surprised they were at the depth of feelings this brought up for them. They now have a real sense of how powerful this can be when used with clients.

We also explored how to set up, structure and facilitate family meetings – again the experiential part of the training and the opportunity to get feedback were highly valued.

DAY FIVE

It has been quite an inspirational week in many ways, poignant but also fun. It was great to see there are so many practitioners who are as passionate

about working with families as us. I have seen much sharing of best practice and I'm hopeful that 'thinking families' is now more on the agenda throughout the UK. This has left me wanting to provide more opportunities for practitioners to come together, reflect on their work and feel newly energised by each other's input and the work they do.

Like families affected by addiction, practitioners can also benefit from knowing they are not alone in facing and dealing with the many challenges the field presents.

MICHAEL (practitioner)

DAY ONE

Twelve professionals and two trainers gathered in Warminster for a week-long course in the very particular field of working with family members. Once the introductions were made and the members of the group began to get to know each other, it was clear to me that I would be working and learning with a highly experienced group of individuals.

An example was the manner in which the group occupied itself around the first task, which was how to make choices. Six scenarios were given and, having been divided up into smaller groups, we were asked to pick the two most deserving. Each group knew that all the families in the scenario were desperate.

By working collaboratively, each group brought a different perspective to the analysis. The dual diagnosis officer complimented the views of the victims of domestic abuse specialist, as did the family and friends support worker, and my own learning was significantly enhanced by joining in with my peers. There was no 'right or wrong', and each group reflected that the process had been challenging but enlightening.

That afternoon Professor Alex Copello and Lorna Templeton came to present their treatment model and supported with it positive outcome evidence. Having referenced Professor Copello in my academic papers, it was a particularly valuable and important afternoon.

DAY TWO

I saw the members engaged in a 'sculpt', a new experience for me. To be shaped into a family system and then moved around it was remarkable, especially as each volunteer reported a significant emotional and physical reaction to the demonstration. My own was one of tiredness, anger and loneliness. My role? It had been that of the caretaker!

DAY THREE

By the middle of the week it was clear that the carefully planned programme was building towards a focal point for those students wishing to gain accreditation from the University of Bath. Following a swift but comprehensive review of motivational interviewing, the group rehearsed 'live' facilitated family meetings, a powerful learning experience for all. Having satisfactorily completed all the video recordings, and with anxiety levels returning to normal, the group reflected on the skill sets each of us had and agreed that to be effective in this area did not require new learning but instead adapting and enhancing an already existing area of expertise.

DAY FOUR

The final full day saw the group educated in genogram construction. Genograms are maps that provide a diagrammatical image of a family structure and emotional processes over a certain period of time. The group practised on each other, which produced warmth, laughter and, in some cases, tears. However the overwhelming impression for us students was that the process could be invaluable in helping clients recognise family systems and see their role in a family dynamic. This can empower clients in helping them make previously unidentified connections and thereby facilitating better levels of communication.

DAY FIVE

Our final morning started with a summing up of the week's work by each member of the cohort.

It was clear that the group energy, willingness and collaboration had been instrumental in ensuring a highly successful learning experience for all, and there was universal praise for the quality of the facilitation, leadership, location and hospitality, with particular praise reserved for the two presenters, Matt Serlin and Cinzia Altobelli.

As the attendees left for all parts of the UK, I was able to reflect on a week of considerable value that had given me an opportunity to learn and change. What I was certain about was that it had been put together by professionals who were passionate about their field and above all cared deeply about their client group.

On the WOBBLY

Michael Linnell's latest film for Lifeline Productions looks at the growing problem of benzodiazepine use, through the eyes of Wobbly Stan. **David Gilliver** reports

Benzodiazepines hit the headlines last month when the government announced it was banning imports of phenazepam and would be taking steps to control it under the Misuse of Drugs Act when Parliament returned (*DDN*, August, page 4). Now Lifeline's Michael Linnell, whose animated films like *Mr Mange Goes Over* (*DDN*, 7 September 2009, page 14) are well known to *DDN* readers, has turned his hand to the subject with his new film, *Wobbly Stan*, about a heavy 'benzo' user in the North East.

So called because of the effect the drugs, particularly when mixed with alcohol, Wobbly Stan spends the film patiently explaining to young Bee McCree why he won't give her a bag of pills. Like all of Lifeline Productions' films, it's based on first-person accounts from drug workers and, especially, users. Around 120 people attended the July premiere in Redcar, a part of the country particularly affected by problem benzodiazepine use. One in six of all tablets seized in England and Wales in 2008/09 were in the Redcar and Cleveland police authority area, with the most popular benzo locally remaining diazepam, usually sold in 10mg tablets as 'blues' or 'wobblies' for as little as a pound.

'Benzos have been around for a long time, obviously, but in terms of what we could gather from the research, the epicentre – in England, anyway – is the North East,' says Linnell. 'That's to do with the fact that the quality of the traditional drugs around there has been fairly poor. People were clear about it – heroin users use benzos so much because the quality of heroin was really, really poor and they couldn't get a gouch off it.'

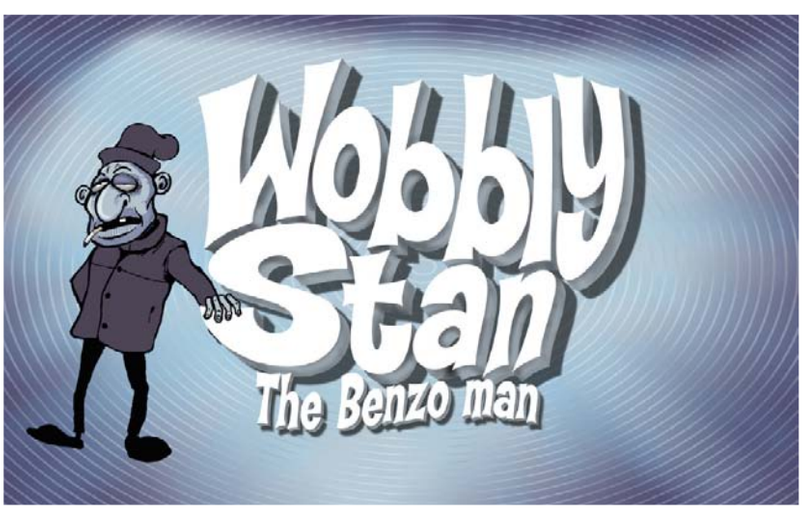
Produced by Lifeline for the Redcar and Cleveland Adult Drug and Alcohol Joint Commissioning Group, the film came about partly because Lifeline has a significant presence the area, running services in Middlesbrough, Tyneside and Cleveland. 'The harm minimisation service in Redcar is a Lifeline service as well,' he says. 'The way they do some of the projects up there – which I think is a really nice way of working – is they basically give the money to a steering group which includes all the local services and user representatives as well as the funders. We became involved partly because we're Lifeline and partly because we did a successful 'saucy postcard' campaign there about hepatitis C.'

Lifeline had been carrying out research into 'Z drugs' (non-benzodiazepine sleeping pills like Zopiclone and Zolpidem) in Middlesbrough a year earlier and had heard some disturbing things, he says. 'It wasn't just that this was a spillover from heroin use – there was a group of people where these were their drug of choice. They were going on binges where they were using enormous amounts of tablets – a hundred at a time wasn't unusual.'

Surely that would be fatal? 'Part of it is that there were a huge range of tablets that people were getting hold of, and most of them seemed to be fake,' he says. 'There was hardly any diverted medication at all, and the quality was really, really variable. To get a gouch, the average was about 30 or 40, and for those who were heavier users, it was week-long binges where you'd fall asleep, wake up and take more. So the way they were talking about it, a hundred was nothing. One of the people we interviewed said he'd had 600 in a week.'

Although many were fake, one particular pill – which unconfirmed reports suggest was phenazepam – had the nickname 'charge sheet', he says. 'People were saying they were really, really strong. You start taking them and the next thing you remember is you wake up a week later and you're either in hospital or being read a charge sheet. So there's a whole range of tablets going around and we can only guess at what half of them are.'

So where are they coming from – are they being imported, or are the fakes manufactured locally? 'It's mainly dealers bringing it from abroad,' he says. 'The



'When you start seeing phenazepam – a really strong benzo – marketed and sold in the festival/rave scene, it's really, really concerning.'

internet has become very popular with drug users, obviously, but a lot of the people we were talking to wouldn't have had access to credit cards, or even the internet, to buy them. It was mainly dealers going abroad and coming back with a suitcase full, although a couple of people said that some of the tablets were supposed to have been made locally – some they described as basically falling to bits in the bag. So the information we had would seem to suggest a mixture, but the thing that was most surprising was how little was diverted medication.'

There's now a *Wobbly Stan* website featuring the film alongside extensive information about benzos, as well as a DVD and booklet to be sent out to services. 'One of the reasons I was keen on putting the research up next to the film is that you can actually see how the film was made by looking at the research,' he says. 'That was followed by consultation with the steering group of drug users, workers and funders – you go up with a load of drawings and ideas and a script and say, "is this right, would this work?" Some of the lines in the film are actually lifted straight from that – you're doing research about a lifestyle and trying to find the humour in that lifestyle that appeals to the target audience. At the launch it was both drug users and providers, and it got the backing of both.'

It's also received the backing of much larger organisations. Despite having just two full-time and two part-time staff, Lifeline Publications and Research is now the first provider of drugs information to be approved by The Information Standard, developed by the Department of Health to help people identify which health and social care information is trustworthy. 'It's a six-month process,' he says. 'You have to audit every single aspect of your production process and research methods, and we used *Wobbly Stan* as one of our examples. So not only did it get assessed during that, it was independently assessed in terms of the research methods we used.'

There are plans to take the campaign wider, but – as ever – budgets are an issue, he says. 'It wasn't a big budget, and within that myself and Russell Newcombe wrote the report, and the other bits like voice fees and fees for the animation company and marketing company had to come out of it as well, but I basically gave my time for free as project manager. The deal was that we were doing it partly to promote Lifeline locally and partly to sell a national version afterwards through Exchange Supplies, but that won't anywhere near cover our costs.'

Having done the research, how concerned is he by the growing levels of benzodiazepine use? 'Benzos have taken off, particularly during the heroin drought, but the thing that really worried us was that they were being used right across the spectrum. They weren't just used by injectors of heroin, they were used by all sorts of people. When you start seeing phenazepam – a really strong benzo – marketed and sold in the festival/rave scene, it's really, really concerning.'

And most people have no idea just how addictive these drugs are? 'They haven't,' he says. 'If you're going to explain to a younger audience what the real risks of benzos are, by far the biggest issue is addiction – they're such addictive drugs.'

The impact on the sector could, potentially, be enormous, he stresses. 'We've got an ageing population of heroin users, and we can't assume the next population will be the same as this one, which is what we're building our services around.

'You'd probably have fewer deaths if you had a population that was using benzos quite heavily, unless they were mixing it with alcohol – which of course they all are anyway – but in terms of the potential implications, you could be looking at an 18-month medically-supervised detox with every client coming into your service. That's quite profound.' **DDN**

www.wobblystan.co.uk

ADS
Addiction Dependency Solutions

ADS OPENS ITS FIRST DETOX UNIT

This is a brand new purpose-built facility for men and women who are alcohol dependent and require residential care and support.

The unit will provide a range of detoxification options in a clinically safe, non hospitalised caring environment. We accept a wide range of service user referrals, including individuals who are stabilised on a methadone script, as well as clients who are diagnosed with certain mental health conditions. The detox unit is ideally located on the west coast mainline.

This brand new ten bedroom facility will provide:
- 7-10 night medically managed alcohol detox
- In addition, where appropriate, 3 night kick-start medical and psychological detox (continued in the community programme)

Services include:
- A safe clinical setting for the assessment and treatment of detoxification needs
- Medically managed withdrawal from alcohol
- Structured therapeutic groups to assist the development of relapse prevention management
- A keywork system to enable clients to engage with a named staff member, responsible for an individual's care whilst in treatment
- An individualised support plan formulated between client and care manager focusing on treatment and maintaining needs post-discharge
- Evidence-based, best practice treatment and programme
- Additional services include: relaxation/auricular acupuncture and advice/guidance regarding access to residential rehabilitation services and structures

Referral Process
The service operates an open nationwide referral process, although all clients must be registered with a GP so that prescribed medication can be checked pre-admission. Referrals can be made by a prospective client or their representative. Individuals must have secure housing to return to, following treatment.

Client Facilities
This brand new service has been renovated and designed to a high specification with client needs, safety, comfort and security at the core.
- All bedrooms are single occupancy and have lockable cabinets
- Accommodation is available on the ground floor to facilitate treatment for people with severe health issues and/or alcohol withdrawal
- A balanced, nutritious and varied menu is available catering for all dietary requirements
- There are a number of communal areas which include a spacious dining room, kitchen and lounge
- All bedrooms are fitted with modern, comfortable furniture
- Ample shower and toilet facilities are provided, including disabled access
- The building is situated in landscaped gardens, where smoking is permitted
- The premises offer maximum security measures to maintain client and staff safety and maintain duty of care protocols

The Team
The service is staffed 24 hours a day by a professionally diverse team which includes medical staff, registered nurses and support workers. The service is underpinned by having a medical specialist in attendance for a set number of clinics per week and 24 hour on-call medical cover.

About ADS
ADS are the leading regional charity specialising in alcohol and drug services. We have been helping people in recovery for over 35 years and treat everyone who comes to us as an individual, tailoring each programme to meet their particular needs. Clients are provided with encouragement, care and support throughout their time with us.

ADS know only too well that recovery is more than just stopping drinking and our detox unit is the first step on a long road. We work closely with community alcohol teams and other agencies to provide the right support to clients when they leave, in order for them to sustain their recovery.

For more information please contact Brian Donaghey, Service Manager on brian.donaghey@adsolutions.org.uk, telephone 01772 701346 or fax 01772 705616

ADS Detoxification Unit, 150 Fletcher Road, Preston PR1 5HE.
Registered charity number 702559

www.adsolutions.org.uk

SPEAKING WITH THE ENEMY

To get anywhere with harm reduction relating to alcohol and tobacco we should be working with industry instead of vilifying it, says **Prof Gerry Stimson**

PUBLIC HEALTH WORKERS HAVE A LONG HISTORY OF WORKING ON THE MOST CHALLENGING OF DRUG-RELATED ISSUES – helping people using illicit drugs to change their behaviour to avoid harm to health and threats to life. This has resulted in highly innovative, and at times quasi-legal activities, such as delivering sterile needles and syringes, and providing effective treatment opportunities.

But what can be done when it comes to licit drugs – namely beverage alcohol and tobacco?

With alcohol, many things are in place to reduce risk – for half of all drinkers globally, product quality control ensures that drink is of known strength and free from contaminants. Producing a safer product depends on having an alcohol beverage industry. Some local and municipal governments have introduced safer city and safer nightlife programmes to try to reduce negative impacts of drunkenness for drinkers and non-drinkers. These measures have more often than not required a linking of key stakeholders across sectors, including bar owners and staff, police, transport and city planning.

However, more needs to done to get manufacturers and bars and pubs to move beyond the rhetoric of responsible drinking, by changing the drinking environment so that it is easier to drink responsibly.

Reducing alcohol-related harm cannot be achieved without working with the beverage, retail and hospitality sectors. However many public health experts focus mainly on issues of reducing availability – through limiting access and raising price. These are key tools, but insufficient to bring about changes in drinking cultures. Rather than seeing the alcohol beverage and hospitality industry as an enemy, opportunities have to be found to engage their interest and help.

Extensive efforts to eliminate smoking have had considerable success, but even the most ardent anti-smoking campaigns and legislation leave a residual population of smokers. The zero-tolerance approach to smoking means that smokers are facing a stark 'quit or die' choice. People smoke for the effects of nicotine, yet get ill from the smoke.

Tobacco harm reduction means providing nicotine habitués with safer ways of consuming nicotine – smokeless non-combustible tobacco, medicinal nicotine, and alternative nicotine products such as e-cigarettes. At present, the most harmful forms of nicotine (cigarettes) are the most readily available and least regulated, whereas less harmful forms of nicotine are more regulated and harder to obtain.

Few people in the UK even know about snus – a moist pasteurised tobacco in a small package that is placed in the mouth. Snus use is credited with the low rates of lung cancer in Swedish men – the lowest in the Western world. A liking for nicotine is not going to disappear, nor are tobacco companies. The biggest harm reduction advance will be when cigarettes are replaced by safer ways of consuming nicotine. There is a growing awareness within some in the tobacco industry that the future lies with safer nicotine products. Public health experts need to encourage that.

Professor Gerry Stimson is a director of Knowledge-Action-Change, an independent organisation committed to evidence-based policies and interventions in the field of substance use, and in public health and public policy.

He will co-chair Drugs, Alcohol, Tobacco & Public Health – Plotting A New Course, a conference on 21-22 September at the Manchester Central Convention Complex. Details at http://bit.ly/q3mNll

LEGAL LINE

'CAN I REFUSE TO BE DRUG TESTED AT WORK?'

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

Reader's question:

My employer has announced that they are going to start random drug testing from next month. I'm really worried as I do sometimes use drugs at the weekend, but this has never affected my work. There isn't anything in my contract about drug testing and I can't see how it's relevant as I do administrative work in an office. Can I refuse to take the test?

Kirstie says:

In order for an employer to do random drug and alcohol tests on their employees there must be a drug testing policy in place. It is possible for a policy to exist which has not been used for some time (or ever), which an employer decides to start implementing. If you are sure that there is nothing in your contract about drug testing then you should check your staff handbook carefully.

If there is a policy already in place, then your employer will be able to drug test you. They cannot physically force you, but if you refuse you may face disciplinary action, which could ultimately result in being dismissed.

The consequence of a positive drug test will also depend on what the policy states. Many employers are understanding when it comes to drugs and alcohol, and will have a practice of referring people to occupational health for assistance. Others may only be concerned if an employee is under the influence of drugs or alcohol at work, so a positive test may result in some disciplinary action, but not necessarily dismissal.

The actual level of the substance found by the test will be relevant in this situation, so you can argue that while it is present you could not have been under the influence – the Release drugs team can offer further information about this. However, some employers have a zero tolerance policy to drugs and alcohol in the workplace and a positive test will be considered as gross misconduct and result in instant dismissal. Depending on the specific circumstances there may be grounds to take an employer to an employment tribunal for unfair dismissal.

If there is no reference to drug testing within either your contract or staff handbook, then your employer cannot legally require you to take a drug test – they would need to vary your contract to allow them to do this. You could refuse to accept the variation but when it is time for your contract to be renewed, your employer is likely to require the new contract to contain the additional clause(s) and policy. Additionally, refusal is likely to arouse suspicion and draw unwanted attention to you and your work.

Email your legal questions to claire@cjwellings.com.
We will pass them to Kirstie to answer in a future issue of DDN.

For more information about drug testing in the workplace please contact the Release legal helpline on 0845 4500 215.

'We had a model of outstandingly good practice. It ticked all the boxes, delivered what it promised and more and bent over backwards to respond flexibly to the ever-changing needs of the local offender population, yet it was kicked into the long grass...'

School of hard k

What lessons can you learn when a successful and highly regarded service is discontinued? **Paul Taylor** shares his thoughts

There's been a tightening of belts for some time in probation offices, with expenses being progressively trimmed. Where I was working in Somerset, Post-Its had long gone and 'duplex' was now the default setting on the printer, so what on earth had gone on in the staff kitchen in March, when the eclectic collection of crockery we'd suffered for years was replaced by a new set of matching porcelain?

I held on to the sink for support when told this was thanks to an underspend. Could this be true? 'Oh yes,' I was told – 'in fact we'd had a call to ask if there was anything else we could do with. Some white goods, a fridge, a carpet?' 'How much is this underspend, exactly?' I asked. 'Across the area, it's £75,000'. That would fund this counselling service another year, with £20,000 left over for some residential treatment, I thought, but I was quickly rebuked. 'It's an underspend. That means it can't be spent on services this year that will be provided next year.' But what about the fridge? Surely that's a purchase this year for keeping things cool *next year*? Welcome to the arcane world of public sector finances.

I'd better explain what, as an independent counsellor, I was doing in this office at all. In 2005, I was offering probation a few sessions with offenders to assess their drinking and see if they might want to make some positive changes. Very much to my surprise, I admit, most of the people I saw were only too keen to talk candidly about their drinking – almost everyone could agree a goal like not finding themselves on the wrong side of a locked door. It's then the shortest of steps to agree the next goal – to manage your drinking in a reasonable and reliable way, because that's the only way you can be completely certain you're not going to attack your partner, bash up a stranger or get behind the wheel of a car when you're drunk.

What it boils down to is treating offenders with respect. According them dignity, assigning them the responsibility for making choices in their lives, sifting through what might be a scenario of poverty and exclusion and transmitting the belief that, if they want it enough, recovery – by which I mean citizenship – is possible.

Offenders responded to this, and it still surprises me how many really did start cutting down on their drinking, including people who were living on the streets, carrying heavy emotional burdens of long-standing pain and isolation, and whose drinking looked like the only speck of comfort in a relentlessly bleak lifestyle. What surprised me even more was how many people sustained that progress.

Probation staff liked these outcomes too. Many of their offenders became more stable, better at keeping appointments, keener to engage and significantly less likely to reoffend. These successes, plus the backing of a small but leading-edge VCS treatment provider, helped us win a three-year contract to partner probation and continue this work across the county.

For hard-pressed probation officers required to put in five or six hours a day in front of a computer screen for every hour face-to-face, our service was a godsend. No one could really explain why the thrust of their work had gone from managing risk – building relationships with offenders and exerting influence – to recording risk. Surely not because computer time was more easily performance managed?

Having formalised a contract and agreed performance measures, I took on the role of collecting the required data. I had a brief struggle getting my head around methodically recording and totalling the numbers – and a much longer struggle persuading my counselling colleagues to do the same – but we were now accountable to our commissioning colleagues. We did this in good heart – surely if the evidence demonstrated our work had value, we could be confident it would continue?

More than 80 per cent of offenders said their understanding of alcohol and its impact on their lives had improved and that they were drinking less. Offender managers, meanwhile, said that over 70 per cent were less likely to reoffend and over 90 per cent were more on board with sentence plan objectives. In terms of the contract, what we delivered was consistently within 1 per cent of the agreed performance measures, but in 2010 the writing was on the wall. A senior manager told me informally that, having had a two-year extension, we were now heading for the chop – unless we could cut costs by 25 per cent.

Within two weeks I submitted a proposal to cut costs by a third. Our availability would shrink by about 16 per cent, but by targeting the cut on poor attenders we reckoned the real impact would be slight. Alas, there was no response, beyond formal notice that the contract was to end. I was willing to bow out gracefully, job done. However, probation colleagues – those holding caseloads and their line managers, that is – were so adamant the service had to continue that I was persuaded to fight on.

What we really needed was empirical evidence to support the overwhelmingly positive feedback we'd had from service users and referrers, so we went through the records to see how many of the 154 people we'd seen in the last 12 months had re-offended.

Of the 128 who had received counselling and had up-to-date records, 28 had re-offended, but 100 had not – a reoffending rate of 22 per cent. The national rate for similar offenders was 37 per cent. I put these figures to the probation senior

nocks

management, but again there was no response. Why not? Isn't the declared aim of the Ministry of Justice to reduce the risk of reoffending? Here was a low cost, high quality service that was delivering exactly that.

When I heard the plan was to provide an alcohol misuse service, using in-house resources, I again wrote to the probation chief, suggesting a meeting so I could pass on the learning of our previous six years. Again, there was no response.

I wasn't quite ready to give up, however, so I wrote to the NOMS regional offender manager with a detailed analysis of the reoffending rates. It boiled down to a simple statement – if one person was being kept out of prison as a result of our intervention it wouldn't be far off full cost recovery of our counselling service, to say nothing of the other 99. He did at least reply, after six weeks, but without responding to the points I'd raised.

We had a model of outstandingly good practice. It ticked all the boxes, delivered what it promised and more and bent over backwards to respond flexibly to the ever-changing needs of the local offender population, yet it was kicked into the long grass without so much as a thank you.

So what have I learned? If you work on the front line, you really can make a difference to the disenfranchised and socially excluded. You can gather the data meticulously, so those who fund your service know exactly how their money is spent, how well the objectives are fulfilled, and what value you're adding. You can elicit feedback and evaluate what you do, endlessly honing and refining the quality of your work. You can work with other professionals to provide a multi-faceted response to people with a range of needs and difficulties. What's happening when you still get a slap in the face with a wet fish?

A psychoanalytic take can help. When things just don't add up, there may be unconscious drivers at work. For example, it might be very helpful for the 25-year-old who goes out drinking, then launches a grievous and totally unprovoked attack on a stranger to understand he has been quietly carrying a lifetime of rage towards his bullying stepfather. My unconscious and, I assure you, unvoiced response to the wet fish was, 'Sod the lot of you'. I realised this could be a good clue as to how offenders might feel if their experience of criminal justice was being punished without being listened to, and how, possibly, some of them might come to reoffend.

But surely, that just doesn't add up. Now about that underspend… **DDN**

Paul Taylor is a counsellor and clinical supervisor in private practice
Email: paul@goodtreatment.co.uk

HOW THE SERVICE WORKED

The aim was to help offenders take control of their drinking and so take charge of their lives. While we signed up lock, stock and barrel to the probation objectives of reducing risk, we also kept the potential benefits in terms of health, finance, employment, accommodation and relationships firmly in focus at all times.

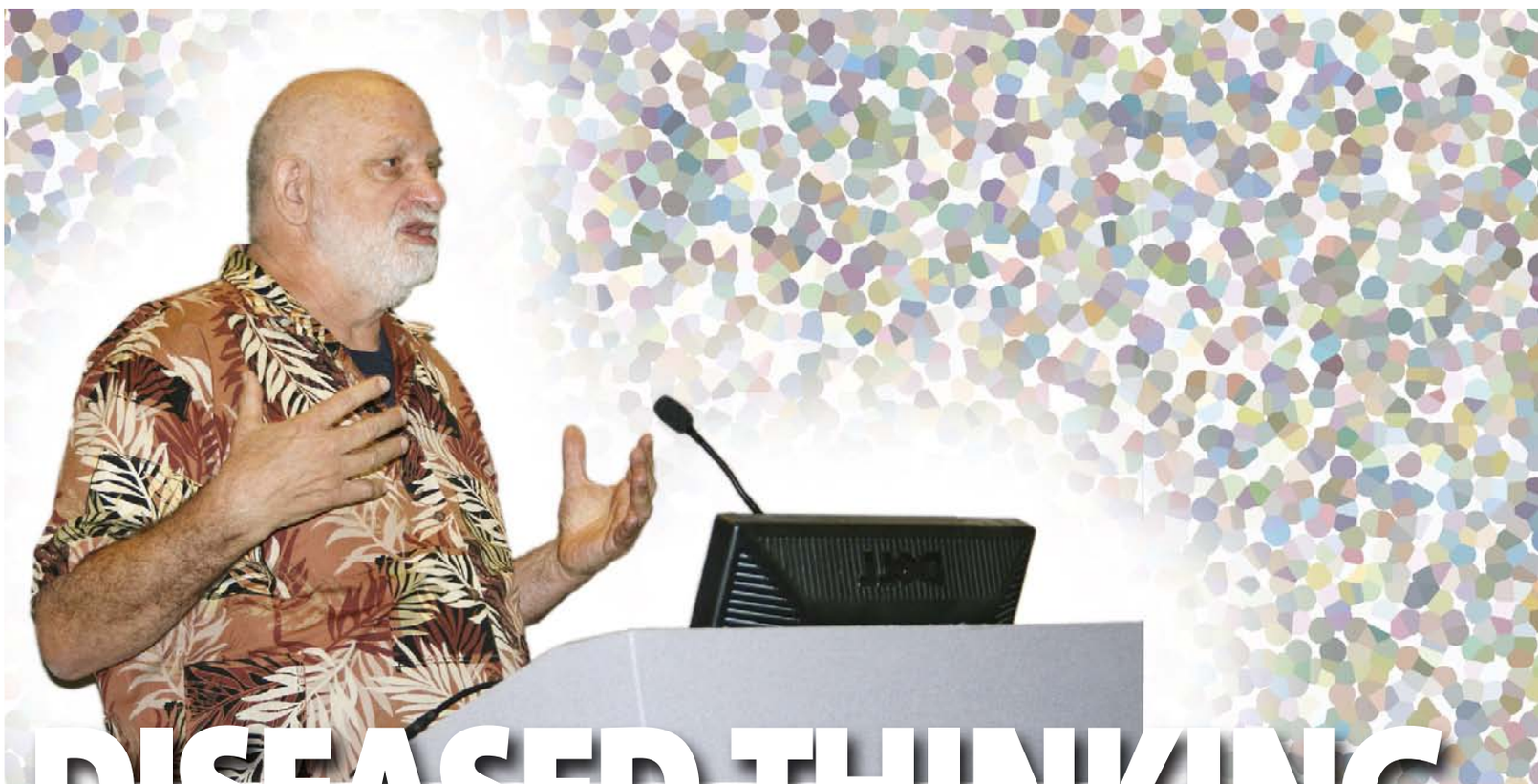
The model was one of brief intervention – assessment followed by up to five further sessions – with the wide range of needs demanding individual therapeutic responses. Assessment had three objectives – to define the alcohol-related need, and set ground rules for the work and goals to which both parties could commit. We did not want to duplicate previous assessments – the purpose was to establish the basis for an honest, mutually respectful, working relationship.

Several factors contributed to the success of the enterprise, but on reflection three stand out as indispensable. First, we had the backing of a small but sharp voluntary sector agency, the Nelson Trust, whose practitioners were highly skilled and highly trained, had access to independent clinical supervision and were paid a decent wage.

Second, the service was thoroughly scrutinised by senior management on both sides of the partnership at quarterly intervals. Were we fulfilling the objectives described in the contract? What were we doing well and where could we do better? How could both parties work together to incentivise attendance, for example? What other resources could we make available? This discourse was enhanced through informal discussion between clinicians and probation colleagues, helping to build mutual respect between the agencies.

Thirdly, in the absence of obsessive micro-management, our clinicians largely had a free hand to exercise their professional judgement in responding to the needs, circumstances and aspirations of individual offenders.

The squeezing out, in recent years, of professional judgement is the operational change most lamented by our former colleagues. And perhaps another reason why they so valued our contribution.



DISEASED THINKING

The disease model of addiction is not only wrong, it 'defiles the human spirit', says American harm reductionist Stanton Peele. He talks to David Gilliver

Later this month, American psychologist and author Stanton Peele will go head to head with Neil McKeganey in two special debates on 'The future of harm reduction and drug prevention.' While McKeganey believes that harm reduction has reached the point where it needs to decide what its purpose really is (*DDN*, July, page 16), Peele's view is that it is the most important innovation ever in addiction policy and treatment.

The debates take place in Glasgow on 21 September and Edinburgh the following day. 'I'm very much looking to it,' says Peele. 'Scotland's always had a romantic place in my mind ever since I became addicted to Hitchcock's film *The 39 Steps*.' Does that mean they'll be handcuffed together for the debate in homage the film? 'I'll have to think about how to do that,' he says.

What makes harm reduction so vital, he believes, is the recognition that permanent abstinence is rare. 'It takes a realistic view of what's going on in life,' he says. 'I'm an American, and people have often noted that we work off of an alternative reality in many areas, none more so than alcohol and drugs. We banned the production and sale of alcohol for 13 years – that seemed like a reasonable thing to us. We're the only Western country where the legal drinking age is 21, but we're never bothered by the fact that everybody else has decided to go in the other direction. We're happy to say, "can you believe those crazy Europeans, how idiotic they are?"

America was also rare among Western countries for its slow adoption of harm reduction practices, he points out. 'In Britain, you avoided the second wave of HIV infection that came with IV drug use. We have a Tea Party version of reality around alcohol and drugs – you can't let kids drink before they're 21, and you can't tell them anything positive about alcohol.'

Yet more than 90 per cent of Americans have already drunk alcohol by the time they reach the legal drinking age. 'And they don't drink well – they binge – so that message is hopelessly confounded and confused,' he says. 'On drugs,

our position is supposedly that we're just going to get everyone to quit taking drugs for ever, yet we have the most medicated teens in the world. Forty per cent of American teenagers have had a psychoactive medication prescribed to them by the time they're 18, and the fastest growing drugs of abuse are psychiatric medication. So even the fundamentals make no sense.'

Part of the problem is the extent to which America is in thrall to the 'disease' view of addiction, he believes. 'So people take drugs and alcohol because "the disease" compels them to do so, and the cure for that illness is abstinence – which is a funny cure for a disease.'

This, he says, is at odds with the evidence, such as the National Institute of Alcohol Abuse and Alcoholism's study of American drinking behaviour, the National Epidemiologic Study on Alcohol and Related Conditions (NESARC), which interviewed 43,000 people face-to-face about their lifetime's drinking. 'It showed that three quarters had recovered from alcoholism or dependence, and more than half of those had done so while continuing to drink,' he says.

Presumably, this was anathema to the country's huge 12-step movement? 'It was almost anathema to the government's own position,' he says. 'It's as though the most radical disclaimer to what we're taught is the government's own research. But people don't change their ideas – in America we have an attitude to drugs and alcohol, and that's just the way it is. They could do 25 studies of 43,000 Americans and it wouldn't matter.'

Instead of drugs and alcohol being 'an external force that impose themselves on human beings and lock them in for life', he says, the reality is that people 'swerve into and out of addiction' as their lives change and they come to grips with its consequences. This makes addiction a 'variable experience', with susceptibility depending on a person's circumstances and what else is happening in their life. The extent to which the disease model ignores factors like class, cultural background or even stress levels renders it 'unscientific and dysfunctional', he states.

'It's not the best way to treat people, it's certainly not the best way to recognise reality, and it also has the possible consequence of convincing people of their inability to naturally overcome their addiction by themselves, which, in a large number of cases, they would.'

So what's behind it – is it partly down to vested interests? 'People say that, and I'm as economic a determinist as the next person, but it's more fundamental than that. There's something that sticks in the American craw, something about good and evil when it comes to drugs and alcohol in the history of America. For example, it cost us money to have that second Aids epidemic, yet we stuck with it because the average politician said it "gave the wrong message" to allow people to have clean injection apparatus, even though that killed people. It goes beyond pennies and dimes, and even life. Which is scary to think about.'

With people's chances of overcoming addiction so tied up with economic circumstances, what kind of impact does he believe the US debt deal's $2tn worth of budget cuts are likely to have? 'It's not so much the spending cuts as how we direct our money and realign our priorities,' he says. 'They're saying, "we'll cut back on education and support programmes" and in a strange way that fits with the disease model because then you can say "certain people become diseased and we'll treat them in hospitals", when it's impossibly expensive to do that. By failing to understand that we need to support individuals and give them options and opportunity we do nothing so much as to guarantee the perpetuation and expansion of addiction.'

Instead, the best treatments are the least expensive – those which are motivationally oriented, he says. 'You teach people skills and you enhance their motivation to change. It's the opposite of intensive reprogramming of their thinking.'

His views can often be misunderstood, he adds. 'The NESARC study said that the majority of people recovered from alcoholism while continuing to drink, something that's a million miles from teaching people to be controlled drinkers. You might be talking about a 20-year period where they came to grips with reducing their drinking. It's something that occurs over people's lifetimes – people are often haltingly approaching it and then they go to a treatment programme and are told, "here's the deal – the only choice you have in life is to abstain or you're doomed". That's a dangerous and negative message.'

'In America we have an attitude to drugs and alcohol, and that's just the way it is. They could do 25 studies of 43,000 Americans and it wouldn't matter.'

The message of harm reduction, meanwhile, is 'perhaps it's best for you to abstain, but in the meantime let's keep in place all the things that can keep you from dying', he continues. 'And although American politicians said needle exchanges sent the wrong message, they actually produce more abstinence in the long run because you allow people to be in touch with healthcare providers in a non-confrontational way. That kind of constructive interaction is a step on the path towards leaving addiction behind permanently. The best way to help people is to say, "we need to eliminate the most dangerous behaviours in your life, and for you to stay in touch with us".'

Nonetheless, he's still had his share of spats with harm reductionists, and puts many methadone providers firmly in the disease-oriented camp. 'They say, "the reason we give them methadone is they're constitutionally addicted to narcotics, so let's give them a less harmful narcotic". To me that defiles the human spirit. People quit narcotics all the time, and therapy should try to assist with that if that's your goal. I'm not going to tell someone they're permanently wedded to a need for a narcotic – it isn't true, and it isn't helpful.'

As well as discounting the disease model, he also has issues with some of those aspects of American addiction discourse that foreground notions of a hereditary component. 'Real geneticists have long ago discounted the possibility that there's a single gene that accounts for alcoholism,' he states 'It's only people with fantasy notions of what genetics comprise who believe that. Genetic explanations have to make sense, and part of what the disease model has done is to remove the role of values and the fibre of a person's life and decision-making. It's a reasonable statement to say that genes have an impact on how people experience alcohol and react to it, but that's 500,000 miles from saying genes cause alcoholism. It's one little corner of the entire puzzle.'

He's been fascinated by these issues for as long as he can remember, he points out. 'I grew up in south Philadelphia, which is something of an urban ghetto, and I had a neighbour who'd come home drunk – out-of-his-mind drunk – every night. When I was five years old that fascinated me – why it happened and what it meant about a person, and I asked my mother endless questions and thought about it forever.'

Studying addiction has since dominated his entire life, he says – 'getting information, testing ideas, talking to people, asking what they do. When I went to buy wine with my ex-wife I'd start asking people about how they drank and she'd say "would you just shut up and get the wine". Dinner with me is just a joke because I'll be asking people about their anti-depressant use.'

He was also one of the first to talk about addiction in relation to things such as gambling, publishing *Love and Addiction* – the premise of which is that people can become addicted to any experience they find sufficiently rewarding or consuming – nearly 40 years ago. 'People thought it was bizarre and laughable. But I knew that addiction applied to a wide range of activities beyond drugs and alcohol, I knew most users don't become addicted, and I knew that people overcome addiction naturally. Now people talk about addiction to gambling and love and sex and video games.

'So,' he says, 'I expect to be awarded the Nobel Prize any day now.' **DDN**

TIME TO AIM HIGH

Professor John Strang's interim report for the NTA shows there's room for greater ambition for recovery within treatment, says Rosanna O'Connor

A LIST OF RECOMMENDATIONS for giving individuals the best chance of recovery forms part of Professor John Strang's interim report on the work of the expert group he chairs on improving recovery-oriented drug treatment. The report, which includes guidance on the proper use of medications to optimise recovery outcomes, was published by the NTA last month (*DDN*, August, page 5).

The document recognises the strong body of evidence for the effectiveness of opioid substitute treatment, but also that there is room for greater ambition for recovery, and that individuals could be better supported throughout their treatment journey and beyond.

Its aim is to build on current practice to sharpen the recovery focus, and a 12-step checklist of recommendations – which the report lists in more detail – is designed to give professionals and services a straightforward and practical framework for maximising recovery outcomes, ensuring people have the best chance of achieving abstinence from their drug of dependence and every opportunity to do so when the time is right.

The 12 recommendations are as follows:

- *Audit the balance between overcoming dependence and reducing harm*
- *Review patients to ensure they have achieved, or are working towards, abstinence – particularly from their problem drug(s)*
- *Encourage more patients to take opportunities for achieving greater recovery*
- *Ensure the eventual exits from treatment are visible from the outset*
- *Review the continuing benefit of ongoing prescribing to patients*
- *Ensure extra support is available to patients coming off medication, along with rapid re-entry if they relapse*
- *Check treatment is optimised, with appropriate range and intensity of interventions*
- *Support services to improve patients' access to social networks, including families, mutual aid and peer support*
- *Support individuals to improve their social capital through work, volunteering and training opportunities*
- *Ensure keyworkers are competent to deliver a full range of psychosocial interventions*
- *Review, and where necessary improve, the quality of recovery care planning*
- *Work with housing and employment services to maximise local access to both.*

This renewed emphasis on improving people's recovery potential reiterates the importance of having personalised recovery-focussed care plans, which support reintegration and maximise the benefits of peer support. Drug treatment services need to strengthen links with wider recovery services, so that prescribing continues to play an important role where needed but is offered alongside, and in support of, other interventions. This balance ensures that the benefits of medication in protecting individuals and their communities support recovery aims.

A lot of this good practice is already in place, of course. Local teams are working to identify which aspects of this approach can have the biggest impact in their community, and how they can work with commissioners to improve outcomes. We know of many positive examples in which treatment services are reviewing people's progress and supporting them to engage with local communities and recovery networks.

The group chaired by Professor Strang will publish its final report early next year. In the meantime, the NTA will be working with partnerships, providers and others on how best to implement the checklist. Our call to action for the treatment sector is to apply these principles wherever possible, and to double-check that recovery opportunities are maximised for everyone.

Rosanna O'Connor is director of delivery at the NTA

Recovery-oriented drug treatment available at www.nta.nhs.uk

MY CANNABIS DIARY

In the sixth part of his story, Nigel seeks stability through therapy

EARLY ON IN MY RECOVERY I thought that I didn't need any kind of behavioural therapy. Then as I was going through the courts to gain access to my children it was suggested that I referred myself to a programme called the SAFE project. It would run for 30 weeks – a big commitment. Was I ready for it?

Initially I thought this was not for me because I don't have an abusive nature – after all I had trained my brain to be the exact opposite of my father. But as I got into the course, everything they were putting on that flipchart was, in fact, me. It was all quite frightening, as I had never been that person in my own eyes. During those weeks we covered subjects that were very hard to handle. It was all very intense, but I needed to sort out all those issues of abusing other people – and also abusing myself in some ways.

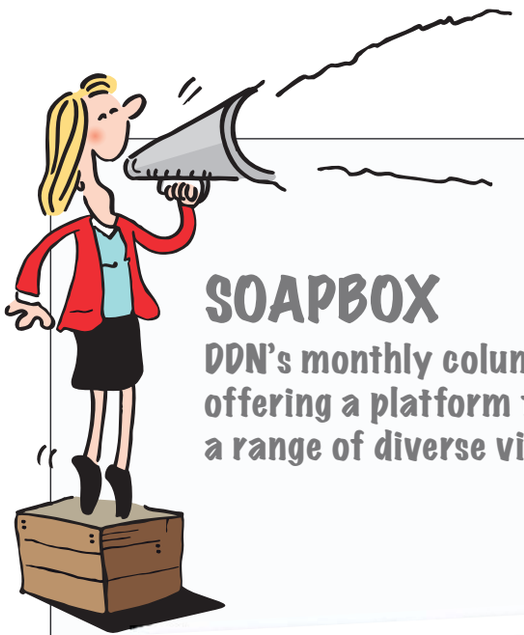
Although it hurt at the time, the course helped me in the long run and gave me peace of mind. I met people from all walks of life, from prisoners to ordinary everyday people, and again I was not judged. It was as if I had been given a second chance of life and it gave me a solid foundation to keep up the good work and question my actions.

Next came counselling, which took me to the root of my problems and helped me to deal with everyday life. I had talked about having counselling at the age of 17, but back then I wasn't ready for it. This time I was not putting up barriers and was very open about all the things that were in my head. I realised it was important to sort these things out if I was to gain essential peace of mind.

My counsellor was a very good listener and gave me input at the right times – I guess he'd seen all this before. He explained something to me that will always sit in my brain – the drama triangle, consisting of perpetrator, rescuer and victim. I had played all these roles throughout my life – the perpetrator when I was abusing people; the rescuer when I was trying to rescue my mother from my father; and the victim playing the pity card, thinking that it was all my fault and it could only happen to me.

The help and treatment that I've received has equipped me to deal with every situation I find myself in. I call it my toolbox, as there's always a tool I can rely on to get me through life and help me deal with any issue that arises. I've been taught that I can only control myself and my actions, but that I cannot control others around me. Counselling has helped me deal with and understand my illnesses and gain a whole new attitude to life.

Next issue: Nigel looks to the future in his final instalment



SOAPBOX

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

FINE-TUNING THE REVOLUTION

Recovery is not just a rebranding exercise, says **Ryan Campbell**

Over the last two years, treatment services have been gilded in the shiny gold plate of recovery. When was the last conference that wasn't about recovery? A new service without recovery in its title? How many job ads are for 'recovery workers' where they used to be for treatment staff or case managers? All of a sudden care plans are recovery plans, treatment pathways are recovery pathways and our organisations' straplines gleam with how much we are dedicated to, striving for, committed to, embracing, building for, recovery.

Fortunately, however, it's not just gloss – something important is happening. Recovery, although hardly new, is a real concept, long used to define approaches in addiction, mental health and other complex areas, particularly where client views, needs and aspirations are critical to the achievement of societal aims. Revision of our system in the light of recovery is causing services to change and work better together, with a new focus on long-term achievement.

But there is a lot of gloss nevertheless. There has been no revolution here yet; the basic elements of our treatment system are largely the same as they were two years ago. What has certainly changed though is that views on what the concept of recovery means has implications for where public money is spent, in a competitive commissioning system (oh my God – we used to think we were running an abstinence day programme/prescribing service/needle exchange/residential – but we've just realised, it's a RECOVERY SERVICE!).

However services don't achieve recovery, people do. The government's drug strategy states that recovery 'will mean different things to different people'. I agree with that statement – recovery doesn't mean specific things in a whole-system sense.

However, this definition is not what my mum thinks recovery means, and I don't think she'd pick up on the nuanced politics within it either. She thinks recovery means 'getting better'. I prefer her version.

This reminds me of the time in the '90s when health and social care was deciding how it would protect vulnerable adults. Much of our initial attention was on creating exact definitions of a 'vulnerable adult', or deciding whether 'neglect' counted as 'abuse', and I guess we maybe needed to go through that process. Thankfully, though, we've now largely ditched the carefully worded definitions, and simply protect people who are being harmed, or who are at risk of being harmed. Now, as then, a common understanding of language matters, but the important point is what we do, and how we know we're doing it.

Perhaps the problem arises when we try to unify what we do in a simplistic way, and to see people in a simplistic sense. I don't think people follow a 'pathway' – that's a way to organise a system, not respond to people. They skip around all over the place, and surge forward and relapse, and choose to do different things, and have different aspirations. The system isn't malfunctioning when that happens, it simply can't move people step by step, en masse, in a uniform, predictable, direction.

What a system can do is help people with their immediate presenting needs, give them hope and aspirations, and help them take the next step towards achieving those. Some people will have an end-point in mind, some people only the next step, some people will get to where they want to get to (or where we want them to go), many won't, but we still try.

The results will be multiple and varied. What we need to do is agree on and measure, not definitions, or single end-points, but the individual outcomes associated with recovery.

So, if we are improving we should see more people getting drug free, health improving, drug-related deaths and BBV infection decreasing, people getting jobs, not reoffending, and finding stable accommodation. Not everyone will achieve these things, but a system that can improve these outcomes overall will certainly be helping people to recover, and supporting those who do not recover.

My organisation prides itself on measuring hard outcomes, and as we spend money given by the taxpayer to reduce crime, we measure the impact of our treatment by how much we reduce reconvictions. This is not a perfect measure, but it does prove we are reducing crime, and if we can't prove that, we have no right to be commissioned. Whether people are engaged in treatment, and whether they tell us they are making progress, is useful information, but unless the outcomes improve accordingly, they are no indication of success. The revolution we need is a move from process monitoring and self-report to verifiable outcomes.

From an individual's point of view, recovery means whatever it means to that individual. But to the wider community, it is about outcomes. We need to challenge ourselves to show what we actually do. How we define the process of achieving that is secondary. **DDN**

Ryan Campbell is development director at RAPt and deputy chair of Mind

INVITATION TO TENDER:

Substance misuse services in Scarborough, Whitby and Ryedale

North Yorkshire Substance Misuse Partnership invites expressions of interest to provide an integrated; recovery focused adult substance misuse treatment service (drugs & alcohol) for the Scarborough, Whitby and Ryedale local authority districts.

The service will provide a range of evidence-based open access, criminal justice and structured interventions to address the needs of substance misusers and their significant others, and referral pathways to wrap-around services, in order to support the delivery of the following outcomes:

- *Prevention of and reduction in personal and social drug related harm*
- *Improved health, well being and social functioning amongst drug and alcohol users, their families and their communities*

We intend to award the contract from 1 April 2012 for a period of 3 years, subject to funding confirmation in successive financial years.

The maximum contract value for the integrated service is £1,241,589 per annum. Of this, a maximum of £1,000,000 is available for drug treatment and a maximum of £241,589 is available for alcohol treatment. Please note that these are subject to change in successive years in response to national and local budget setting arrangements.

Expressions of interest are sought from organisations that can evidence the following in their application:

- *Minimum 2 years recent (within last 5 years) track record of providing substance misuse treatment services. Please include: name of contract, length of contract, brief description of services provided, and if structured drug treatment and/or brief interventions/structured alcohol treatment; latest full financial year NDTMS or NATMS report.*
- *Care Quality Commission (CQC) Registration, (if this is mandated for the services provided) – please include certificate and detail any relevant conditions which have been placed on your registration. If your organisation is not currently CQC registered, please provide the reason(s) for this.*

Multi-organisation (consortia) applications will be considered. Bidders may only bid to provide the full integrated service at £1,241,589 per annum, or only the drug service at £1,000,000 per annum, or only the alcohol service at £241,589. Please note that bidders who only wish to express an interest in providing the drug service or alcohol service will be expected to describe, at the tender stage, how they will deliver this element of the service within an integrated service model with other organisations.

TUPE may apply to this contract and further details will be provided with the tender application packs.

The closing date for applications is 7 October 2011.

Please send your expression of interest, accompanying evidence or any questions to gary.metcalfe@nhs.net

Late applications will not be accepted.
Further information is available at www.nyypct.nhs.uk

North Yorkshire County Council

York and North Yorkshire Probation Trust

NHS North Yorkshire and York

SLOUGH DRUG & ALCOHOL ACTION TEAM

www.slough.gov.uk Slough Borough Council

Slough Drug and Alcohol Action Team (DAAT) are seeking EXPRESSIONS OF INTEREST for the provision of a new recovery-focused treatment system

Slough DAAT is looking for suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver drug and alcohol services to meet the needs of a diverse population.

BLOCK 1

Early engagement and harm minimisation service including:

- Local Area Single Assessment and Referral System (LASAR)
- Treatment centre management
- Assertive outreach for hard to reach groups
- Specialist needle exchange and harm reduction
- Brief interventions to drug and alcohol users

We require this service to be independent and delivered by a different supplier to those lots listed in Block 2. Further details are provided in the PQQ documentation.

BLOCK 2

These services are being tendered in lots. You may submit bids for one or more of the following lots and /or as an integrated service:

1. Key work interventions service for drug and alcohol users who need support whilst accessing prescribing / community detox. This service will need to work closely with the clinical prescribers and will be responsible for the administration and co-ordination of clinics.
2. Psycho-social recovery service to include structured counselling and group work.
3. Intensive engagement and social reintegration service for parental substance misusers and adults with multiple complex needs.

BLOCK 3

The DAAT in conjunction with Supporting People are also seeking expressions of interest from organisations with the capacity and experience to deliver an accommodation based support service for people with substance misuse issues. This is a stand alone service so integrated bids will not be accepted with block 1 or block 2.

The contracts will be based, in part, on performance related payment in relation to achieving a set of outcome indicators. ***Contract start date is the 1st April 2012*** *and will be for a term of two years with a possible extension of two years. Interested organisations should note that Transfer of Undertakings Protection of Employment (TUPE) will apply.*

For further information about the procurement process, interested parties are invited to look on www.businessportal.southeastiep.gov.uk where it is possible to download the pre-qualification questionnaire (PQQ). Providers who are successful at this stage will then be notified of invitation to tender.

Please note the latest date for receipt of expressions of interest and the completion of PQQ's is 12.00pm Friday 23rd September.

BOURNEMOUTH ALCOHOL & DRUG SERVICE USER FORUM

The Bournemouth Alcohol & Drug Service User Forum (BADSUF) are a registered charity established in 1995 providing a range of services to ensure maximum effectiveness for the treatment of drug and alcohol users in Bournemouth.

BADSUF now has the following vacancy:

General Manager

37 Hours per week.

Salary: £29,859–£34,146 (depending on experience)

The post requires an adaptable person with a managerial background and experience of working in partnership with statutory and voluntary organisations. **BADSUF** is committed to equal opportunities and welcomes applications from all sections of the community. *Please note that this post is subject to CRB checks.*

For an application pack please go to www.badsuf.com or contact Jackie Twine on 01202 535748.

Closing date: 23rd September 2011

ROCHDALE METROPOLITAN BOROUGH COUNCIL

Tender for the

ROCHDALE SUBSTANCE MISUSE RECOVERY SERVICE

We are inviting a suitably qualified and experienced organisation to tender for the above Service.

The successful provider will be expected to provide our abstinence based provision within a community setting for substance mis-users in the Rochdale borough. The appointed service will deliver a range of evidence based and innovative interventions to our clients to support them in the final stages of their treatment journey.

The contract is for a period of 2 years anticipated to commence on 1st April 2012 with an option to extend for a further year (subject to funding).

Organisations interested in providing this service should submit a tender using RMBC's e-tendering portal "The Chest": - To register go to www.thechest.nwce.gov.uk

Rochdale Safer Communities Partnership

Tenders should be completed and submitted no later than 2pm on Monday 26th September 2011

Drugs, Alcohol, Tobacco & Public Health - Plotting A New Course

H2 EVENTS | Esprit de Bois | 21ST & 22ND SEPTEMBER 2011 | Manchester Central Convention Complex

To find out more visit *www.eventsforce.net/drugs,alcohol,tobaccoand publichealth-plottinganewcourse* or email sam.harrison@h2-events.co.uk

Oxfordshire drug & alcohol action team

Tender for Oxfordshire Recovery Services

Oxfordshire DAAT would like to commission approximately two providers with an annual budget of circa £2 million per annum.

As part of the development of Payment by Results we are now in the position to provide more detail therefore we would like to ensure that all potential providers have the following information:

- *We intend to commission approximately 2 providers*
- *Annual budget of circa £2 million per annum*
- *Payment by Results for Recovery – Draft Outcome definitions can be found at www.dh.gov.uk*

The introduction of community recovery services, to run alongside the separate Harm Minimisation Service and the current Residential Detoxification and Rehabilitation Services framework, is a key element in ensuring that the needs of all drug and alcohol users are met. This service will be the focal point of the Payment by Results (PbR) pilot and put recovery at the core of our treatment system. A core function of these services will be to provide interventions to people who are ready to recover from addiction and would like to work towards leading a life free from dependence. Oxfordshire's Drug and Alcohol System model is outlined on our web site at **www.oxfordshiredaat.org**

The scope and scale of this service is detailed in a Memorandum of Information (MoI) which can be accessed by all interested organisations via the Procurement web-site referred to below.

The services will work with individuals across Oxfordshire aiding them to develop their 'recovery capital' to ensure that they are able to maximise all opportunities to become free from dependence. This will include the provision of a range of interventions, including detoxification prescribing, but not limited to the elements described in the MoI.

It is currently envisaged that providers will operate under a framework model aligned with the Developing Public Health and Health contracting policy.

TIMINGS

The PCT would like to be in a position to appoint recovery providers by December 2011, for commencement of the new services from April 2012.

THE PROCUREMENT PROCESS

For further information about the procurement process, interested parties are invited to access the electronic portal www.pro-cure.bravosolution.co.uk where all Pre-Qualification Questionnaire (PQQ) documentation and a Memorandum of Information (MOI) can be accessed.

The Procurement will be conducted via this e-tendering web site and if you want to express an interest in this opportunity please:

- *Register your organisation on the www.pro-cure.bravosolution.co.uk web-site;*
- *Access the Pre-qualification Questionnaire (pqq_28846) for Recovery Services for Oxfordshire DAAT.*

Please note that the latest date for receipt of expressions of interest and the completion of PQQs is 17:00 on Monday 26 September 2011. All PQQs to be completed and returned via the web-site.

PQQs received/posted to the web-site after 17:00 on the Friday 26 September 2011 will not be allowed or evaluated.

Should you require any assistance in accessing or registering on the e-tendering web site please contact the Bravo eTendering Helpdesk – Phone 0800 368 4850.

EXPRESSIONS OF INTEREST

INTEGRATED COMMUNITY TREATMENT SERVICE

The Wiltshire Community Safety Partnership would like to offer potential providers an exciting opportunity to be involved in the commissioning of an integrated Tier 2 and Tier 3 Community Drug and Alcohol Treatment Service.

The Service would extend across the whole of Wiltshire (excluding Swindon) and include the locality areas of Salisbury, Kennet, West Wiltshire and North Wiltshire.

A consultation day will be held for interested parties to contribute to the commissioning process details of which will be made available after the deadline below. Any expression received in response to this advert will be taken to be an expression of interest in any tender(s) which may result.

Expressions of interest must be submitted in writing or by e-mail to Marie Strachan, Drug and Alcohol Team, Wiltshire District Council, County Hall, Trowbridge, Wiltshire, BA14 8LE.

email: marie.strachan@wiltshire.nhs.uk
or caroline.rose@wiltshire.nhs.uk

Deadline for submissions: 5pm, Friday 21st October 2011

SERVICE MANAGER

(Female*)
37.5hrs
Salary: NJC Spinal Point 40 – £33,661 per annum

Brighton Oasis Project aims to improve the lives and maximise the potential of the diverse range of women, children and young people affected by substance misuse.

We are currently seeking to appoint a new a full time Service Manager (Female*) who will take a lead on the ongoing development of services within the organisation. Working within a recovery focused system the post holder will be responsible for the management of all aspects of the service ensuring consistent delivery of high quality services meeting statutory requirements.

Candidates should possess a minimum of two years previous management/supervisory experience in the voluntary or statutory sector in a social care setting. Previous experience of working in the specialist drugs/alcohol field in the voluntary or statutory sector would also be desirable. A demonstrated ability to lead a team, manage performance, and deliver service improvements as well as knowledge and detailed understanding of the issues relating to drug use and women and the impact of this on families is also essential to this role.

* *This post is female only; section 7(3) of the Sex Discrimination Act applies.*

For more information, or for an application pack, please contact Mary or Eleni on 01273 696970 ext 200, or visit our website: www.oasisproject.org.uk

Closing Date: Monday 26th September, 12pm
Interview Date: Monday 3rd October

INVESTOR IN PEOPLE

want to join a young, dynamic, expanding team?

RECRUITING NOW!

North West

New Business Manager

£Competitive Salary + Commission, Laptop, Blackberry

This role is suited to a driven individual looking to make a real impact for themselves and the business and reap the rewards that this brings. The successful candidate should ideally come from a background in Health and Social Care and will possess strong experience in building customer relationships, developing new accounts and have an impressive list of industry names and contacts.

For an informal chat in the first instance, please call Tom Kirkwood on 01925 405040

Warrington

Counsellor

With Counselling Diploma and at least two years experience in substance misuse field essential – 12 step knowledge and/or experience an advantage, 21 -25k

Coventry and Bradford

Housing Support workers

(part time)

To work evenings and weekends in our new Housing Project, 14k

Bradford

Support worker/ recovery coach

With experience in delivering substance misuse groups and peer support

Bradford, Kingston and Chorley

Bank nurses

RMNs and RGNs for our Inpatient Detox Facilities, 21-25k

Internal applications from within TTP and IHP are encouraged. For an application form and job description, please call Angela Cochrane on 01582 589040 or alternatively contact by email on angela.cochrane@ttpcc.org. TTP is an equal opportunities employer. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/sober are also encouraged to apply for the above positions.

ttp counselling

alcohol and drug rehab

www.ttpcc.org