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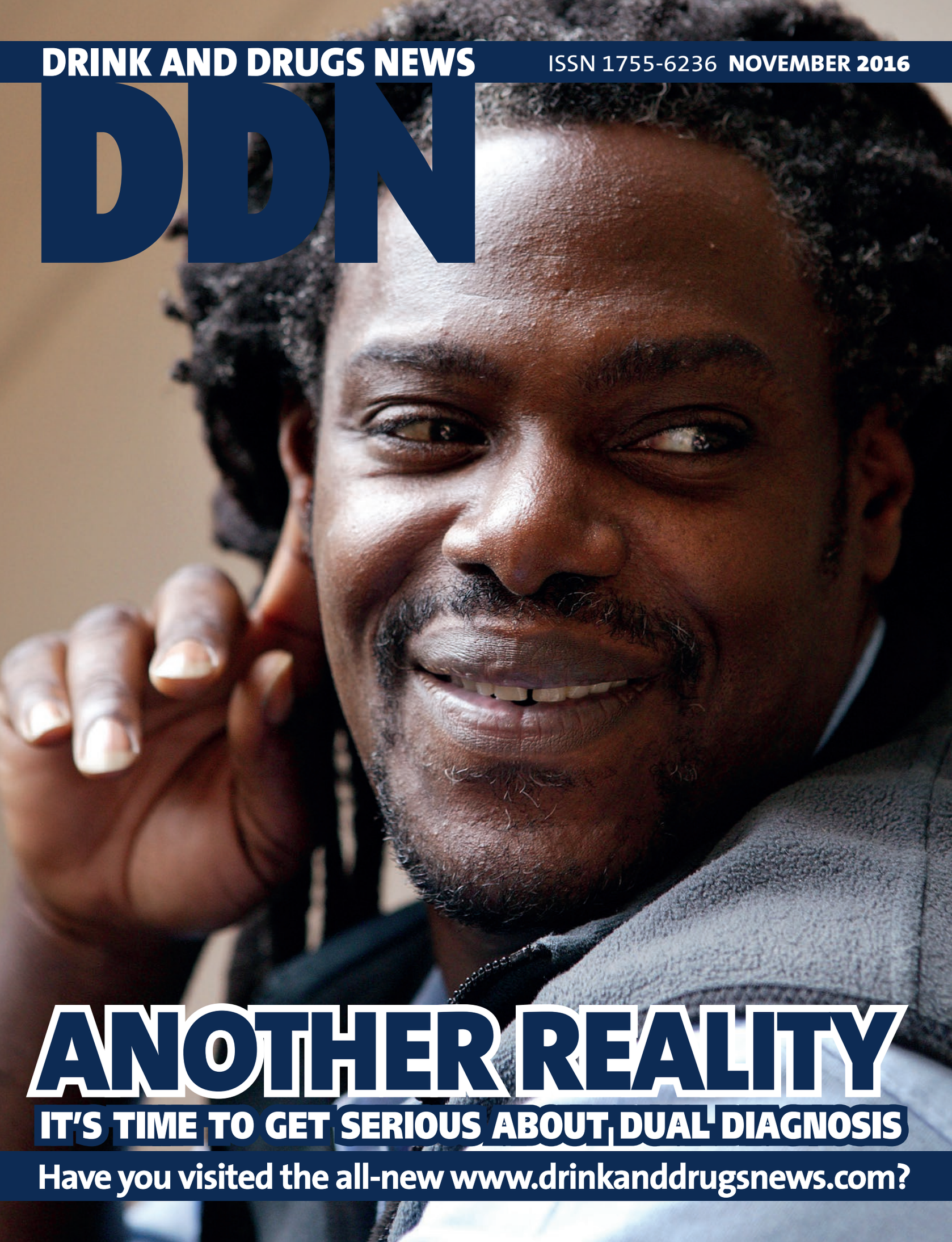

ANOTHER REALITY

IT'S TIME TO GET SERIOUS ABOUT DUAL DIAGNOSIS

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Mental health in crisis – *DDN* reports from the Minority Mental Health conference

EDITOR'S LETTER

'Dual diagnosis has been much talked about, but are we addressing it adequately?'

There is an absolute moral imperative on all of us to tackle the 'outrageous discrimination' against people with mental health problems, said Normal Lamb MP at a recent conference (cover story, page 6).

I don't think any of us would disagree with that – the question is, how? As our article shows, the problems are magnified for people from minority groups, and when you add the stigma of a drug or alcohol problem, it's not surprising that people are not presenting for help. Dual diagnosis has been much talked about in recent years, but are we addressing it logically?

The conference itself was an extremely positive experience, with ideas flying around throughout the day. Participants pledged to network beyond the event, and there was plenty of support for integrating mental health, substance misuse and social care. But it also highlighted the need to reach beyond our sector – it was seen as crucial to engage people at a much earlier stage, which means joint planning with health services and education to catch them before they are at crisis point. Yet who has the time and money to think beyond a day job that's full to capacity?

We have to talk about this, or it renders our good intentions meaningless. It requires a different way of working and a different level of investment that has to be underpinned by political support – and not just that of our free-speaking shadow ministers. If you have experience of working with dual diagnosis, please share it with us.

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GLASGOW CONSIDERS CASE FOR UK'S FIRST CONSUMPTION ROOM

GLASGOW COULD BECOME THE SITE OF THE UK'S FIRST CONSUMPTION ROOM, after the Glasgow City Joint Integration Board officially approved the development of a business case.

A full business case for both a consumption room and heroin-assisted treatment will now be drawn up, and formally considered when the board meets in February. Any facility established in the city should also offer wraparound services such as counselling, primary health care and advice on issues like housing and welfare, however, according to a working group established by the local alcohol and drug partnership (ADP) (*DDN*, July/August, page 4). This would help maximise engagement with the target population and increase 'the potential for harm reduction', the group said.

The working group reviewed how existing consumption room services operated in places like Europe, Canada and Australia, as well as considering feedback from stakeholders. A detailed costing of the facility will now be carried out, alongside a consultation with local residents and businesses to identify a location.

There are an estimated 5,500 people who inject drugs in Glasgow, according to NHS Greater Glasgow and Clyde, with around 500 'very vulnerable' people injecting in public places around the city centre. Last year the city saw a spike in new HIV infections – 47 compared with the 'previously consistent' annual average of ten – and also recorded more than 150 drug-related deaths, while police and community safety teams regularly deal with problems associated with discarded needles.

'...this facility will make a major impact in reducing health risks and the resulting costs for this group.'

DR EMILIA CRIGHTON

The ADP said it would now develop a 'robust' case to support the development of the service, which is likely to prove controversial. 'Today's decision marks real progress towards delivering a service model that meets the needs of this small, but very vulnerable, group,' said the partnership's vice chair Dr Emilia Crighton. 'We are now one step closer to catching up with other countries in the way we tackle this problem. This public injecting group has high rates of hospital admissions, incarceration and homelessness. While conventional treatment and services are effective for the majority of people, we believe this facility will make a major impact in reducing health risks and the resulting costs for this group.'

Although the ultimate goal was for users to remain drug free, until people were 'ready to seek and receive help to stop using drugs it is important to keep them as safe as possible while do they continue to use drugs', she stated.

Meanwhile, France's first consumption room has been opened in Paris by health minister Marisol Touraine and the city's mayor, Anne Hidalgo. Located in a hospital near the Gare du Nord, the facility is a partnership with harm reduction organisation Gaia-Paris and employs a multi-disciplinary team of 20, with staff expecting around 200 visitors a day. Touraine called the centre a 'breakthrough for public health in our country' and 'an innovative and courageous response to a health emergency'. A second facility in Strasbourg is also expected to open before the end of the year. *www.glasgow.gov.uk gaia-paris.fr*

CONVICTION POLITICS

PRISONS ARE FAILING to rehabilitate offenders and should be radically restructured, according to the final report of the RSA's 'Future prison' project (*DDN*, September, page 10, and June, page 7). Inconsistent political leadership has created a system that 'puts public safety at risk' says *A matter of conviction: a blueprint for community-based prisons*. Among a range of recommendations in the document is that a new 'rehabilitation duty' be legislated requiring prisons and probation services to track individual and institutional progress towards rehabilitation. *Report at www.thersa.org*

PREVENTATIVE PRIORITIES

GETTING PEOPLE BACK INTO WORK is a key way to tackle health inequalities in the North East, according to a report from NECA (North East Combined Authority). Last year the region recorded the highest number of drug-related deaths in the country for the third year running (*DDN*, October, page 4) and it also experiences high rates of alcohol-related harm. The document calls for a 'radical shift' to close the health and wealth gaps with the rest of the country, including better joint working, shifting the spending focus towards prevention and developing training for primary care staff on helping people with mental health conditions back into the workplace. 'The entire system needs to shift its priority towards preventing poor health,' said PHE chief executive Duncan Selbie. *Health and wealth: closing the gap in the North East at www.northeastca.gov.uk*

HUMAN HARMS

ENFORCING AMERICA'S DRUG LAWS has caused 'devastating' and 'unjustifiable' harm to individuals and communities, says a report by Human Rights Watch and the American Civil Liberties Union. The document is calling for personal use and possession to be decriminalised for all drugs, as well as increased funding to improve and expand harm reduction services. *Every 25 seconds: the human toll of criminalizing drug use in the US at www.hrw.org*

OPIUM UP

AFGHAN OPIUM PRODUCTION has soared by 43 per cent compared to 2015 levels, according to UNODC's latest *Afghanistan opium survey*. The increase – to 4,800 metric tons – was 'worrying', said UNODC executive director Yury Fedotov. While the area under opium cultivation has also risen by 10 per cent, the most important driver in the increased production is higher yield per hectare, the document explains. The country's western and southern regions – which together account for 84 per cent of total poppy cultivation – have recorded increases in yield per hectare of 37 and 36 per cent respectively. *Document at www.unodc.org*

The Project will give 'a voice to a group who are poorly understood and rarely listened to'.

PROF DAVID BEST

FAMILY FOCUS

A JOINT RESEARCH PROJECT into what recovery means for the families of those with substance problems has been launched by Adfam and Sheffield Hallam University. The 'Family life recovery project' aims to map the recovery journey of family members through an in-depth survey and a series of workshops, with the results published next summer. The work would give 'a voice to a group who are poorly understood and rarely listened to – those who bear much of the burden of addiction and who themselves are affected by the experience', said project lead, Professor David Best. *www.adfam.org.uk*

SCOTTISH COURTS UPHOLD MINIMUM PRICING PLANS

A LEGAL CHALLENGE FROM THE SCOTCH WHISKY ASSOCIATION (SWA) and others against the Scottish Government's plans to introduce minimum unit pricing for alcohol has been rejected by Scotland's Court of Session.

Although the government has said the drinks industry 'must now respect the democratic will of the Scottish Parliament' and the ruling of the court, the association has not ruled out an appeal against the decision. 'We will study the details of the judgement and consult our members before deciding on next steps, including any possible appeal to the UK Supreme Court,' said SWA chief executive David Frost.

'The democratic will of our national parliament has been thwarted by this ongoing legal challenge.'
AILEEN CAMPBELL

The ruling is the latest development in the long-running saga of the Scottish Government's attempts to introduce the legislation. The Alcohol Minimum Pricing Bill – which set a 50p minimum price per unit as a condition of licence – was finally passed by the Scottish Parliament a year and a half after the previous Alcohol etc (Scotland) Bill had its provisions for minimum pricing removed (*DDN*, June 2012, page 12).

The subsequent four years, however, have seen the proposals referred to the European Court of Justice following the SWA's legal challenge (*DDN*, June 2014, page 4). While the European court's initial ruling was that minimum pricing could potentially breach EU free trade laws (*DDN*, October 2015, page 4), the case was then referred back to the Scottish courts for a final decision.

The Scottish government has called the court's latest ruling 'a landmark' moment. 'I am delighted that the highest court in Scotland has reinforced the initial judgment in our favour from 2013,' said public health minister Aileen Campbell. 'This follows the opinion of the European Court of Justice, which ruled that it was for our domestic courts to make a final judgment on the scheme. This policy was passed by the Scottish Parliament unopposed more than four years ago. In that time, the democratic will of our national parliament has been thwarted by this ongoing legal challenge, while many people in Scotland have continued to die from the effects of alcohol misuse.'

NHS Health Scotland said the decision was 'an important day for public health in Scotland', while Balance North East called it 'a victory for democracy and for some of the most vulnerable people in society'. While SWA states that it continues to believe that MUP is a restriction on trade and that 'there are more effective ways of tackling alcohol misuse', a recent report from the Alcohol Health Alliance found that products like high-strength white ciders – typically drunk by dependent and underage drinkers – were now on sale for as little as 16p per unit. Cuts in alcohol taxes had allowed shops to sell alcohol at 'rock bottom prices', it warned.

Scotch Whisky Association and others v Lord Advocate and Advocate General for Scotland at www.scotland-judiciary.org.uk

Cheap alcohol: the price we pay at ahauk.org

CBD CONFUSION

Products containing the active cannabinoid cannabidiol (CBD) for medical purposes 'meet the definition of a medicinal product', according to a review by the government's Medicines and Healthcare products Regulatory Agency (MHRA), but anyone selling CBD products will now need to apply for a licence. Co-author of the recent All-Party Parliamentary report on medical cannabis, Professor Mike Barnes, called the decision 'confused'. 'If the MHRA and the UK government now consider that cannabis-derived CBD is a medicine, this is incompatible with the continuing schedule 1 status of cannabis under the Misuse of Drugs Act that clearly states that cannabis has no medicinal value,' he said. *MHRA statement on products containing cannabidiol at www.gov.uk*

LOWER THE LIMIT

A COALITION OF EMERGENCY SERVICES organisations, road safety charities and health bodies is calling for the drink driving limit in England and Wales to be reduced in order to save lives. Around 240 people die each year as a result drink driving, a figure that has remained unchanged since the start of the decade, while the 80mg alcohol per 100ml blood limit has been in place since 1965 and is higher than almost anywhere else in Europe. 'With hundreds of lives lost each year, we can't afford to let England and Wales fall behind our neighbours in road safety standards,' said director of the Institute of Alcohol Studies (IAS), Katherine Brown. 'It's time the government looked at the evidence and what other countries are doing to save lives and make roads safer.' *IAS drink drive video at www.ias.org.uk*

The impact of the government's flagship 'troubled families' programme has been negligible.

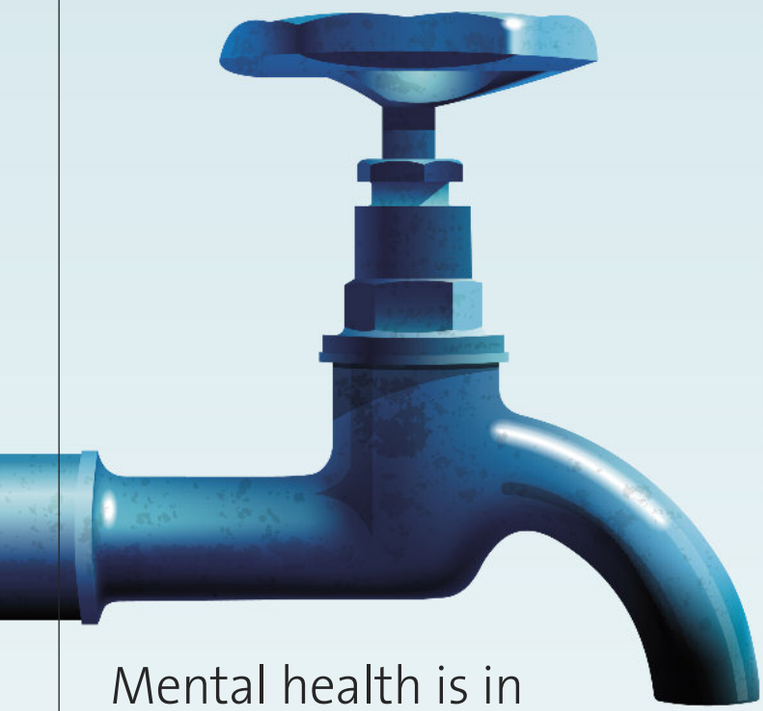
TROUBLING TIMES

THE IMPACT of the government's flagship 'troubled families' programme has been negligible, according to an evaluation report from the Department for Communities and Local Government. Although the programme 'clearly raised the profile of family intervention country-wide' and transformed service development in some areas, these achievements did not 'translate into the range and size of impacts' that might have been anticipated based on the programme's original aspirations, it says. In terms of outcome measures like use of drugs and alcohol in the previous three months, there was 'no statistically significant evidence of any impacts of the programme'. *National evaluation of the troubled families programme: final synthesis report at www.gov.uk*

'Almost a quarter of the homeless people staying in hostels in the central London borough of Westminster are using synthetic cannabinoids like "spice".'

WESTMINSTER WORRIES

ALMOST A QUARTER of the homeless people staying in hostels in the central London borough of Westminster are using synthetic cannabinoids like 'spice', the local authority has said – a figure that would 'have been closer to zero just two years ago'. The drugs pose a risk to both rough sleepers and frontline staff, said cabinet member for public protection, Nickie Aiken, and the council is calling for the police to be given increased powers to confiscate them.



TURN OFF THE TAP

Mental health is in crisis – more so for people from minority groups. How do we reach them before they drown? *DDN* reports from the Minority Mental Health conference

'There is outrageous discrimination against people with mental health problems... there is an absolute moral imperative on all of us to do something about the situation,' said Norman Lamb MP.

The shadow Liberal Democrat spokesperson on health was addressing the Minority Mental Health conference, *Ending discrimination in mental health: turning the crisis tap off*, held in London last month. The event brought together professionals from all areas of health and social care to look at 'one of the deepest and most discriminatory social failures of our education, social, health and criminal justice services'.

In many cases substance misuse was identified as playing a crucial part in developing mental health problems, while others used substances to self-medicate their mental health issues. In all cases, people were being failed by a complete lack of coordinated care and a health and social care system in crisis.

'People need diversion [into the appropriate support] when entering the system – but we need to do more than this,' said Lamb. 'We need to address the underlying causes of mental health problems, and we need to stop the dreadful flow into the criminal justice system.'

Among the headline statistics, Black African Caribbean men were up to 6.6 times as likely to be admitted as inpatients or detained under the Mental Health Act as the average population. While attending a recent event organised by the charity Black Mental Health UK, Lamb – who has long campaigned for better treatment and understanding of people with mental illness – said 'the degree of anger, frustration and disadvantage I came across shocked me to the core. I came away feeling something had to be done to address the anger from people in that situation.'

The aim of this latest event was 'not to call for more research, but to look at what we can do together to turn the crisis tap off,' said Gill Arukpe, chief executive of the Social Interest Group, created by Penrose and Equinox to support people with a range of needs, including mental ill health and alcohol/drug dependence. 'Why do so many black people end up in mental health services or prison?' she asked. 'Why do so many end up in a crisis situation?'

Ending discrimination needed a change of approach, to look at how we can make a difference to individuals' lives, said Antony Miller, Penrose's director of operations. Early intervention was important; The Sainsbury's Centre for Mental Health said counselling should always be available, but people were having to wait six to nine months for access to talking therapies.

'What do we do to make people feel they can access services and engage?' he asked. 'Early intervention has to be better than dealing with problems when they are fully entrenched.'

We also needed to be much more responsive. 'It's not about saying to people, "this is your journey, this is your pathway". It's about listening.'

At workshop discussions on 'the service user's voice', a delegate from Camden and Islington Mental Health Trust commented, 'We need to start listening to the service

More on mental health at www.drinkanddrugsnews.com

'We need to use data much more effectively and intelligently... discrimination is a great source of stress but nothing is as powerful as true commitment and collaborative work...' JACQUI DYER

users who are the experts – take from them what works and go back to them. They are the ones who are feeling it... Just because people have mental health issues or substance misuse issues doesn't mean they don't have hope too. We need to catch these issues before it becomes a crisis.' A director from Norfolk and Suffolk Foundation Trust added: 'It's about unity... people can't afford to be little monoliths, doing things on their own.'

'We need to understand what's in front of us – there are people who are not mad, not bad, but need support,' said Commander Christine Jones, the National Police Chiefs' Council lead for mental health, addressing the conference on 'the imperative for change'.

With the prospect of less money in the system, our joint health needs analysis needed to be a lot more sophisticated, instead of applying a 'sticking plaster approach' to people in crisis.

We were missing vital opportunities to coach young people 'at the point when they're most malleable, most recoverable,' she said. 'Damage caused by entry into the criminal justice system at the age of 14 means they'll be involved into their 30s. Things are easy to spot at an early stage and intervention points can change a life.'

Police had a 'huge part' to play in this, as they were often the first contact point, 'and if they don't know how to respond, it can escalate'. There were many reasons why people hadn't come into services before crisis point, including stigma, fear and embarrassment.

Going forward, we needed to think about more efficient options, she said. 'We need to make decisions at the right place and the right time, to deal with a problem that's been misunderstood and under-resourced for too long.'

'It's about joint working and joint training,' commented a head of social care at question time. 'The criminal justice system doesn't work with local authorities and health as well as it could. If police and health colleagues had more joint understanding, we could move the agenda forward.'

The afternoon sessions were dedicated to 'solutions' and Luciana Berger MP offered insights from her visits to mental health projects across the country.

'It's worth reflecting that we have made some progress in the last three years, particularly on stigma' she said, mentioning the recent World Mental Health Day. 'Mental health is not a sign of weakness – we all have mental health.'

However, the BME community was disproportionately represented in our mental health wards, and the fact that you're more likely to be sectioned or end up in prison if you're black was 'one of the most glaring examples of inequality in our society'. There was a gap in data from both physical and mental health services that was needed to collate a national picture, she said, and government was shirking its responsibility to know 'so much more' about BME mental health, to properly develop services.

The financial implications of not helping people early on were showing in mental health costs to the NHS of £105bn every year. Furthermore, Berger's FOI request to every clinical commissioning group in the country had showed disinvestment in mental health.

The 'fragmentation of our system' needed to change to 'seamless integration of mental health and social care,' she said, and this relied on everyone working together: 'If we're thinking about these mental health issues through the prism of the NHS, we're thinking about them too late. Our local authorities should be supported in keeping services going.'

Dr Geraldine Strathdee of the Mental Health Intelligence Networks said that there was plenty of data and 'fantastic analysts working across the system', but a lack of representative leaders from the target population – the best way to find out about the needs of each area.

'We need to use data much more effectively and intelligently,' said Cllr Jacqui Dyer of the Mental Health Taskforce. Everyday discrimination was 'a great source of stress', but there was 'nothing as powerful as true commitment and collaborative work... solutions are possible in every level of the system, but what it takes is collaborative effort.'

And this effort needed to be made at a much earlier stage, according to Maria Kane, chief executive of Barnet, Enfield and Haringey Mental Health NHS Trust.

'We need to do services cradle to grave, sperm to worm!' she said. 'Turning the crisis tap off is about introducing services much earlier – perinatal services. Those first 1,000 days are key to your mental wellbeing.'

Mental health relied on having 'somewhere to live, someone to love, something to do,' she said. 'We need to line up our services and outcomes to make sure this is what we're giving to people'.

There were 'fantastic' projects going on in many areas, but they depended on short-term funding and needed 'mainstreaming'.

In the Q&A session at the end of the day, there were questions relating to many aspects of discussion, from recruitment of the right staff to better integration and communication. Asked about the poor experience of many people with substance issues within services, Leo Downey, Equinox director of operations, said referral to the right services could be difficult when mental health and substance misuse were so separate, and suggested that many mental health staff needed more training on substance misuse issues.

'We need to make sure we don't keep this conversation to ourselves,' commented one delegate – a point underlined by the panel's chair, Antony Miller.

'It's about sharing the work now,' he said. 'We've heard of at least ten projects today that are making a change. We need to stop talking about this and start moving it forward.' **DDN**

Pictures, left to right: Jacqui Dyer, Christine Jones, Antony Miller, Gill Arukpe, Norman Lamb, Maria Kane, Antony Miller, Geraldine Strathdee, Leo Downey.

NO TIME TO LOSE

The evidence on rising drug deaths points to the need for a public health model, according to speakers at the Drugs, Alcohol and Justice Cross-Party Parliamentary Group

Drug poisoning accounted for one in six deaths among people in their 20s and 30s in 2015 in England and Wales – figures that included accidents and suicides and drug misuse and drug dependence, according to Vanessa Fearn and Neil Bannister of the Office for National Statistics. Data from the coroner showed that drug-related deaths (DRDs) had reached the highest level since records began, with the North East showing the highest DRD mortality rate and the East Midlands the lowest.

Deaths involving heroin or morphine had doubled in the last three years and there had been a 'dramatic rise' in male DRDs – some attributable to an increase in heroin purity.

Initiatives to gather and review regional evidence had shown that increased availability of heroin had 'clearly had an impact', combined with an ageing cohort of users, who were becoming 'iller, frailer and less able to withstand the rigours of a drug-using lifestyle', said Rosanna O'Connor, director for alcohol, drugs and tobacco at Public Health England.

'Deaths map onto areas of high health inequality.'

ROSANNA O'CONNOR

At least half of the people dying were not currently in treatment, so some were likely to be chaotic. The increase in problems with prescription medicines was another contributing factor.

'Until the needs of this ageing group are met, these figures may continue to rise,' she said, adding that 'Deaths map onto areas of high health inequality.'

PHE had developed principles for action, which included applying a 'whole system approach' to meeting people's needs and addressing both mental and physical health, alongside drug use. Recent initiatives included getting a DRD indicator into the public health outcomes framework and giving commissioners advice on naloxone provision.

'The capacity of treatment services to deal with other than their typical cohorts is being reduced'

JOHN JOLLY

As so many people dying were not in treatment, how could we protect outreach services to ensure they reach them, asked John Jolly, chief executive of the treatment charity Blenheim. 'The capacity of treatment services to deal with other than their typical cohorts is being reduced,' he said.

'We need engagement in all places where people butt up against the criminal justice system,' said O'Connor.

Ed Morrow, PR and campaigns manager at the Royal Society for Public Health, explained that public health had previously been 'a bit reluctant to get involved with the discourse around drugs – but that's changed'.

'There's too much government fixation on measuring use, but we have to remember that a lot of people use without having problems,' he said. 'We need to give people the information to make informed decisions.'

There were 80,000 people a year involved with the criminal justice system relating to drugs (not just incarcerated) and this had a 'major effect on their lives'. Transferring responsibility for the drug strategy from the Home Office to the Department of Health would be an 'important symbolic move', he said.

Decriminalisation could help to counter the damage caused by disinvestment in outreach work and the RSPH was also keen on the idea of a wider public health workforce – 'people who have an opportunity to work with problematic drug users'.

Steve Rolles, senior policy analyst for Transform Drug Policy Foundation, had worked with RSPH on their approach and hoped that 'this has paved the way for other public health bodies to look at these issues'.

'It's not a marginal issue anymore,' he said. 'Big lumbering conservative institutions are supporting these initiatives.'

Political support was accompanied by a growing bank of evidence. 'We know that criminalisation has a direct effect on risk – it makes people harder to reach,' he said. People were more likely to use alone or to share equipment.

'We know that criminalisation has a direct effect on risk.'

STEVE ROLLES

In the 90 supervised injection facilities across the world, there had never been an overdose death, making them both effective and cost effective, said Rolles – 'Yet still in the UK we don't have a single one.' We could create one through localism, he pointed out – 'we don't need to change the law to open one'.

I'm worth...

There are more than 200,000 people in the UK living with hepatitis C, but only half of these are diagnosed and as few as 3 per cent are receiving treatment.[1] If left untreated, hepatitis C can cause serious or potentially life threatening complications like liver cancer.[2] The majority of people living with hepatitis C are from disadvantaged or marginalised communities.

RECOVERING FROM HEPATITIS C:
STEPS TO EMPOWERMENT THROUGH PEER SUPPORT

People who inject drugs or have injected them in the past are at the highest risk of becoming infected with hepatitis C. This highlights the importance of ensuring those affected are receiving appropriate support and guidance, to encourage timely diagnosis and the best possible care. Peer support can play a vital role in helping people in this way.

A hepatitis C diagnosis can feel daunting for people suffering with drug or alcohol addiction and taking the first step towards finding support can be challenging. Peer worker Tim Palin knows this first hand, having had direct experience beating his own drug addiction and hepatitis C. Tim now provides support to people trying to make a recovery and acts as a campaign ambassador for *I'm Worth...*, an empowerment programme for people with hepatitis C in the UK.

On his journey to recovery, speaking to peers allowed him to understand that he was not alone and gave him the chance to connect with people who offered a more personal perspective as they had been through similar challenges and overcome difficult times in their lives.

'It was incredibly important and valuable for me to have someone to turn to when I was diagnosed. The diagnosis was a shock and the course of treatment I was given was really tough. Having people to talk to who had gone through similar experiences made the journey easier,' says Tim.

Peer support meetings offer a safe and confidential environment for people trying to beat addiction to discuss thoughts, feelings and experiences related to diagnosis, treatment and recovery. They can give people on the road to recovery information about accessing care, point them towards organisations that may be able to support, and offer tips and guidance on how to stay positive.

'I've been through drug treatment services and know how isolating it can be when you are diagnosed with hepatitis C.'

TIM PALIN

'I really appreciated the support I received from the staff at Telford After Care Team which helped me immensely at a time when I needed it most. Now that I no longer use substances, I take pride in being a peer worker and helping others who are going through similar experiences,' says Tim.

No matter what is stopping someone from getting the care they need, a support network can play an important role in recovery.

'Opening up about my past experiences and hepatitis C diagnosis was such a relief, and with the right support I was able to work towards a more positive future,' says Tim. 'There are so many organisations and groups that can provide support and guidance for these difficult times – the first step is reaching out.'

Tim is a campaign ambassador for *I'm Worth...*, which aims to address the stigma that many people with hepatitis C face, encouraging and empowering people living with hepatitis C to access care and services no matter how they were infected. You can view his story, alongside others at imworth.co.uk/ambassadors.

1 *Public Health England. Hepatitis C in the UK. 2015/2014 [Accessed October 2016]*
2 *NHS Choices: Hepatitis C. http://www.nhs.uk/conditions/hepatitis-c/pages/introduction.aspx [Accessed October 2016]*

The *I'm Worth...* campaign has been developed and paid for by Gilead Sciences Ltd, a science-based pharmaceutical company. Content development has been supported by input from numerous patient groups with an interest in hepatitis C in the UK.

November 2016, HCV/UK/16-10/CI/2599

For more information on the campaign and to access materials designed to support people living with hepatitis C please visit **www.imworth.co.uk**

INDUSTRIAL STRENGTH

The relationship between alcohol health campaigners and the drinks business has long been a fraught one. *DDN* reports on a recent Westminster Social Policy Forum event that heard the industry put its side of the case

The 2012 alcohol strategy (*DDN*, April 2012, page 4) had set the policy direction that local areas were still following, head of public services and welfare for cross-party think tank Demos, Ian Wybron, told last month's *What now for alcohol policy?* event. The significant exception, of course, was minimum unit pricing, the strategy's commitment to which was later shelved (*DDN*, August 2013, page 4).

'Binge drinking across the UK is in decline and has been for ten years, particularly among 16 to 24-year-olds,' he told delegates. However, alcohol-related hospital admissions were increasing, and alcohol-related violent crime remained a major issue. The strategy had contained a great deal on local area partnerships, he said, but the government appeared to have gone 'very quiet' on the controversial public health responsibility deal (*DDN*, 6 December 2010, page 4) – a 'very interesting engagement' between itself, the industry and the voluntary sector. Other elements of a changing policy landscape included the newly revised chief medical officer guidelines (*DDN*, February, page 4) and the potential implications of Brexit – 'it feels like there's an awful lot of uncertainty around alcohol policy there,' he said.

According to Demos's own research, there were a number of factors that could explain declining rates of binge drinking among young people, he told the event. 'There seem to have been successes in terms of the health messaging around alcohol, with lots of young people taking those messages on board and moderating their consumption. There's also a big role for social media, and the sheer amount of time that young people spend on it when perhaps they might otherwise be out drinking. Working with the statistics is always difficult, but one thing they do indicate is that while fewer people are drinking, the ones who are, are drinking more. So what's needed is a much more targeted approach.'

The think tank's interviewing had found that young people still did not use units to calculate or moderate their drinking, however. 'They don't really understand them, so we do need a new language in terms of consumption – one that makes sense to young people – as well as more emphasis on developing preventative programmes in schools.'

While there had been 'a lot of effort' around unit awareness, clearly more was needed, acknowledged the British Beer and Pub Association's director of public affairs, David Wilson. The binge drinking figures, however, showed that some policy measures were working, he said. 'So we need to learn what works and do more of it. The more we can do together – as policy makers and industry – the more effective we can become, rather than having all our debates pitched as stand-offs between the two.'

The industry would continue to develop, and promote, greater choice in areas such as lower-strength products, he said, but this had to be combined with more government help in terms of things like tax policy and advertising rules. 'We believe that policy – fiscal and otherwise – should encourage and promote low-strength products,' he said, while one possible opportunity in terms of Brexit was the chance it offered to review beer, wine and cider duties, which are calculated according to alcohol by volume (ABV).

Around 70 per cent of convenience store retailers have an age-verification scheme like 'Challenge 25' in place.

In terms of the retailer role in helping to reduce harm, alcohol remained an 'incredibly important' category for shopkeepers, said public affairs executive at the Association of Convenience Stores, Julie Byers. 'Our members have a huge responsibility when it comes to things like ensuring there are no under-age sales.'

Around 70 per cent of convenience store retailers had an age-verification scheme like 'Challenge 25' in place, with more than a quarter refusing under-age sales around ten times a week – something that was not always easy for staff working alone in the shop and facing aggression. Her organisation also distributed information to raise awareness of things like proxy purchases – when children persuade older siblings, friends or even parents to buy alcohol on their behalf – and many local authorities and community alcohol partnerships now had campaigns explaining to parents that proxy purchasing was illegal.

'When people think of the drinks industry they tend to think of huge multinationals, but 90 per cent of it is small and medium sized enterprises – something that's hugely important to bear in mind when looking at policy,' chief executive officer of the Association of Licensed Multiple Retailers, Kate Nicholls, told the event. 'The night-time economy is worth £66bn – it's big business for UK PLC.'

Her organisation's members had a vested interest in tackling alcohol-related harm, she told delegates – 'it's not good for business if we don't have a safe night-time economy' – and partnership was key. Two thirds of alcohol was now sold and consumed away from the on-trade, she said, which meant that 'top-down policy approaches' targeting clubs, pubs and bars were not going to achieve the desired results. 'You can obtain the same end objectives working in partnership,' she said. Initiatives like promoting lower-strength products and smaller measures would always be more effective than bureaucracy or 'finger-wagging and lecturing'.

'It feels like there's an awful lot of uncertainty around alcohol policy.'

IAN WYBRON, DEMOS

'Our members have a huge responsibility when it comes to things like... under-age sales.'

JULIE BYERS, ASSOCIATION OF CONVENIENCE STORES

'We can build more trust between the public and private sectors, the industry and the public health community.'

HENRY ASHWORTH, PORTMAN GROUP

'When people think of the drinks industry they tend to think of huge multinationals, but 90 per cent of it is small and medium sized enterprises.'

KATE NICHOLLS, ASSOCIATION OF LICENSED MULTIPLE RETAILERS

'[France has] very, very tight regulation, but under-age drinking is actually on the increase.'

MARK BAIRD, DIAGEO GB

'We do need to recognise success as well,' she said, 'which means we need a clear benchmark of where we start from to work together'. Her members were frustrated, however, that 'the goalposts seem to keep moving,' she stated. 'You need to give the trade the credit where it's deserved, and you also need to make sure there's joined-up thinking across government. In our own dealings with government we'll say "people are drinking less" and they'll say "ah yes, but now they're drinking all those nasty soft drinks that are full of sugar instead".'

'It's worth saying that, in any social policy area, to have these sorts of trends in things like reductions in binge drinking is very significant,' said Portman Group chief executive Henry Ashworth. 'But we really need to make the effort together to tackle things like the rise in alcohol-related hospital admissions.' One of the main tasks was to see how local challenges related to the bigger picture, he said – for example binge drinking rates in Newcastle or alcohol-related hospital admissions in Blackpool, both of which were way above national averages.

The 'negative' attitudes towards the alcohol responsibility deal had also not been helpful, he argued. 'The drinks industry committed to, and delivered, 80 per cent of alcohol products on the shelves carrying unit and health information and pregnancy warnings – voluntarily.' Things were now 'in a different place' when it came to labelling, however, as, 'having achieved that 80 per cent figure, the CMO's guidelines have changed'.

There was a 'plethora of fantastic' local alcohol partnerships and schemes that were addressing the challenges in a coordinated way, he said. 'We need to continue to robustly evaluate these partnerships to understand what's working well. That way we can build more trust between the public and private sectors, the industry and the public health community, and identify and overcome the barriers to effective partnership working.'

Binge drinking across the UK is in decline and has been for ten years, particularly among 16 to 24-year-olds.

When it came to a policy area that was nearly as controversial as the responsibility deal – advertising regulation – the last three years had seen a 'sharp decline' in the number of complaints about alcohol adverts, said regulatory policy manager at the Advertising Standards Authority (ASA), Malcolm Phillips. There had also been a smaller decline in the number of alcohol cases his organisation – which enforces the UK's advertising codes – had decided to formally investigate, he explained. However, the authority knew it could not 'rely on complaints alone to tell us what we need to know', and was committed to maintaining a proactive approach towards the issue.

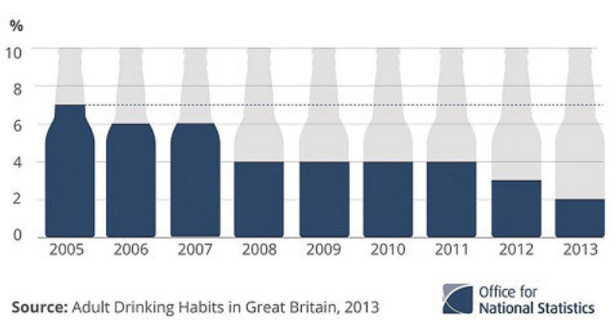
'A claim often made by critics of advertising self-regulation is that the codes have no teeth, and there's no incentives for companies to not bend the rules,' said Diageo GB's head of alcohol in society, Mark Baird. 'This is not true.

'If you spend hundreds of thousands of pounds making an advert and buying advertising slots only to find out you can't use it – that has an impact, believe me.' Advertising self-regulation served to complement national laws, he said, and 'always went beyond' the legal requirements.

'Alcohol advertising comes under regular government scrutiny, but it's very difficult to isolate a single factor – advertising – from all the other factors that influence alcohol consumption,' he argued. Denmark, for example, had liberalised advertising regulations and seen consumption decline, he said, while the introduction of the Loi Évin – designed to restrict children's exposure to alcohol marketing – in France in the early '90s had had limited impact on consumption levels. 'It's very, very tight regulation, but under-age drinking is actually on the increase in France, at the same time as it's declining here.'

In a 'mature market', advertising did not increase overall demand, he maintained. 'So that brings us to the question people always come back with – "If you say alcohol advertising doesn't work, why do companies spend so much money on it?" Well, of course it works, it just doesn't work in the way critics and commentators say it does – does Andrex think it can grow the market for toilet paper? The purpose of advertising is to raise awareness of your product, and to steal market share from your competitors. We want people to buy our product, rather than someone else's.'

Frequent drinking among young adults,
Great Britain, 2005-2013



Source: Adult Drinking Habits in Great Britain, 2013

Office for National Statistics

OBITUARY

REMEMBERING DARREN WALTERS

Colleagues pay tribute to a worker who used his experience to help those in trouble

TRIBUTES HAVE BEEN PAID to charity worker Darren Walters, who died in May aged 44 following a heart attack. Darren turned his life around following issues with drugs, and contributed to shaping the future of prison healthcare in Lancashire.

Darren, from Accrington, spent 20 years in and out of prison for a variety of offences after becoming involved with drugs at the age of 15. After linking up with Red Rose Recovery, a charity that helps people deal with substance misuse issues, he managed to start a new life.

Through his work with the charity, Darren came into contact with the NHS where he was able to advise on the way healthcare in prisons should be delivered. NHS England's health justice commissioning manager for the North (North West), Simon Smith, said: 'Darren has first-hand experience of the delivery of prison health services. He was able to use his unique perspective and bring a sense of realism to how we develop these health services.'

Darren brought the benefit of a service user perspective to a multi-agency panel, reviewing tenders alongside doctors, nurses and other health professionals, and stakeholders such as local authorities and the National Offender Management Service.

Speaking at the time, he said: 'If my input makes a change for all the right reasons, I can take great satisfaction from that.'

RESOURCES CORNER

The essential skills

From the many books on addiction, *George Allan* selects a guide that makes a worthy handbook for both students and experienced workers

FROM CONFESSIONAL MEMOIRS to detailed analyses of complex research, substance issues have an extensive and diverse literature with plenty of books describing 'treatment' options in broad terms. There are, however, remarkably few that take an in-depth approach to examining how interventions are actually applied in practice: one such book is *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide*.

The authors eschew preliminaries, such as methods of social control and theories as to why problems develop, and dive straight into the practicalities of working with people. After addressing general skills, assessment, goal setting and motivational interviewing, they lead the reader through all the well-evidenced interventions.

Cognitive therapy, behavioural self-management, relapse prevention and pharmacotherapy are explored, along with brief interventions, assertiveness skills and the other components of an holistic approach; self-help groups, dual diagnosis and case management are also addressed. There is a liberal sprinkling of tools and handouts for service users, and the writing style is characterised by clarity and accessibility.

There are weaknesses: more is needed on working with relatives in their own right and there is little on the implications of parental use for children. Nevertheless, this text was right at the top of my reading lists for students; it was the bar that I set for myself when I sat down to write a text book of my own. Although it is described as an 'introductory guide', experienced workers will find much in it to help them refresh their practice.

Of course, reading is no substitute for hands-on work under skilled supervision, but just as the Highway Code is a prerequisite for competent driving, so a detailed guide to applying interventions is the essential starting point. This book provides the necessary knowledge.

The authors are Australians but the UK shares with Australia similar assumptions regarding the nature of problematic substance use and how to address it, so any differences are marginal. The past decade has seen the emergence of the recovery agenda and the rise of a plethora of different psychoactive substances so it is hoped that a third edition of this book is in the offing.

> 'There are remarkably few [books] that take an in-depth approach to examining how interventions are actually applied in practice.'

Jarvis, T., Tebbutt, J., Mattick, R. and Shand, F. (2005), *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide is published by Wiley.*

George Allan is chair of the Scottish Drugs Forum. He is the author of 'Working with Substance Users: a Guide to Effective Interventions' (2014; Palgrave).

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, CJ Wellings Ltd, 57 High Street, Ashford, Kent TN24 8SG. Letters may be edited for space or clarity.

PAINFUL ISOLATION

I was very pleased to see your piece on support (or lack thereof) for those of us struggling with addiction to prescription and over-the-counter drugs (*DDN*, October, page 10). People often refer to mental health – rightly, in my view – as a 'Cinderella service' but it seems to me the same could be said for support for people whose problems are with legal substances, despite the truly heroic efforts of people like David Grieve.

In my experience the problem is not only that GPs are happy to dish out repeat prescriptions for the sake of a quiet life, and that there's little in the way of specialised support, it's also the attitude you can face when attempting to access generic drug services or attending groups or meetings – the general feeling can often be that, as you didn't buy your drugs from a dealer, your problems are somehow not nearly as serious or important.

More money for specialised support would obviously be very, very welcome, but it's hard to see how that's going to be a priority at the moment, and the BMA's proposed national helpline would also be a useful first step. But until we can address this hierarchical attitude that exists in some places then I'm afraid we've still got a very, very long way to go.

Name and address supplied

FOUL LANGUAGE

At the Conservative Party conference, a lesser reported fact is that Liz Truss, the new justice secretary (and Lord Chamberlain) referred to 'junkies' with the phrase 'homes burgled to feed a junkie's habit'.

I am furious that she would use such a derogatory term on a national platform, and depressed to see the lack of notice the press took of her comments. The most vulnerable people in our society have blame heaped on them for a range of complex social and emotional problems, which are very far from simple to understand, let alone resolve. To determine (extremely simplistically) that crime is down to 'junkies' flies in the face of even the government's own evidence. The *'modern crime prevention strategy'* illustrates clearly the significant falls there have been in shoplifting and burglaries – something which Ms Truss conveniently forgot, because it didn't fit with the narrative of the day.

We all need to do more to tackle stigma, and calling out language like this is the very least we should all do.

Karen Tyrell, Addaction

LET'S CONNECT!

HAVE YOUR SAY BY COMMENTING ON OUR WEBSITE, FACEBOOK PAGE AND TWEETING US

In response to DDN retweet from @BBCNews on 'fix rooms' plan set for approval

@DDNMagazine @BBCNews where is money coming from for this when basic drug services being cut? *@BOPjo_anne*

@DDNMagazine @BBCNews great idea! hopefully rest of country will catch up, let's not let people die needlessly anymore *@Jackinthos*

Cardiff looked at DCRs as did Brighton... here's hoping Glasgow takes it to the doing stage, recent HIV cluster highlights need *@KFxNews*

In response to 'train your staff to empower service users with #naloxone' (Oct, p20):

Wish we could. Still not available in my country [NZ] *@julianbuchanan*

In response to Pat Lamdin article (Oct, p16):

I had the pleasure of working with this guy – happy retirement Pat *@LauraWebbMktg*

In response to 'Punishing regime' (Oct, page 8):

@WE_ARE_ANPUD @INPUD @DDNMagazine Well done here, I'm quite sure a short phone call from @POTUS would stop this murder *@lovelifewhy*

In response to 'How I became a social worker' (Oct, page 18)

Thanks DDN Magazine for the opportunity to discuss the topic of Social Work in Substance Misuse Services #socialwork #proud @AlcoholDrugServ *@hfeeneyASWP*

Just read October's @DDNMagazine. As usual 101 thoughts running through my mind. Great read! Have a read yourself *@RecoveryDundee*

/DDNMagazine @DDNMagazine
www.drinkanddrugsnews.com

MEDIA SAVVY

The news, and the skews, in the national media

HEROIN 'SHOOTING GALLERY' to open in Glasgow for addicts to get hit as kids play in CRECHE
***Express* headline, 31 October**

SHOCKING MOMENT two women 'inject drugs while slumped in a doorway in broad daylight' just yards from a PRIMARY SCHOOL
***Mail* headline, 25 October**

THE LESSONS OF A FAILING NATIONAL POLICY need to be learnt. The approach of harm reduction was born – under a Conservative government – in response to the threat of HIV. It saved countless lives.

When focus shifted away from harm reduction, deaths began to rise. We welcome the incorporation of drug-related deaths as a measure in the outcomes framework. However, if death rates are an accepted measure of system performance, the current trend is surely evidence of system failure.
***BMJ* editorial, 17 October**

THE PROBLEM FACED BY PEOPLE WITH ADDICTION is not that they are unaware of the negative consequences of their condition, but that they can't see a way out. If we want to end the opioid crisis, we need viral videos of recovery, not overdose.
Maia Szalavitz, *Guardian*, 7 October

YESTERDAY, the National Institute of Economic and Social Research issued a report concluding that the troubled families programme had failed... All that money (£1.4bn), time and effort – for what? Just so a handful of people could show off at dinner parties and perhaps enjoy a glowing editorial in The *Guardian*. Like the controversial charity Kids Company founded by Camila Batmanghelidjh (another bottomless money-pit my husband opposed), the troubled families programme was kept going at massive taxpayers' expense to salve the consciences of politicians cowed by half-baked notions of political correctness.
Sarah Vine, *Mail*, 19 October

THE MEDIA'S TREATMENT of the troubled families programme, whose evaluation has recently been made public, cannot have cheered David Cameron in his last week as an MP. History does not look likely to be kind to his great social policy. We should, however, be grateful to the former prime minister for his quixotic attempt to do the right thing on a massive scale. Because in doing so he exposed the fallacy which has dominated social policy since 1945: the idea that the government is infinitely capable of solving social problems.
Danny Kruger, *Spectator*, 29 October

Reaching out

Now that naloxone is officially 'out there', CGL are among those searching for the people most in need of it. DDN reports

Guy Phillips is preparing for his nightshift as an outreach worker in Newham, east London. In his rucksack he will carry needles, a first aid kit, condoms, information leaflets – and four naloxone kits, plus a training kit. His mission is to give naloxone to 'anybody that needs it' and to offer friendly advice and a route to further help.

Phillips is employed by CGL but coordinates his shifts to do joint outreach with East London NHS Foundation Trust and homeless charity Thames Reach, to find the people in most need.

'I'll have my lists of people I want to see and they'll have their list of people they want to see, so we'll form a plan before we go out,' he says.

Shifts vary to try to cover all hours within a fortnightly period, and can be as early as 4am to 8am. Many of those they will be trying to reach will be rough sleepers 'who might be walking around, about to bed down somewhere'; others will be tuned into the night-time economy – sex workers, who don't keep hours that fit in with regular drug services.

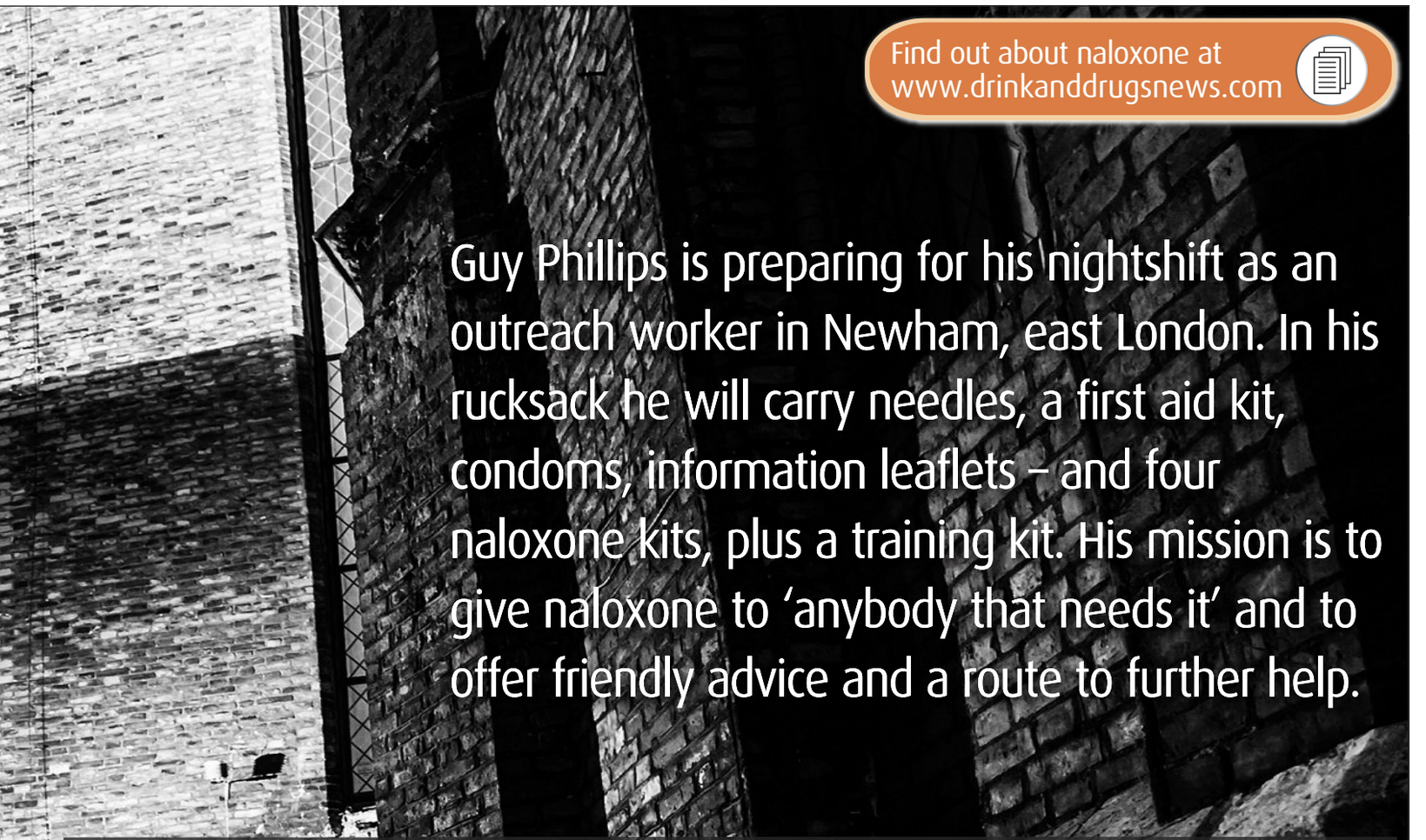
Some of the people they meet are glad of a friendly face and interested in hearing about naloxone – particularly if word has already reached them of this life-saving drug. Others are more difficult to engage – the sex workers for example, who may be earning £400 a night, can buy as much heroin as they want, don't need methadone, and can't see the need to talk to a drugs worker.

Looking at those most at risk, 'It's difficult to say who's most likely to overdose, but imagine the effects of rough sleeping on people, in terms of being out in the cold and not having the facilities we normally have, plus the likelihood of having a lowered immune system,' says Phillips. So the night's schedule focuses on rough sleepers.

'I'll ask them if they want to have naloxone, and if they say no, I'm going to have to persuade them it's a good idea,' he says. He might get the reply 'I'm only smoking', and will have to dig deeper to find out if they are taking anything else.

'Most people who die of overdose die because they've used more than one substance – and each drug can multiply the effect of the other substance,' he says. A brief chat will often reveal they are taking 'all sorts of drugs at all sorts of times – methadone, buprenorphine, alcohol, anything that suppresses the central nervous system'.

Then there's 'quite a bit of persuasion to do, because people think they don't necessarily need naloxone, and I have to explain that they do'. When he's got their attention, Phillips runs through what an overdose can look like and what can happen throughout the course of it.



Find out about naloxone at www.drinkanddrugsnews.com

Guy Phillips is preparing for his nightshift as an outreach worker in Newham, east London. In his rucksack he will carry needles, a first aid kit, condoms, information leaflets – and four naloxone kits, plus a training kit. His mission is to give naloxone to 'anybody that needs it' and to offer friendly advice and a route to further help.

'Then there's obviously telling them how to use it, which is a mechanical thing. They can say whether they've understood or not, and have a go with my test kit to learn how to use it.' He tells them that each shot will last for 20 minutes and that people can go back into overdose afterwards – which is why there are five shots in each syringe. He also cautions them that 'people can be quite angry with you for administering it' while coming round.

The other important part of the message is that 'if in doubt use it – because you can do no harm. And also call 999' to get the ambulance on its way.

The whole intervention – the information, training session, Q&A – has to take place quite quickly. 'You've got to get the information out and it's got to be quite snappy. You might be on the street, or in an exposed situation; there might be people walking by. You might be in the darkness, doing it by torchlight, and you also need to consider your own safety because you're crouched down.' There are also 'a lot of places to go and people to see' on each shift.

While the immediate benefits of the naloxone are obvious, the other important reason for using it in outreach is to connect with people and offer them the lifeline into services.

Unfortunately this rarely happens immediately, says Phillips. 'You wish they'd say "I'm going to change my ways today" but this rarely happens. So it really is about mounting a campaign, visiting people more than once and persuading them, giving them leaflets, increasing their awareness, showing that your door's open and that you're a nice kind organisation.'

At CGL's head office, Stacey Smith is director of nursing and clinical practice and explains that the organisation created a naloxone strategy and turned it into a project management process. The purpose was to spread naloxone training and distribution far and wide – from all frontline workers and community partners to anyone who might need it, whether in services or not.

'We thought, we need to really get passionate about this, because the formula is so simple when you think about it. It's given, it saves lives, and people have a second chance,' she says.

So when the law changed, allowing wider distribution, CGL were ready. 'Naloxone champions' had been trained within every project and the initiative was being taken out to pharmacies, community groups, rehabilitation centres, shelters, lifeguards, toilet attendants, to 'saturate the high-risk areas with naloxone'.

The overall aims, just as for outreach, are 'obviously to cut down on death – and the other is to get people to feel that they can come into services, no matter what state they're in or what they're using'.

Smith is encouraged by the 261 people who have reported back to them that they have administered naloxone, but says 'the potential for life-saving is a lot higher'. It's the second year of the strategy now, 'so we're looking at areas where people are not actually getting into services – people that are just on the brink and feel that services maybe aren't for them,' she says. This includes districts with 'extensive homeless populations', as well as talking to hospitals to make sure people who have been admitted with an overdose are discharged with naloxone, and working with prisons around giving naloxone on release.

'There's no closed door on how we can get naloxone to people,' says Smith. 'We talk to the police about them carrying it, and we talk to all sorts of people who have contact with our service users to try to get as much out there as possible.'

It's not just about the naloxone, but about 'the whole harm reduction message', she says. 'We're trying to make it a whole health and wellbeing approach, rather than just "here's naloxone".'

Among the community partners, she says pharmacies have been an important link to people who may need naloxone, 'as they often see people way before we do'.

The superintendent of a community pharmacy in Birmingham agrees with the benefits of the naloxone programme. She explains how her colleague had received training and knew exactly what to do when a client in the tattoo parlour next door overdosed and staff ran into the pharmacy for help. The pharmacy colleague took a naloxone kit and saved his life.

'The guy was in the right place at the right time, which was really very lucky because he only came round after the second injection,' says the superintendent. 'Had I been in the branch, I'd not been trained to do this. All of us pharmacists should be aware of what we can do with these injections. We're trained to give the EpiPen – adrenaline for anaphylaxis. But to my knowledge this programme for the drug users is not a general programme, and I think it should be.

'Let's hope the programme can be extended – without it that guy wouldn't be here now.'

Karl Price is someone who would wholeheartedly agree with that. As one of the 'success stories' he says he 'wouldn't be sitting here today' if it wasn't for naloxone. He had three life-saving injections to reverse overdose, when he was in 'the power of addiction'.

'I've had a friend that's died and a partner that died – accidental overdoses because the person at the time is not thinking that they're using too much, or that they're at risk of overdose,' he says. 'But if I'd had a naloxone kit with me, my partner would probably still be here today.' **DDN**

Tell us about your naloxone initiatives – email claire@cjwellings.com

A pill for every ill?

New alcohol medication Selincro has had a controversial route to market, as **Mike Ashton** explains

In 2013 Danish pharmaceutical company Lundbeck was authorised by the European Medicines Agency (EMA) to market Selincro – their trade name for the opiate-blocking drug nalmefene – to reduce consumption among dependent (but not physically dependent) drinkers.

Authorisation paved the way for nalmefene to tackle the bulk of dependent drinking lying below the iceberg-tip of physically dependent drinkers aiming for abstinence – and opened up for its manufacturer a large and potentially lucrative market, provoking accusations of an expensive and inappropriate medicalisation of lesser degrees of dependence based on unproven effectiveness.

To grasp the essence of the controversy, first we have to understand the dubious world of the post hoc sub-sample analysis, the type of analysis on which authorisation was based.

Imagine you have carefully levelled the playing field in a study by randomly allocating patients to a medication or to an identical but inactive placebo. Then eliminating any further bias, you check how the patients do. It can be likened to randomly loading coins with medication or placebo, then tossing them in the air and leaving them to fall – a process over which you have no control once the coins leave your hand.

If the medication worked, you would expect to see not an even split of heads (healthy outcome) and tails (not so good), but the medication-loaded coins tending to fall on the healthier side. That might happen, but not consistently enough to meet conventional criteria for a significant effect. However, now you have a great advantage: you can actually see how the coins have fallen. You can check the one-pences, the two-pences, the five-pences, the ten-pence coins, the 20-pences, the pounds and the two-pounds. Maybe in one of these subsets there is such an excess of heads that you can pronounce the medication effective, at least among (say) the ten-pence patients. Had you said in advance you would focus on the ten-pence patients, you would have risked another negative finding. But with the data in, now you can see what the outcome actually was.

The conventional criterion for a significant effect is that the difference between the outcomes of medication and placebo patients would have happened less than one in 20 times by chance – a result considered so unlikely that something more must have been involved. Everything else having been equalised, that 'something' could only have been the medication.

Now we can see that researchers have an almost sure-fire way to generate a statistically significant finding: slice up the sample in lots of ways until in one subset the magical 'less than one in 20 by chance' result emerges. Try more than 20 slices, and a significant finding becomes more likely than not, even if in reality the medication is ineffective.

It is not enough to back-engineer good reasons for after-the-event (or post hoc) sub-sampling, and to deny trawling the data until a 'significant' pattern of excess heads was found. The possibility that this could have happened has to be eliminated. Otherwise the analysis can merely suggest the medication might be found effective in another trial limited to these patients, or at least where sub-sampling was planned in advance. Without this, it remains of unproven efficacy.

Authorisation to market Selincro rested on just such an analysis, undertaken in response to unconvincing initial findings in Lundbeck's trials. Most ways of assessing the primary drinking outcomes had left nalmefene with no significant advantage over a placebo. When it was assumed patients not followed up were drinking at their pre-trial levels, none of the comparisons with a placebo reached statistical significance.

Faced with these results, Lundbeck and their research associates conducted sub-sample analyses which excluded medium-risk drinkers, and those at higher risk who had rapidly remitted even before treatment started – drinkers who tended to stay remitted, leaving Selincro little to improve on. What remained was a higher risk sub-sample who remained at high risk when treatment started. Among these patients, nalmefene had greater scope to reduce drinking, and the results were more consistently positive – but in the process, scientific credibility had been sacrificed.

The EMA's scientific advisers admitted it was 'not ideal', but shrugged off post hoc sub-sampling as common in psychiatric trials due to high dropout. But in this case, high dropout was not the rationale. Instead, sub-sampling had been 'proposed' by Lundbeck 'in order to define a population where the benefit of Selincro would be greatest'. Not just the effect, but the intention it seems was to find a slicing strategy which favoured Selincro. Sub-sampling also helped exclude about half the randomised patients, leaving a small and probably atypical remainder to supply the critical data. Together with multiple reasons for excluding trial applicants, it meant the results could not be relied on as an indication of nalmefene's likely impact among the generality of drinkers.

Once made, the EMA's decision initiated a chain leading to its approval for the NHS in Britain. In self-justifying loops, during European authorisation Lundbeck conducted the sub-sampling analysis in order to maximise nalmefene's apparent impact, which in turn justified authorisation for these kinds of drinkers. This

> 'In 2013 Lundbeck had paid a 93.8m euro fine imposed by the European Commission after being found to have paid rivals manufacturing generic antidepressants to "stay out of its market..."'

justified a published analysis focused on these drinkers and led to cost-effectiveness analyses based on the sub-sample, leading the National Institute for Health and Care Excellence (NICE) to say the NHS must make the product available for these types of drinkers.

Each link in the chain retained the original analysis's vulnerability to bias and its questionable applicability to patients in general. To this, NICE added acceptance of the company's argument that it was neither appropriate nor possible to compare nalmefene with naltrexone, its cheaper parent drug. One strand in the argument (justified by the unreliable sub-sample analysis) was that nalmefene was licensed to reduce drinking, but naltrexone to promote abstinence. In fact, naltrexone usually promotes reduced drinking, and does so among the same types of drinkers.

The other argument which led NICE to discount naltrexone was the company's assertion that required data was lacking from trials, and that these were so different from the nalmefene trials that comparison would have been invalid. Contradicting their own case, Lundbeck later sponsored and co-authored just such a comparison. Its findings were broadly but not always significantly in favour of nalmefene, but were undermined by the sub-sampling decision. In the three largest of the four nalmefene trials, this gifted the drug an advantage not replicated for naltrexone. The dice were stacked against naltrexone, but only a reader familiar with the source studies would have known.

Eliminating naltrexone from Selincro's therapeutic ball-park or finding it less effective was vital to Lundbeck. Financially, the company had suffered from the expiring of patent protection, leaving its medications open to competition from cheaper, non-branded, 'generic' equivalents. Selincro was meant to help plug the resulting revenue gap, but this would not happen if it too faced competition from generic naltrexone. An indication of how crucial this kind of issue was, in 2013 Lundbeck had paid a EUR 93.8m fine imposed by the European Commission after being found to have paid rivals manufacturing generic antidepressants to 'stay out of its market and delay the entry of cheaper medicines'.

Beyond naltrexone – and beyond this abridged version of the story – is whether any medication is appropriate for the kinds of drinkers at whom nalmefene is targeted.

Full story and supporting citations at http://findings.org.uk/PHP/dl.php?file=Palpacuer_C_1.txt&s=dd

Mike Ashton is editor of Drug and Alcohol Findings, http://findings.org.uk

More from Mike Ashton
www.drinkanddrugsnews.com

LEGAL EYE

Joanna Sharr of Ridouts answers your legal questions

Our residential rehab has a good reputation but is the target of a negative online campaign by a disgruntled resident. How can we challenge this?

JOANNA ANSWERS:

The advent of social media and the ability of individuals to make online reviews has placed significant power into the hands of those who may wish to damage a service's reputation. Even if your contract with the service user has regard to the use of social media while resident, engaging contractual provisions does not remedy the underlying issue.

This is a sensitive issue and should be handled with care; if dealt with in a heavy-handed manner, not only could the service be perceived to be unreasonable, but the online campaign could easily escalate to cause further damage to the service's reputation.

For whatever reason, the resident did not seek to raise their concerns with the service directly but went to social media to vent their concerns. Perhaps the resident did not feel that their issues would be taken seriously, but they should be reassured by the service that they are. We would therefore treat the online campaign as a complaint.

A service's formal complaint procedure should involve particularising the concerns and recording them, exploring the issues and possible resolutions and ultimately responding to the complaint. It may be helpful to include the resident's family (or advocate if there is any capacity issue) in any discussions to ensure that the resident feels supported throughout the process. The service should discuss the outcome of the matter with the resident and ensure that the situation is resolved to the resident's satisfaction. This will also help evidence CQC's key questions, 'well-led' and 'responsive' in any future CQC inspections.

The resident should be encouraged to raise any future concerns or complaints with the service directly. The service could request the resident removes their negative comments from social media and ask that the resident desists from using social media to vent any future concerns about the service, particularly if the matter had been resolved to their satisfaction.

There will always be cases where, no matter what a service does, a resident will simply be unhappy and will seek to maintain their damaging course of action online. If that happens, and all conciliatory routes are exhausted, the service may wish to consider its contractual options to serve notice to the resident. This course of action will not necessarily quell the negative social media campaign and may lead to an increase in posts. We would advise taking specific legal advice regarding contractual remedies and the implications and subsequent actions that could be required if the matter cannot be resolved amicably.

Joanna Sharr is a solicitor at Ridouts LLP, a practice of health and social care lawyers, www.ridout-law.com

Send your legal queries to legal@drinkanddrugsnews.com

HOME AND AWAY

Three residential rehabs in different locations understand that whatever the location, what matters is providing a range of interventions and treatments, with each one tailored to the individual.

Addiction can affect individuals from all walks of life, and each person has their own unique story.

Because of this all of our programmes are uniquely tailored to the person. Each client receives a thorough physical and psychological evaluation, taking into account their medical and addiction history in order to create the best possible care package. Looking beyond their addiction, our qualified assessors will study diet and nutritional requirements, and screen for conditions associated with addiction such as liver disease.

We offer a rapid detoxification programme, which can quickly and safely withdraw a client from their drug of addiction, through to a full 12-step therapeutic programme based on the Minnesota Model. This 12-step programme is presented in a contemporary way, focusing directly on the addiction and looking at issues of denial, unmanageability in life and getting through the very early stages of living without alcohol or drugs.

With more than 30 years' experience of treating addiction, our team has medical and therapeutic staff, including some who are in long-term recovery themselves. Each client is allocated a key worker to help understand and clarify the programme, and ensure that stress is kept to a minimum while working towards recovery. Though no two people are the same and every client will have an individual plan, many of the sessions come as part of group discussions providing an opportunity for mutual support and learning.

We take an holistic approach, with yoga and art classes helping stress management, while providing cognitive skills and mindfulness applications to provide the tools to help build a new, healthier life in long-term recovery.

Following the programme, a strong emphasis is placed on aftercare with clients learning how to spot signs and triggers that can lead to relapse. A support team and helpline are in place, as well as strong links with local fellowship groups for those that need them.

CASSIOBURY COURT, LONDON

This 17th century former hunting lodge of the first Earl of Essex is based on the outskirts of Watford, and just 15 minutes from central London by train.

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If you would like treatment for addiction for yourself or someone you know, please call 01923 804 139. Visit www.cassioburycourt.com

Following the programme, a strong emphasis is placed on aftercare with clients learning how to spot signs and triggers that can lead to relapse.

OCEAN RECOVERY, BLACKPOOL

Our residential rehabilitation centre in Blackpool is able to treat a range of addictions including drug, alcohol and behavioural addictions such as gambling addiction, sex addiction and eating disorders.

With a medical team on hand to observe patients' progress in recovery 24 hours a day, patients receive the full assistance and support during detoxification. Our Blackpool centre offers luxury rehabilitation, and patients travel here from all corners of the UK.

The centre is designed to promote a feeling of relaxation during treatment, with an atmosphere that promotes learning during rehabilitation and aids the detoxification process whenever uncomfortable withdrawal symptoms arise.

If you would like to discover how our Blackpool centre is able to aid your journey into recovery please call today on 01253 595 628. Visit www.oceanrecoverycentre.com

STEP ONE RECOVERY, SPAIN

The La Paz Step One recovery centre is situated on an exclusive two-acre Mediterranean estate in Javea, on the Costa Blanca in Eastern Spain. We firmly believe that travel generates an enthusiasm for new possibilities and that removing yourself from harmful distractions back home will aid your recovery. The beautiful town of Javea has scenic mountain ranges on one side and white sandy beaches on the other. There are some incredible views of the sparkling blue ocean from our estate.

La Paz Step One provides clients with a high-end environment in which to concentrate on their treatment and recovery, rather than being distracted by any domestic concerns. The centre combines luxurious bedrooms, healthy gourmet food prepared by our in-house chef, and facilities including a cinema, sauna and swimming pool. With a maximum capacity of only 12 guests at a time and a staff to client ratio of two to one, you have our undivided attention.

Whether you're making that call for yourself, or on behalf of somebody else, we will be able to provide all the help you need. Call today on 0800 011 1242. Visit www.step1recovery.com

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