IT'S NEARLY HERE – SERVICE USER CONFERENCE 2013

DDN
Drink and Drugs News

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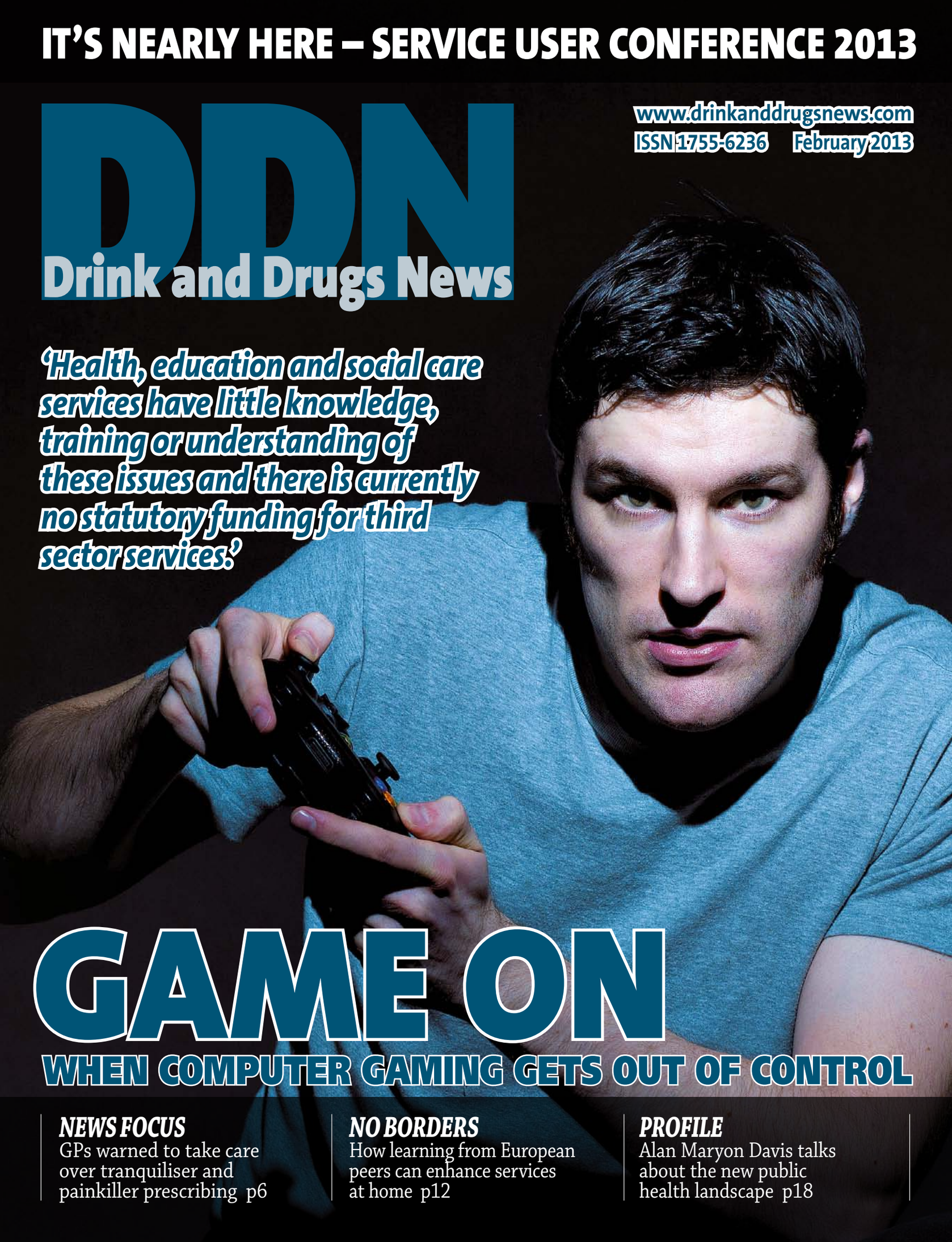
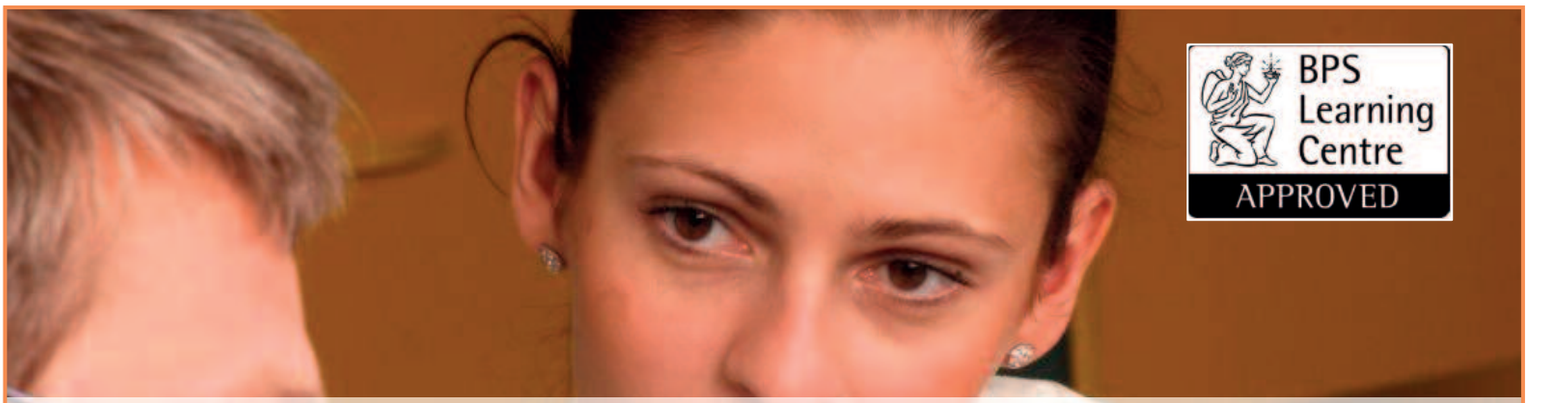


'Health, education and social care services have little knowledge, training or understanding of these issues and there is currently no statutory funding for third sector services.'

GAME ON

WHEN COMPUTER GAMING GETS OUT OF CONTROL



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FULLY BOOKED

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19 – 20 SEPTEMBER 2013 Places available

BPS Learning Centre confirmed that Essential Supervision Skills 2 day course from SDS Ltd meets the standards required to confer eligibility to **the British Psychological Society's Register of Applied Psychology Practice Supervisors (RAPPS).**

STOP PRESS

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Life games

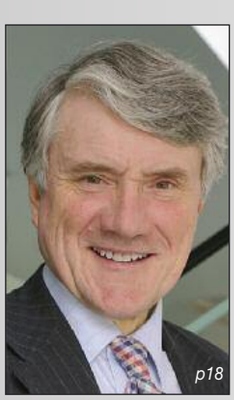
New addictions, age-old needs

This month's cover story (page 8) reflects an issue that's hitting the headlines – the increase in addiction to gaming, which extends to online gambling and all its compulsive cousins. According to author Peter Smith, we are well placed to take a proactive role in treatment and provide all-important family support. It's a tricky issue that defies neat categorisation. When does a hobby become an obsession? It's an unenviable task for parents trying to detect and deal with a problem, but hopefully the article will give some useful pointers on support.

There are contributions in this issue that demonstrate why DDN will always strive to be an open forum for debate. In our Soapbox (page 20), Dr Eliot Albers eloquently makes the case for preserving respect and dignity alongside harm reduction, and highlights stigma created by an abstinence-focused recovery wave. While on page 14, Marie, as she nears the end of her 'journey of self-discovery' series, credits colleagues and activists in recovery with reaching out to her and helping her to retrieve her life. The views are very different, but the common bond of individual rights is a timely reminder that mutual respect should be sacred.

We're looking forward to seeing you at our *Be the Change* service user involvement conference this month. We've got groups coming from all over the country – go to www.drinkanddrugsnews.com to book your place!

This issue



FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

NEWS IN BRIEF

SOUND INVESTMENT

Every pound spent on family support services in the drug and alcohol sector saves the public purse £4.70 in NHS and criminal justice costs, according to new research by Adfam. An independent social return on investment (SROI) study commissioned by the charity, the first of its kind in the sector, demonstrates the powerful case to fund and expand family services, it says. 'This research provides sound evidence to what we already know – that supporting families makes both moral and economic sense,' said chief executive Vivienne Evans. *Full briefing on the research available at www.adfam.org.uk. See Family Matters column, page 13.*

EVIDENCE EXAMINATION

The ACMD's recovery committee (*DDN*, January, page 18) has published its first report, intended to 'map out the terrain' that it will examine in more detail in a forthcoming series of focussed reviews. *Recovery from drug and alcohol dependence: an overview of the evidence at www.homeoffice.gov.uk/agencies-public-bodies/acmd/*

IT'S MUTUAL

The first in a series of *Recovery resources* briefings to help commissioners and service providers improve the recovery orientation of their services is available to download from the NTA website. *Turning evidence into practice: helping clients to access and engage with mutual aid* includes suggestions for practical steps that services can take as well as tips on developing dialogue with service users. *www.nta.nhs.uk*

ESCAPED KHAT

Khat should not be controlled under the Misuse of Drugs Act, the ACMD has recommended after being asked by the government to review the evidence. The herbal product is chewed for its stimulant properties, and its use is widespread in parts of the UK's Somali, Ethiopian and Yemeni communities. 'The ACMD considers that the evidence of harms associated with the use of khat is insufficient to justify control,' the council stated. *ACMD khat report 2013 at www.homeoffice.gov.uk/agencies-public-bodies/acmd*

TREADING THE BOARDS

The stage version of Elizabeth Burton Phillips' book, *Mum, Can You Lend Me Twenty Quid? What Drugs Did To My Family* (*DDN*, October 2011, page 20) tours the north of England this month, with a southern tour to follow in April. *Details of dates and venues at www.drugfam.co.uk*

Drinks industry launches minimum pricing fightback

Alcohol industry body the Wine and Spirit Trade Association (WSTA) has launched a campaign against the government's plans to introduce a minimum price per unit of alcohol. Evidence for minimum pricing is based entirely on 'modelling projections', says the association, which represents nearly 350 drinks industry companies,

The aim of the *Why should responsible drinkers pay more?* campaign is to 'start the debate with ordinary people about the impact of the government's plans on them', says WSTA, which has launched a website where people can sign an online petition or send a pre-written letter to their MP via email or Twitter. The association has also commissioned a ComRes poll, with nearly half of those responding claiming they would 'feel angry at being punished for others' irresponsible drinking'.

'Evidence shows that there is no simple link between alcohol price and harm and we do not believe that increasing the price of alcohol will effectively tackle problem drinking,' said WSTA chief executive Miles Beale. 'Our campaign aims to warn the public that the government's plans to set higher alcohol prices will cost responsible drinkers more. The UK already has some of the highest alcohol prices in Europe, and given that alcohol consumption has fallen by 13 per cent since 2004, these radical plans to increase the price of alcohol seem completely unfair, untargeted and ineffective.'

The Alcohol Health Alliance, however, accused the industry of using the 'tactics of Big Tobacco' to undermine evidence-based policy. 'A minimum unit price is a targeted policy that will impact heavy drinkers whilst leaving the majority of moderate drinkers unaffected, and the international evidence (from Canada) shows that it works,' said executive committee member Nick Sheron. The Institute of Alcohol Studies, meanwhile, called the campaign a 'sinister attempt' to block a policy that would save lives and prevent crime. 'To claim to be "responsible" retailers on the one hand, but sabotage public health initiatives with the other implies that the motives of these organisations are purely profit-centred with no regard for the health and wellbeing of their customers,' said policy director Katherine Brown.

Alcohol Concern chief executive Eric Appleby called the campaign 'shameful and cynical', while the Faculty of Public Health claimed that moderate drinkers may even save money through reduced pressure on hospitals and the police. 'It makes sense from a health and a financial perspective to everyone except those that make millions from selling more alcohol to those that already drink too much,' said president Lindsey Davies.

www.whyshouldwepaymore.co.uk

See Alan Maryon Davis profile, page 18

Decriminalise possession of all drugs, urges all-party group

A report from the All-Party Group on Drug Policy Reform has recommended decriminalising the possession and use of all drugs, along with a system of regulated supply – such as in licensed shops – of 'those new drugs which are the least harmful'.

The report is the result of the group's inquiry into new psychoactive substances, which began in 2011, and wants to see a review of the Misuse of Drugs Act as well as the removal of politics from decisions on drug classification in the same way as with the 'setting of interest rates', as the issues 'involve scientific judgements and are too sensitive for politicians to handle directly'.

It also recommends that a minimum of £1.5m be made available to pilot ten club drug clinics across the UK, and follows a report from the House of Commons Home Affairs Committee at the end of last year that called for a royal commission to be set up to look at UK drug policy (*DDN*, January, page 4).

While the all-party group's report acknowledges that 'appropriate controls' are necessary to minimise drug-related harm, a 'clear conclusion' of the inquiry is that 'banning drug use does not materially affect the overall level of demand' for drugs. 'Drug policies which criminalise young people generate higher levels of unemployment, homelessness and relationship problems, and cost the taxpayer considerable sums,' it says.

Meanwhile a report from the British Medical Association (BMA) has called for health to be put 'at the heart of the UK's drugs policy', with doctors leading the debate in a move away from a criminal justice focus. It also wants to encourage dialogue between the medical profession, policy makers and the criminal justice system.

'The BMA believes that drug users are patients first,' said chair of the association's science board, Averil Mansfield. 'We fear that too great a focus on criminalisation is deterring drug users from seeking medical help. While the medical profession would never condone illegal drug taking, we believe that we should show understanding of the illness of drug addiction and respond in the way that we would with any other medical problem.'

Towards a safer drug policy: challenges and opportunities arising from 'legal highs' at www.drugpolicyreform.net

Drugs of dependence: the role of medical professionals at bma.org.uk

Alcohol services 'improving'

The situation regarding alcohol treatment in England is improving, claims a new report from the NTA. While alcohol has long been seen as a 'poor relation' compared to drugs, waiting times are now lower and more people are coming forward for treatment, says *Alcohol treatment in England and Wales 2011-12*.

The number of people successfully completing treatment is also increasing, it says, with just over 38,000 people doing so in 2011-12, 6 per cent up from the previous year. The majority of those in treatment – 70 per cent – were in the 30-54 age range, with an average age of 42, and two thirds of the treatment population was male. Nearly 90 per cent were in the 'white British' ethnic group, and 19 per cent were referred by their GP, compared to 38 per cent who self-referred.

More effort was still needed however, the agency stated, adding that alcohol treatment would be a 'significant priority' for Public Health England (PHE). The proportion of people waiting fewer than three weeks to start treatment stood at 85 per cent, compared to 78 per cent in 2008-09, and while the figures were 'heading in the right direction, there remains plenty of room for further improvement', says the document.

'The high number of people who require help with problem drinking remains a great cause for concern,' said the NTA's director of delivery, Rosanna O'Connor. 'The signs that more are seeking to overcome their alcohol misuse and more are successfully completing treatment are, however, encouraging. This progress will continue to be driven by Public Health England, working with local authorities to ensure that the full range of effective alcohol services are available and accessible.'

She warned against complacency, stating that around 1.6m people were thought to have some level of alcohol dependence. 'The health problems and costs associated with alcohol misuse are rising year-on-year, and preventing and tackling it will be a key priority for PHE,' she said.

Rosanna O'Connor: 'More are seeking to overcome their alcohol misuse and more are successfully completing treatment.'

Meanwhile, the latest set of alcohol-related death figures has been issued by the Office for National Statistics (ONS). There were 8,748 alcohol-related deaths in the UK in 2011 – a figure largely unchanged from the previous year – with more than 66 per cent among males and death rates highest in the 55-59 age group.

NTA report at www.nta.nhs.uk

Alcohol-related deaths in the United Kingdom 2011 at www.ons.gov.uk

Doctors warn on prescription addiction

A consensus statement has been issued by the Royal College of General Practitioners (RCGP) and Royal College of Psychiatrists (RCPsych) cautioning against the long-term prescribing of medicines that carry a risk of addiction.

The statement, which is supported by nearly 20 other organisations including the NTA, SMMGP, National Pharmacy Association and the British Association of Social Workers, says medicines such as tranquilisers and painkillers should not be prescribed for long periods 'except in exceptional circumstances'. While many patients may feel that the drugs are beneficial, it is vital that they understand the risks and are able to make informed choices, say the organisations, which also call for 'rigorous and holistic' reviews to be regularly carried out.

The statement acknowledges the challenges faced by people who have developed an addiction to prescription or over-the-counter medicines, and stresses that 'extreme caution' should be taken when reducing or stopping the medication, including seeking specialist help. Some medicines – such as benzodiazepines – carry a known risk of dependence, which can be 'devastating to those affected and their families', it states, and stresses that prescribing should always be informed by up-to-date guidance. Patients should also be offered 'appropriate non-pharmacological options' where appropriate.

Health and social care professionals across the statutory and voluntary sector need to work together to prevent addiction from occurring and support 'all those suffering dependence and its impact', the document adds, with GPs well-placed to work in partnership with other agencies.

This joint-working approach had 'been shown to be successful in helping patients to slowly adjust their treatment and achieve their recovery goals, including providing them with more access to alternatives such as psychological therapies and physical rehabilitation for pain relief,' said RCGP chair Dr Clare Gerada. 'GPs and health professionals are already helping these patients to reduce their medication and understand all the options – but there is general agreement that we all need to do more.'

The statement has been welcomed by the NTA, with the agency adding that much of what it called for was already underway. Public Health England (PHE) would 'continue to support local authorities to ensure that appropriate help is available for everyone who needs it', it said.

Addiction to medicines consensus statement at www.rcgp.org.uk

See news focus, page 6

NEWS IN BRIEF

HOMELESS HELP

DrugScope has joined forces with St Mungo's on a new campaign to make sure that women who are homeless and facing drug or alcohol problems get the help they need. The organisations want to hear examples of best practice in supporting homeless women, as most homelessness provision has traditionally been designed for men. 'Women experiencing homelessness face stigma from society,' said DrugScope chief executive Martin Barnes. 'For those who also have problems with drug or alcohol use, this can be even more severe. We want to hear from practitioners on the ground and women using services themselves about what works and what support is missing.' *rebuildingshatteredlives.org*

COMMUNITY CASH

The 2013/14 budget for local public health services will be just under £2.7bn, health secretary Jeremy Hunt has announced, rising to around £2.8bn in 2014/15. Every local authority would receive a 'real terms' increase in funding, he said. 'By putting local authorities in charge of public health, we are giving them the power, freedom and the funding to tackle the issues that blight their local areas and help improve the lives of their local communities.' *Full details of allocations at www.dh.gov.uk/health/2013/01/ph-grants-las/*

LICENSING LINKS

A new briefing on public health and alcohol licensing has been published by the LGA and Alcohol Research UK. The briefing contains a list of potential partnership bodies and useful documents, and explains the policy context. *www.local.gov.uk*

FRANK DECADE

The Home Office's drugs advice service FRANK is marking its tenth anniversary with the launch of three new adverts and an online live chat facility for its website. More than 35m people have visited the website since its launch. *www.talktofrank.com*

AIMING TO SCORE

A mephedrone awareness campaign, *Do you know the score?* has been launched by the Welsh government to coincide with the Six Nations Rugby tournament. Leaflets, posters and radio adverts highlight the risks associated with taking the drug and let users know where they can get help, while campaign beer mats will be distributed to every Wetherspoons pub in Wales.

PRESCRIPTION FOR CHANGE?

With addiction to prescription and over-the-counter drugs at epidemic proportions in the US, GPs here are being warned to take care when prescribing any drugs that could lead to dependence

'Prescription drug abuse' is classified as an epidemic by America's Centers for Disease Control and Prevention, prompting the Obama administration to issue a specific prevention plan to expand on its 2010 National Drug Control Strategy (*DDN*, May 2010, page 5). As former White House drugs advisor Keith Humphreys told *DDN* last year, legal pharmaceutical drugs are the leading cause of overdose in the US, and one in eight American teenagers have taken potentially addictive legal drugs like Vicodin and OxyContin (June, page 16).

Now UK doctors and psychiatrists are warning that care must be taken 'in the initiation of any drugs that can lead to dependence'. A consensus statement issued by the Royal College of General Practitioners (RCGP) and Royal College of Psychiatrists (RCPsych), and supported by 17 other organisations, says that medicines such as tranquilisers and painkillers should not be prescribed for long periods 'except in exceptional circumstances' (see news story, page 5), and that patients need to understand the risks involved in order to make informed choices.

'Addiction psychiatrists are increasingly working with people who have developed dependence problems with prescribed or over-the-counter medication,' said RCPsych consultant psychiatrist, Dr Emma Whicher. 'Although these medications are beneficial to many people, awareness of the alternatives and risks is also important.' Prescribing must be informed by the very latest guidance – such as that from NICE – says the statement, and patients should also be offered appropriate non-pharmacological options as adjuncts, or alternatives, to their prescription.

'We talk about addiction to prescription-only medicines, but we're not talking about one group – we're talking about a range of medications, from laxative abuse right through to serious opioid misuse,' RCGP substance misuse lead Dr Linda Harris tells *DDN*. 'That means that the complexity of these presentations can vary enormously.'

While the statement was welcomed by the NTA, the agency stated that much of what it called for was already being done. 'I think that's a fair assessment,' says Harris. 'This is an area where I don't think one agency or college is going to be in a position to take all the responsibility – there's a firm platform of activity that we're developing and building on. Where I might disagree is that there are some gaps around options in primary care. I get doctors saying to me, "yes, we'd clearly like to do less prescribing but we need more options". That means more access to counselling, psychotherapy, psychosocial and the like.'

Isn't it the case that there can sometimes be long waiting times for NHS mental health services, though? 'I don't know the full national picture but for me locally I can draw on my IAPT [Improving Access to Psychological Therapies] services – our substance services are well joined up to IAPT, and our waiting times are within national targets. But I suspect that it might be patchy. It's down to localities now to identify if there are gaps, and there are things that GPs can take more control over if they think that locally they haven't got those resources.'

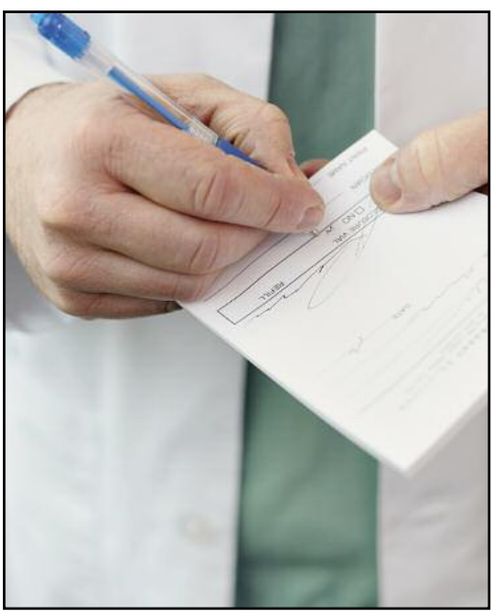
According to the statement, the issue is best addressed through collaborative action – is there enough joined-up working going on around this? 'I think we're poised – we should be able to do it,' she says. 'And the clinical commissioning groups are commissioning more assertively to meet local need.'

Does she feel that drug treatment services generally give enough consideration or priority to prescription and over-the-counter drugs? 'I think they're beginning to. The 2010 drug strategy firmly identifies this as an area that substance misuse services should be responding to, and they certainly have the skills, but many services have been commissioned with a focus and emphasis on illicit drug misuse – they might not be seen by the general population, or even GPs, as the place where you'd refer. So we want to do a lot of work to raise awareness, that absolutely there are skills, and particularly with shared care.'

What about people who say that there are some GPs who are quite happy to just sign prescriptions, as it's the easiest thing to do? 'I would challenge that position,' she states. 'We have to understand that the GP cohort is mixed – there's a mixture of ages, and people at different stages of their careers, where experience of education and training may be different. With our younger GPs, the modern curriculum equips them with the full competencies around safe and effective prescribing, and obviously if GP training were to be extended – as the Royal College would love to see – that would give us more opportunities for young GPs in training to be exposed to services and wraparound care.

"They'd be even better placed – when faced with those decisions, when they've got the pressure of day-in, day-out consultation in primary care – to really do the right thing. My feeling is that we're really getting on top of this.' **DDN**

Consensus statement at www.rcgp.org.uk



'We talk about addiction to prescription-only medicines, but we're not talking about one group – we're talking about a range of medications, from laxative abuse right through to serious opioid misuse.'

DR LINDA HARRIS, RCGP

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Iain Duncan Smith's Work and Pensions department [are] planting stories about large families on benefits and other supposed wastrels in friendly tabloids on a daily basis. The government will expect to pluck much more of this low-hanging fruit in the coming months as its assault on tax credits, housing benefit and generally those regarded by some as needy and by others as scroungers intensifies.

This reinvention of IDS, sacked by his party in 2003 on the twin grounds of being preternaturally incompetent and sensationally dim, is one of the wonders of the political age... here he is reborn as the deepest of thinkers on the most intractable of social problems, a gleaming-pated anti-Beveridge... In his defence, he seems genuinely to believe that stigmatising people by obliging them to use vouchers at the shops, and forcing millions without access to a computer to make their claims online, is tough love.
Matthew Norman, *Independent*, 1 January

Just why is this Government so intent on persecuting the hardworking middle classes while letting those who sponge off the state get off scot-free?
Sunday Express comment, 27 January

Britain cannot possibly afford its welfare state for much longer... I am sure a lot of welfare money goes to people who need and deserve it, whose problems are no fault of their own. But I am just as sure that a lot of it goes to people who do not deserve it.
Peter Hitchens, *Mail on Sunday*, 13 January

In any fair society it cannot be right that benefit claimants are rewarded more generously than those struggling to hold down jobs.
Leo McKinstry, *Express*, 7 January

As part of Britain's absurdly lavish overseas aid budget, we give £3.6 million to the mad mullahs of Iran. Mind you, it's not all wasted. Some of it goes towards hanging drug dealers. Apparently, it's the only language they understand.
Richard Littlejohn, *Daily Mail*, 3 January

As well as trouble, Britain's buttoned-up society gets a lot of precious bonding and cheer from the bottle, which is too often ignored in the public browbeating.
Economist editorial, 5 January

The most powerful argument against the puritan zealots who don't want us to drink, and would like us to subsist on a diet of boiled sprouts and lentils, is that their ideal world would be a thoroughly miserable one, and life in it scarcely worth living.
Stephen Glover, *Daily Mail*, 2 January

It was Tony Blair who warned, almost ten years ago, that binge drinking was in danger of becoming 'a new British disease'. He got it wrong. Binge drinking is now just a way of life.
Bryony Gordon, *Telegraph*, 2 January

The prime minister says the current policy is working. I wish it were. But as the use of cannabis has declined by a few percentage points over the past few years, the use of 'legal highs' has soared. The position for drugs users is therefore more dangerous than it was a few years ago.
Molly Meacher, *Guardian*, 15 January

Post-its from Practice

Partnership for life

We have to keep trying to help patients effect change, says **Dr Steve Brinksman**

One of the privileges of being a GP is the opportunity to follow through the 'cradle to grave' ethos that the NHS was founded on. Sadly this does mean that sometimes we are caring for people whose lives end prematurely.

Gary was registered with the practice before I joined 22 years ago and I knew him as a young man with a young family and only occasionally saw him when one of the children was ill. It was in his late 20s that his drinking first raised itself as an issue. He was convicted of a drink driving offence and as a condition of getting his licence back he had been told to see us for help. He was a typical binge drinker, often having several days without alcohol. But when funds were available, he would drink heavily at weekends.

Little happened for five years but then he reappeared, ostensibly in an effort to preserve his marriage, which was by now being affected by his daily heavy drinking. Blood tests revealed mildly abnormal liver function but he declined a referral to support services, as he was sure he could 'sort himself out'.

He divorced, a new relationship came and went, he lost his job, and then another. Eventually he came to see me; the alcohol and a poor diet had taken its toll. He was underweight, unkempt and slightly jaundiced. This time his liver function was severely deranged but he had insight into his situation and agreed to be referred to the specialist alcohol service.

Gary successfully completed a medically assisted withdrawal but despite encouragement to engage with mutual aid, he found the prospect of a lifetime of abstinence too difficult to deal with and resumed drinking. Now the pattern became one of acute hospital admissions, cessation of drinking in hospital and then resumption soon after discharge. His cirrhosis progressed to decompensated liver disease and just before Christmas last year he was admitted for the last time. He died aged 43 from complications of his alcohol-related liver disease.

We have a practice policy of reviewing all deaths and I wondered if at any time in the past, before he became dependent, we might have been able to influence him to change his behaviour.

It is difficult for many of us to understand how, in the face of irrefutable evidence of the harm being caused, some people fail to change their behaviour – but this shouldn't prevent us from trying. I was somewhat taken aback by some of the responses to the recently published Screening and Intervention Programme for Sensible drinking (SIPS) study, which some have chosen to interpret as suggesting that a few minutes asking about alcohol use and then providing a leaflet is all a GP needs to do.

This may well apply across a large section of the population; however in general practice we work with individuals and it is our duty to deliver the best possible care to each patient we see. If we do this then we contribute to the wider public health picture.

Gary's death at such a young age is a tragedy. For me it reinforces the need to ask all my patients about their alcohol use more often and in more detail, to support those at risk and offer help and support. Unfortunately we never really know when our interventions do prevent adverse outcomes happening, but seeing the results of the times they don't, keeps me trying.

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

GAME ON

With big business behind it, the hobby of computer gaming can turn into an unhealthy obsession. The addiction field is well placed to offer support, says **Peter Smith**

The video and online gaming industry is big business. The recently launched video game *Call of Duty: Black Ops II* recorded sales of £324m in the first 24 hours after going on sale and another, *Halo 4*, took more than £150m in the same period. People ordered well in advance and queued to be among the first to obtain their copy and start playing.

Such was the intensity and excitement that people in homes across the UK – most of them young men – were up all night and into the next day playing virtually non-stop, depriving themselves of sleep, food and attendance at school or work. Parents, partners and siblings were left bemused, dismayed, dejected and angry – though for some it has become an all-too-familiar and often-repeated pattern of behaviour.

We are in an age dominated by 'screen' technology; one that many younger people have embraced and benefited from. Referred to by some as 'screenagers', this group has grown up with the advances in information technology. They recognise it as a core school subject, can apply for college and university courses in one of its innumerable variants and ultimately seek jobs where computer skills are a core requirement. But for a few young people the use of this technology, specifically related to game playing, is a growing cause for serious concern.

*****

Game playing is not unlike the use of alcohol, where most people use within healthy and responsible limits and benefit from its social and pleasurable aspects. Many millions worldwide play video and online computer games and gain a considerable amount of pleasure from doing so. However research studies indicate that as many as 4.6 per cent of adolescents engaging in regular internet use do so to the point of excess and will likely experience negative consequences as a result.

While discussion continues around accurate and suitable wording – including such terms as excessive, dependant, addictive and pathological – terminology is purely academic for those individuals and families where the problem is present. In

this situation, parents are often struggling to find the best way of dealing with their teenage son as his repertoire becomes progressively more limited to computer game playing. The gamer becomes more alienated from the rest of the family, limits his relationships to other online players, and is reluctant to consider any other activity that might restrict his game playing, leaving those around him increasingly anxious, frustrated and resentful.

Such a situation creates upset, arguments and tensions within the family. Any attempt to control, reason, negotiate or compromise can end in anger, a breakdown in communications and an increasing sense of helplessness and hopelessness. While examples have been documented of more extreme outcomes resulting from excessive game playing, including fatalities, the help most frequently sought by family members is associated with the insidious wearing away at established family relationships and norms, and fears for the future if nothing changes.

The impact on the family is of very real concern, but the consequences of excessive game playing for the individual can be at least as serious. In a recently reported case at a Plymouth primary school, the head teacher was surprised to find that pupils as young as seven and eight were arriving at school tired and 'not ready to learn', and discovered that some were playing games until late at night. In a survey of a Weston-super-Mare Secondary School, teachers were able to identify pupils in each year group where educational attainment had suffered as a result of computer game playing.

Among the calls from people seeking advice recently received at Broadway Lodge, a significant number were from parents looking for help as a result of their sons' exclusion from university. In such instances, failing to maintain course requirements was related to the removal of the parental controls that were in place while at home, allowing unrestricted game playing to escalate to the detriment of academic achievement.

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The games that probably give rise to greatest concern are referred to as massively multiplayer online role playing games (MMORPG). These MMORPGs invite players to immerse themselves in complex virtual worlds. Players can live out fantasies through a 'virtual personality' of their own creation and play with millions of other players around the world at any time of night or day. These games do not have an ending, so can be played continuously, and such is the immersion in them that players consistently report becoming so preoccupied that they easily lose track of time and the need to eat, and get frustrated at being interrupted by the need to go to the toilet.

'Any attempt to control, reason, negotiate or compromise can end in anger, a breakdown in communications and an increasing sense of helplessness and hopelessness...'

While older people sometimes get into difficulties with playing games to excess – a recent caller sought advice about her husband who spent all evenings and weekends playing online games – the issue still has a generational dimension to it. Many people playing and experiencing problems are younger and many of the people with the greatest concerns about it are older. This may be due to the adult generation having limited understanding of the technology and its capabilities.

In discussion with a 17-year-old male gamer recently, parents were surprised to learn from their son how much he felt he gained from playing games, including the skills, strategic thinking, information processing and decision-making involved; the connections he made with others worldwide; and the socialising aspects of 'lan' (local area network) parties – where friends brought their own computers to plug into a network to play the same multi-player game.

However, while it was helpful for them to learn this, the parents were still concerned that balance seemed to have been lost as game playing became ever more consuming, and raised questions about its physiological and neurological impact. Sitting for hours without any physical activity might contribute to circulation and digestion problems and while gaming may be training the brain to process large inputs of information speedily and make decisions quickly, excessive game playing may be to the detriment of less adrenalin-inducing cognitive processes, such as reading or revising for exams.

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There is currently very limited help available, so where does someone experiencing problems of this nature go? Health, education and social care services have little knowledge, training or understanding of these issues and there is currently no statutory funding for third sector services. The UK Interactive Entertainment (UKIE) games industry representatives are unwilling to help in this area or to accept that they might have at least some level of social responsibility, and central government has not yet fully acquainted itself with the implications for public health.

In fact at present, the games industry is lobbying parliament for tax concessions to maintain the UK's leading role in game production and has suggested that computer games should be introduced to primary schools. We can only hope that any concessions of this type are conditional upon a financial commitment from the industry to support the development of specific counselling and advisory services for those who get into difficulties. I would suggest that UKIE follow the good example set by the gambling industry in making financial contributions to the voluntary sector, distributed through the Responsible Gambling Trust (RGT), to support people experiencing problems resulting from gambling.

As for the future, we might predict that the problems resulting from this issue are likely to increase in coming years and that data gathering and research studies will be essential. At present we are managing one generation, but as this generation grows up (with some continuing to play into their adult life), the next generation of game-competent youngsters will emerge and add to the numbers of problem users, with increasing demands on services. Eventually, cross-generational status will be reached.

At the same time, current research investigating the impact of game playing will begin to report on findings with results from longitudinal research studies, which we hope will provide us with detailed and accurate information regarding the precise nature of the issues and the specific help required. Who knows, while not in DSM V (the fifth edition of the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders*), with research evidence to support it we may find its inclusion in DSM VI.

I believe that the alcohol, drug and gambling treatment fields could be well placed to help in this area, delivering the advice, support and treatment necessary to manage the consequences of excessive game playing. While there are differences, there are also sufficient similarities with chemical and other 'process' addictions and the skills and knowledge of practitioners in this field can be harnessed to respond to the presenting problems of this new client group. It would be timely for organisations to gather information, seek appropriate training for staff, and talk with gaming enthusiasts themselves to learn about their experiences. **DDN**

Peter Smith is development director at Broadway Lodge.

Suggested reading: Young, K.S. and de Abreu, C.N. eds (2011). Internet Addiction, Wiley Aboujaoude, E. and Koran, L.M. eds (2010). Impulse Control Disorders, Cambridge University Press

LEGAL LINE

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

THEY'RE CUTTING MY HOUSING BENEFIT – HOW CAN WE LIVE?

READER'S QUESTION:

I have just received a letter from the council saying I'm 'under occupied' in my two-bed flat and my housing benefit will reduce from April this year. There is only me and my five-year-old son – how can we have too much room? I'm really worried as I already struggle financially and can't work because I've just started hepatitis treatment.

KIRSTIE SAYS:

From April 2013 the housing benefit (HB) rules change so benefit won't be paid for a separate bedroom for a child under the age of 16. Although you may be entitled to a larger property through your council/housing association, benefits will not cover the full rent for this.

As you have one more bedroom than you need (living rooms are considered as potential sleeping areas), your HB will be reduced by 14 per cent of your rent. So, if your rent is £100 per week you will receive £14 less HB per week. One possibility is to pay the difference (shortfall) between the rent and the HB, but this is not necessarily realistic if you are on benefits and unable to work.

There are a few options available to you. One suggestion, that the council may already have made, is to move to a one-bedroom property with their assistance. This could be via a transfer or mutual exchange. There are often limited properties available, but councils should give priority to people who are under occupied. Many authorities also offer compensation for downsizing and/or pay for removal costs. Moving may be problematic in terms of location to your son's school and you will not necessarily have free choice of properties.

Alternatively, the council may give you permission to take in a lodger – this has to be approved in advance, as tenancies don't normally allow this. However, this needs to be considered carefully, as depending on the lodger's financial circumstances this may negatively affect your benefit even more.

The most appropriate option for your circumstances would be to apply to the council for a Discretionary Housing Payment (DHP). This is a fund that is operated to meet shortfalls between rent and HB. You will need to show exceptional circumstances or vulnerability to be considered eligible – your hepatitis treatment, and the effect on this of moving or worrying about finding the shortfall amount, will go towards this. You should provide supporting letters from any doctors or other people that you are engaging with for support or treatment.

However, DHPs are generally only awarded for a year, with an expectation that during that time you change your circumstances – this may mean that you start work after treatment has completed and pay the shortfall yourself, or that you go forward with one of the other options outlined.

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

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

LETTERS

'With the police vetting there is no appeal process so I do not get to plead my case and tell them what I have done since those convictions. So really, what my local police are saying is that people don't change...'

PAST PREJUDICE

My past is still being held against me, even though I am over 15 years clean. I am 45 years old now, but without going into my life story in detail, I spent years in care, have been homeless and have been through domestic violence.

I had a problem with drugs until I was 30 years old and got myself a criminal record. I brought up my two sons through this, who have turned out to be lovely young men – my oldest won an award four years ago for the work he does with kids, teaching them street dance and break dancing; my younger son works full time.

I have worked for the last six years in a local homeless hostel, helping the most vulnerable of people, and have completed many courses including my Health and Social Care NVQ3.

I recently applied for a job as a drug and alcohol practitioner with a local service. Before I could start the post I was to undertake an enhanced CRB check, which the employers were fine with as the offences were historic – most were committed between 1994 and 1998 and one other in 2000.

I was also subject to police vetting as my post would need me to enter the cells in the police station. I received a letter from the police vetting office telling me I failed the vetting due to my convictions, even though they were so long ago. With the police vetting there is no appeal process so I do not get to plead my case and tell them what I have done since those convictions. So really, what my local police are saying is that people don't change.

I now cannot take up the job in the field I would like to get into – it would be good to use my past to help others.

Name and address supplied

UNFAIR COMMENT

The letter entitled *Comedy Turn?* by Molly Cochrane contained not one piece of information on the respective positions of those who appeared on Newsnight (*DDN*, January, page 13). It just served to denigrate Eliot Albers and INPUD as a whole, who are not just pushing for legalisation but also bring harm reduction work to countries where drug users are arrested, imprisoned and executed for

possessing small amounts of drugs and also just for possessing drug-taking paraphernalia.

Peter Simonson, by email

NO CONSPIRACY

Planning for the 5th UK Recovery Walk is underway, this year hosted by Birmingham. With the support of the UK Recovery Federation, the steering group committee has been formed and planning groups are meeting regularly. There is a lot to be done of course, and we are looking for people and services from across the UK to support the event.

This year we would like to extend the welcome not just to those affected by dependency on substances, but also to make the walk inclusive for people to celebrate their recovery from other forms of addiction, and related health conditions such as HIV and mental health – all of which lead to stigma in society.

There will be entertainment for all ages on the day and we're looking to see how we can show off the great skills and resources there already are within the recovery community. We're open to all ideas so please engage with us on our social media pages below. We'll be promoting to the walk at the *DDN* conference on 14 February, by which time the September date and route should be confirmed.

Building on the success of previous years we hope to be able to continue the legacy and make 2013 brilliant in Brum! You can see the event on Facebook (search 'The 5th UK Recovery Walk') and follow the updates on Twitter @UKRW2013

Stacey Smith, communications lead, The 5th UK Recovery Walk, @StaceInspire

We welcome your letters...

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

ENTERPRISE CORNER

OPPORTUNITY KNOCKS

Successful entrepreneurs offer a valuable lesson in grabbing life's chances, says **Amar Lodhia**

'Seema explained that it is up to us as individuals to either take the leap or stand still and do nothing.'

Seema Sharma is an entrepreneur, dentist and Channel 4's *Slumdog Secret Millionaire* who lives in South East London. Seema was born in July 1967 and set up her first practice in 1991, at the age of 24. She now owns a small group of dental practices trading as Smile Impressions Ltd. She is also a partner in an innovative William Place NHS Dental Practice in East London.

At 40, with daughters aged ten and eight, and a dependable practice management team akin to her second family, she cut back her hours at work, participating in a children's oral health education project in East London, to pursue her dream to help deprived children. That dream really came true two years later, in 2009, when she was part of a winning team that secured a coveted tender to run an NHS dental practice for underprivileged residents in Bow, and she was invited to India to be the 'real slumdog secret millionaire' in the popular Channel 4 philanthropy series.

Seema took time out of her busy schedule to speak at our flagship self-employment programme being run at the Guildhall and co-funded by City of London. Her talk centered on her journey from starting her business in a male-dominated industry at a young age and what she did to become a multi-millionaire at the age of 45. Seema inspired all of the participants and moved some to tears describing her work on the Channel 4 documentary. She also spoke to the TSBC participants about 'boarding the bus of opportunity', explaining that it is up to us as individuals to either take the leap or stand still and do nothing.

Seema believes her success has been due to hard work, luck and an element of being in the right place at the right time. She shared something her father once told her: 'First you learn, then you earn, and then you return.' Seema plans to continue her journey into her heritage, and to further her charity work with underprivileged communities in India and East London. She also spends time building links with others who, like her, were satisfied with their personal achievements and wanted to do more to help those less fortunate.

To enquire more about our new service or our work in general please contact me at ceo@tsbccic.org.uk and follow me on Twitter @amarlodhia or @tsbclondon. Don't forget to use the #tag DDNews when tweeting!

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

Services with

Learning from peers across Europe has helped to enhance services at home, writes the team at **Phoenix Futures**

Phoenix Futures has been involved over the past year with a European Commission 'mobility' project under their Leonardo de Vinci scheme, working with ECEtt (European Companionship in Education training by travel). ECEtt helps organisations to work with partners across Europe, exchange best practice and increase staff expertise by enabling them to share skills, knowledge, networking and partnerships.

This year Phoenix Futures sent 15 staff members from a range of services and roles, in groups of three, to centres across Europe – in Belgium, Greece, Poland and Spain. Staff were sent for two weeks and gained invaluable experience through witnessing projects and services similar to their own, and Phoenix Futures also facilitated visits from trainees from these countries to our own projects in the UK.

'Working with ECEtt has enriched our organisation's practice in so many ways,' said learning and development manager at Phoenix Futures, Fran Gray. 'Not only have the 15 members of staff benefited through their travel experiences and shared best practice but it has created an awareness and acute interest throughout Phoenix Futures of our EU partners' work in similar services and shared the common theme of improving service users' lives. The staff returned with elevated motivation which has been infectious, interesting and enlightening.'

The ECEtt placement created a sense of unity among European colleagues and 'enables us to see just what amazing work is taking place across so many fascinating services', added Nicola Owens, programme manager at Phoenix Futures Wirral Residential Service.

Recovery navigator at Phoenix Futures Trafford Recovery Service, Helen Cleugh, travelled to Poland alongside two other staff members and had the opportunity to live as a member of a therapeutic community – an experience that will 'stay with me forever', she said.

Senior practitioner at Phoenix Futures HMP North Sea Camp, Lucy Morris, meanwhile, travelled to Spain with two colleagues. 'My biggest learning point was the way that Proyecto Hombre embraced not only the service user but their family, and how they provide support and treatment to the family to educate them in how to support their loved ones in the best possible way,' she said. Since her return she has designed a leaflet for service users and their families about the family support available and how to access it.

After travelling to De Kiem in Belgium, Jennifer Robertson was able to enhance her own service in Scotland. 'We have begun to implement certain practical features from De Kiem in the Scottish residential,' she said. 'Residents now have their own office and computer to complete certain administrative duties – trust, responsibility and respect are essential elements of any therapeutic community and this is a good way of offering this to residents. We are implementing budgeting groups in line with good practice at De Kiem and residents now spend more time in departments to expand the principle of work as therapy.'

Families are at the heart of what Phoenix Futures does and one programme that has been implemented since the ECEtt project began is FLAMES, which was developed by Nicola Owens in the Wirral and has now been rolled out to all Phoenix Futures residentials. The key elements of FLAMES (Families and Loved ones Accessing Mutual and Emotional Support) are not only providing families with

hout frontiers

greater awareness, knowledge and understanding of what treatment and recovery entails but giving individuals a mutual sense of support via shared experiences, unity strength and empowerment.

Some of the main objectives of FLAMES are to provide a sense of understanding around treatment and recovery – where sometimes ignorance has caused conflict and dysfunctional relationships – and to support families, loved ones and residents by offering a sense belonging in an environment that aspires to achieve long-term change. It also aims to have a direct impact on achieving a greater level of social capital for each of our residents thus impacting on community dynamics, peer relationships, family relationships and commitment to their own recovery.

To mark the achievements of the 15 trainees who travelled to Europe, Phoenix Futures held an ECEtt event in Sheffield last month, during which we were also lucky enough to hear from representatives from Spain and Belgium. 'ECEtt Networks are a wonderful opportunity for workers in social occupations to train and to learn so much from their peers,' said assistant director at the Trempoline service in Belgium, Fabienne Vanbersy. 'The event was a real success – the trainees from Phoenix Futures were brilliant in their presentation of their traineeships. The sum of knowledge they had learned and shared during their journey was impressive as well as the implementations at their workplace after their return.'

'The Phoenix Futures ECEtt event proved very worthwhile in the respect that we were able to share our experiences and discuss areas of good practice,' said drug worker at HMP Wymott, Mick Fowler. 'There was much in the way of positive feedback which emphasised the success behind the ECEtt experience.'

So what has Phoenix Futures gained from the experience? This project has enabled workers and staff teams working in the field of addictions to deal with professional challenges – staff could meet experienced peers facing similar challenges in their own working environment and see how they managed to achieve their professional targets. The act of travelling to meet other workers enriches both parties, leads to the development of one's own competences and gives a broader understanding of alternative practices that have proved to be successful in improving people's lives and situations.

Phoenix Futures strives to continually deepen and strengthen its specialist skills and abilities by sharing and developing practices that are recognised and validated across Europe, by ECEtt partners who share a common goal of improving and developing staff by training through travel. This ultimately benefits service users, their families and the communities beyond.

Staff implement at least one best practice initiative gained from their trip in their own services on their return – some initiatives have been rolled out locally, some nationally. The dissemination of practices filters through services, teams, managers and service users and is widely advertised throughout the organisation to maximise practice sharing and uniformity.

Good practice from all European trainees is stored on the ECEtt database after validation, for ongoing reference, networking and sharing, and the training and follow-up support is ongoing for trainees via the online platform, where they have access to validated examples of best practice and new initiatives.

'As a chief executive I have the privilege of visiting services and it is fantastic to give staff from so many different services the opportunity to do the same,' said Phoenix Futures chief executive Karen Biggs. 'The feedback from them demonstrates how effective this is as a learning tool. It has developed them as individuals and they have used that learning to develop their services and their approach.'

This article was written by the organisational team – Vicky Holdsworth, Fran Gray, Bob Campbell; and the ECEtt trainees – Nicola Owens, Helen Cleugh, Lucy Morris, Jennifer Robertson and Mick Fowler, at Phoenix Futures

FAMILY MATTERS

FAMILY VALUE

Latest research shows the value of investing in family support, says **Joss Smith**

In an increasingly outcomes-focused world we are all being asked to measure our impact and our effectiveness, which can be a particular challenge for family support services that have traditionally focused on 'softer' outcomes. Nonetheless it is important to recognise the environment we now operate in and measure the change that our intervention can make.

One of the challenges of commissioning family support is the lack of clarity on what are the outcomes that a good service can effect and how these can add social value to the local system and community. Family support services have enjoyed a certain freedom over reporting historically and many have developed their own tools and systems to capture the information they wish to measure. This obviously can provide a really rich source of information very specific to the needs of local clients but it can be difficult to draw any national conclusions over the effectiveness of 'family support' as a sector.

While we want to encourage local providers to continue to use their own tools that work for the families they support in their local areas, Adfam is also interested in understanding what the common outcomes are which support families, providers and commissioners to improve family support. So this month we are hosting consultations with different audiences to understand their thoughts on common outcomes for families and seeking to get some idea of what a good outcome model should include.

One of the other focuses is to show that a service saves money or that it creates a greater amount of value than the investment, which is why many organisations are interested in Social Return on Investment Evaluations (SROI). It is a type of cost-benefit analysis that uses outcome measurement tools and helps organisations communicate the social value they create. Adfam commissioned our SROI research to provide an independent evaluation of family support services, using an established and proven assessment model to help commissioners and funders make more informed decisions. The research also looked at the SROI that Adfam's guidance and infrastructure support provides to family support sector.

Key findings include:

- ***Overall the value created by the family support service is more than £240,000. The total investment in the service is £52,000 which gives an SROI ratio of 4.7:1. This suggests that for every pound invested in the service, £4.70 of social value is generated.***
- ***The highest outcome values were generated through health and wellbeing benefits for the family member (£54,974) and reduced impact on the criminal justice system (£50,984).***
- ***The structured family support service provided the following outcomes to family members: improved health and wellbeing; improved household finances; increased knowledge and understanding; increased confidence; improved coping skills; and enhanced ability to set and keep boundaries in the family.***
- ***Adfam's own services achieved a SROI ration of 2:1 – saving the state £2 for every £1 of funding it receives.***

We believe these results show the effectiveness of family support and the value it can create in a local system. Now we just need to convince the local decision makers.

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

In the sixth part of her story, Marie picks herself up from her lowest ebb and grabs hold of life

My journey of self-discovery

SO THERE I WAS, emotionally unstable, vulnerable – and in custody. By teatime I was in HMP Style. I phoned home and Joseph answered the phone: 'Mum are you OK? Where are you? Shall dad come and pick you up?'

'No son, I'm in jail.' He was a 15-year-old boy, reassuring his mum. I spent Christmas away from my children, as well as their birthdays. Self-harming was one of my daily rituals to cope with the pain inside. But something kept me going – my neuro-linguistic programming (NLP) books and coaching. When I came home the family had a surprise party for me and I finally knew the true meaning of home.

It was 2009, and it had taken me 18 months to rebuild myself and finally get the courage to go back to college. It was there that I witnessed how learning can change people, increasing their self-esteem and connectivity. I realised I didn't want to be a corporate coach, but a life coach NLP practitioner in the health and social care sector. I enrolled back on the course I had started two years ago, my legs like jelly, not knowing if they knew that I had been to prison. But my legs kept walking, as I knew I had to be there.

I was met by people who felt the same and that gave me comfort – I realised that feeling alone and worried in certain situations was just a normal human response, regardless of any issues with substance misuse or mental health.

I thrived at college, even though I struggled with some aspects. My narcolepsy was really bad and it was diagnosed as sleep apnoea. It was so severe that I would have to have naps in college – I would put chairs together or get under the table and sleep. I also had carpal tunnel, but I was determined, with an insatiable appetite for learning, so I was allowed to use a computer from college that had voice-recognition software.

I started voluntary work, first as a learning guide, then a mentor, then community learning champion. My life was growing at such a rate and internally I was becoming whole again, becoming part of something – my community and college had such positive effects on my wellbeing. My enthusiastic approach really seemed to connect with people who had barriers to learning and I embraced all my voluntary roles while preparing to do my coaching qualification.

I passed my course and soon registered on others – I certainly had the learning bug. I was doing counselling, mentoring, developing as a community learning champion, NVQs, coaching, voluntary work… and I also had a busy family life. My recovery seemed to be last on the list, as in my eyes I was OK.

At this point, something clicked inside my head. I had had no intention of coming off methadone and didn't see it as a problem, but I started noticing people in recovery. A lot of people I started out with all those years ago had sadly passed away, but the few who were left were making really positive changes in their lives and were productive, happy members of our community. While working as an employability coach I felt a bit of hypocrite – although I did my job extremely well, as was shown by my being nominated for a volunteer of the year award.

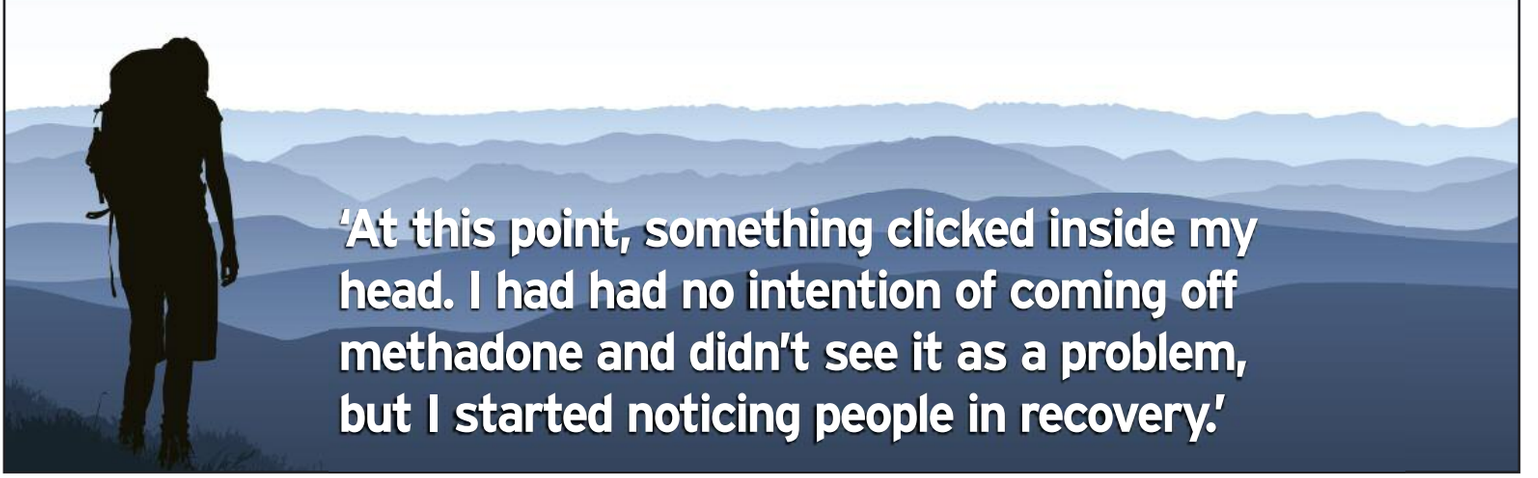
I decided to finally let go. Yes I was terrified – methadone had been my best friend and worst enemy, all in one. I would not recommend this to anybody, but I wanted to do it on my terms. I got from 100mls down to 50 – and returned more than 6000mls back to the chemist – then from 50 to 7.5 by Christmas 2010.

The last two years have been a rollercoaster. I graduated in advice and guidance and saw the proud faces of my mum, sister and husband. Just before we were due to hand in our portfolios, my tutor arranged for me to have an educational psychology report, which found I was dyslexic – my counselling tutor had always said my verbal understanding was exceptional but my written work was like a bull in china shop!

I was unaware of the stress of these changes creeping up on me. My recovery should have taken precedence over everything, including my studies and voluntary work. I needed some time out, to heal, and discover who I was.

I started to go to SURF, a local service user group, and got the opportunity to go to the DDN/Alliance national service user involvement conference. I heard Annemarie Ward and Alistair Sinclair speak; they spoke from their hearts and reflected the underlying current of change, which really awoke real passion in me. The atmosphere was fantastic and I met some amazing people with similar aspirations – we were just people. It's this shared understanding that has been instrumental in my recovery.

Next issue: In the final part of her story, Marie looks to the future



CANNABIS CLASS

With cannabis problems more prevalent than ever, Edinburgh charity Crew has devised a masterclass to share knowledge. **Fergus Boden** reports

Why are there are so few opportunities to learn about cannabis when it is the most widely used illicit substance and referrals for treatment are rocketing? Crew held a cannabis masterclass to discuss cannabis use and treatment today, including the increasing number of referrals, the content of substances and the role of synthetic cannabinoids.

The masterclass grew out of discussions between Dr Adam Winstock, a consultant psychiatrist, addiction specialist and founder of the Global Drug Survey, and Crew staff, who put forward the idea at Crew's National Substance Use Symposium (CREWSUS) in March 2012. With 130 people attending from various backgrounds, Crew hope it can now be rolled out through the rest of Scotland and the UK.

Dr Adam Winstock launched the plenary, explaining some of the scientific differences between hash, traditional herbal cannabis and the dominant high potency forms known as skunk. His presentation questioned whether people knew the strength of what they were taking: 'It's not like going to the bar and saying I'll have a pint of lager or a double scotch and knowing you'll get roughly the same amount of active ingredient.'

He also touched on one of the other recurring themes of the day – the development of synthetic cannabinoids and the comparison between these and cannabis. Adam gave an insight into people's perceptions of synthetics as 'more likely to affect memory, cause paranoia and be more harmful to lungs,' and highlighted research showing that 93 per cent of people who used substances would still prefer cannabis to a legal high.

The next speaker, Crew's Katy MacLeod, addressed some of the matters surrounding recreational drug use. She gave insight into how cannabis was one of the most common substances used by Crew's clients and spoke about some of the problems a recreational user might face. Katy also explained some techniques for reducing the effects of cannabis use, such as setting S.M.A.R.T goals with people, helping them track their patterns of use and identifying triggers.

Synthetic cannabinoids were the subject of Dr Malcolm Bruce's presentation. He shared his concerns that synthetics hadn't been around long enough for anyone to pass judgment, but said they had a less credible track record than cannabis and, like so many novel drugs, were promoted to get around the law and be marketable to young people. He warned that the current approach to making these substances illegal was prompting the creation of new, potentially more dangerous, synthetics to get through loopholes in the law.

With levels of referrals for cannabis-related issues going up – despite this year's Global Drugs Survey showing no rise in the number of people using the drug – it was no surprise that the help available for people using cannabis became one of the biggest topics of the day.

A panel of service providers and psychiatrists offered their insights. Dr Adam Winstock gave a medical view on how to manage cannabis withdrawal. The take-away message was to encourage clinicians to defer the diagnosis and prescription of antidepressants until the person had been off cannabis for two to three weeks, because they often didn't need these medications, and early side effects of some drugs – such as SSRIs like Prozac – could worsen cannabis withdrawal. He reminded people that the cannabis drugs meter (www.drugsmeter.com) was a simple way for people to think about their use and harm reduction.

Dr Malcolm Bruce explained that while some people using cannabis did present themselves to NHS cannabis services, the numbers were low, which was why the role of service providers like Crew was so important in filling the gap.

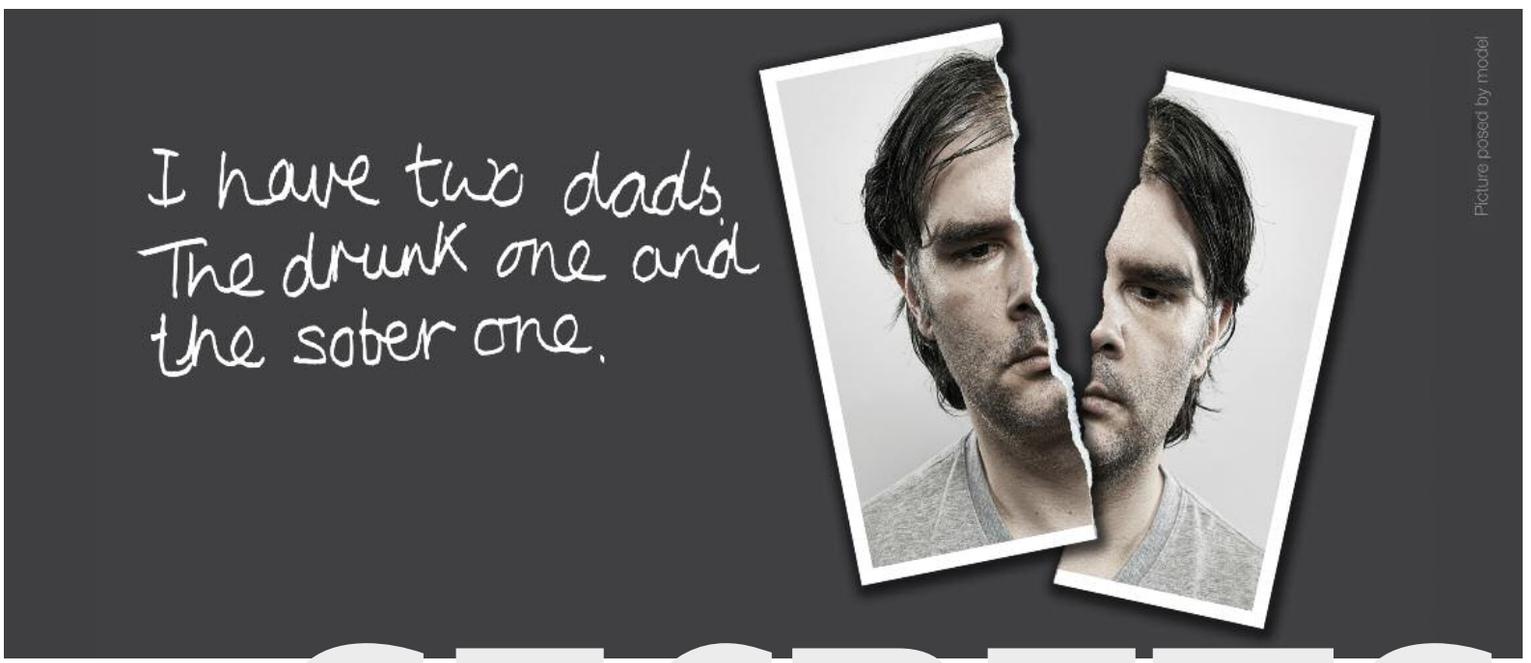
The final presentation of the day came from Mike Linnell, director of communications for Lifeline, who gave some of the history of the media's reporting of drug use – including its tendency towards hysteria.

One of the main aims of the event was to bring together people from different backgrounds to discuss some of the issues they faced and find ways to deal with them, and interactive workshops – such as Lisa Waiting's session on cannabis and young people – were beneficial in this respect. Information sharing and networking were equally important and Crew hopes to offer a limited number of cannabis masterclasses across the UK over the next 12 months.

Fergus Boden is a final year PR & marketing student at Queen Margaret University, Edinburgh, currently on a placement with Crew. Crew is an Edinburgh-based charity which offers non-judgemental support, advice and information on drugs and specialises in support relating to non-opiate substances.

Crew Substance Use Symposium (CREWSUS) is in November in Edinburgh with keynote speaker Fiona Measham. To book a place, or to host training in your area, contact CREW – www.mindaltering.co.uk

Photos by Cordelia Toennies.



HOME SECRETS

With National Children of Alcoholics Awareness Week held this month, **Emma Spiegler** urges us to tackle the silence, secrecy and stigma faced by many children and young adults

For many young people, feeling desperately alone comes with the territory of growing up with a parent who has an addiction to alcohol and/or drugs. Life is lived on a constant edge, as children try to work out when their parent is next likely to embarrass them, when their dad will lose his job again, when mum might leave the cooker on – and for some, when the next push, punch or tirade of abuse will come in their direction.

The usual teenage worries fall to the bottom of the priority list when it comes to what they wish for, and how they see their future. The number one wish for many young people will be for their parent to give up an often long, painful, and self-destructive cycle of misusing alcohol or drugs. As we know, it's no easy feat to give up an addiction, and more often than not it requires professional support and ongoing aftercare, not to mention the parent recognising they have a problem and having a desire to get help. Children, however, may see things differently.

Through a child's eyes, when dad tells his son that he is a 'complete and utter nuisance' and that he 'wishes he had never been born' on a daily basis, the young boy may spend much of his time wondering where he has gone wrong and what he can do to make things better, thinking this might give his dad a reason to stop drinking.

A recent case study is all too typical. A young boy aged 11 (let's say his name is Joe) loves his dad. He looks up to him and enjoys being taken to football every Sunday. After football, Joe's dad goes to the pub and comes home at 2am, then wakes Joe up to tell him how much he loves him. Joe then finds it confusing in the mornings, when he asks dad for the milk, and his dad then shouts at him to 'get it yourself you lazy shit'. Joe's mum doesn't seem to want to talk about dad's drinking. Her response to the regular drunken 2am wake-ups is to just ignore dad and go back to sleep. So in Joe's eyes, there's no big problem here at home.

But Joe often lies awake at night hearing mum and dad argue about the bills and dad's drinking. He sits at his school desk wondering if mum will really do what she said, and leave the family home. A heavy burden is on his shoulders, and yet he is not sure why he feels the way he does and who he could talk to. For these young people who do know what the problem is, and are aware that their parent has an addiction, they will often keep this family secret hidden behind closed doors.

Telling a friend or teacher that their mum or dad is an alcoholic is unthinkable and the shame and loyalty to their parent keeps them silent. To tell isn't an option because of the fear of being 'taken away' by social services and because mum and dad have told them not to, or they might suffer the consequences. Telling isn't an option because the unspoken law in the alcoholic home is not to tell, not to talk, and not to trust.

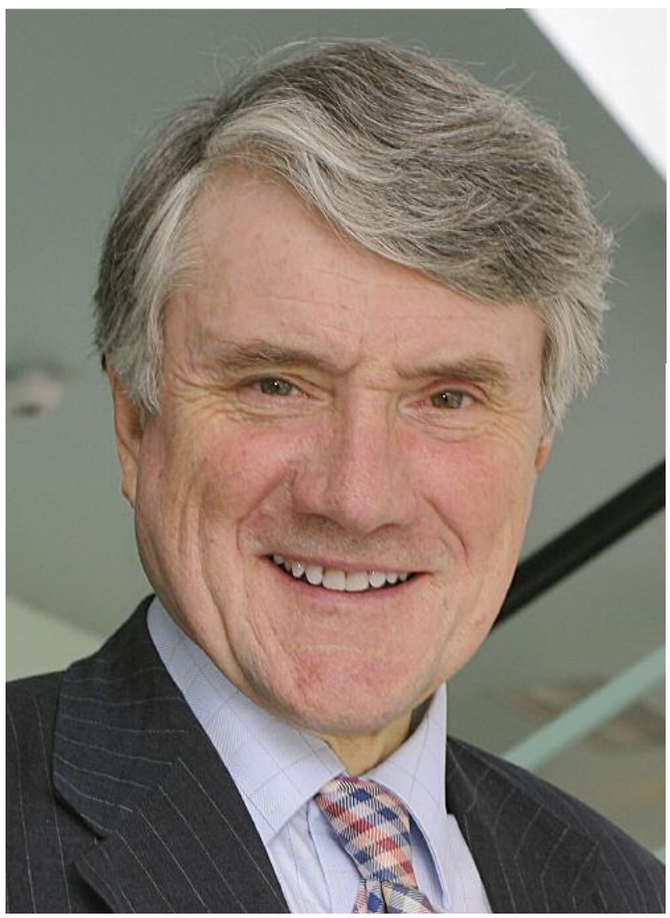
Sometimes there seems nowhere to turn. One 16-year-old, contacting NACOA, said: 'I'm alone in the house with my sister. Mum and dad have just left, they had a massive fight. Dad has been drinking. He always drinks and then hits us and says it's our fault and that he wishes we hadn't been born.'

The annual National Children of Alcoholics week is from 10 to 16 February. Set up by the National Association for Children of Alcoholics (NACOA), it brings together organisations such as Children of Addicted Parents and People, and Active Europe, to raise awareness of the 2.6m young people affected by parental alcoholism. As professionals we can take this opportunity to put up posters, hold events and reach out to young people who are afraid to talk and may not know what the problem is.

Emma Spiegler is founding director of Children of Addicted Parents and People (COAP).

COAP will be running a school poster campaign throughout 2013 with the support of Libertine London. Saying the Unsaid, an event to raise awareness of parental alcoholism and addiction, will be held on 15 February in London. For more information email info@coap.org.uk and visit www.coaweek.org.uk for more information about COA week.

A heal



Alan Maryon Davis has spent his life in the public health arena. As Public Health England prepares to oversee drug and alcohol service provision, he talks to **David Gilliver**

This April will see oversight of drug and alcohol services pass from the NTA to Public Health England, the advent of which, according to chief executive Duncan Selbie, is the 'opportunity of a lifetime to make health and prevention everyone's business', (*DDN*, December 2012, page 11). As honorary professor of public health at King's College London, does Alan Maryon Davis think that's realistic, or hyperbole? 'It's good to see him being so optimistic,' he says. 'But it is a new beginning and I think, although it's a mainly structural change, there are some opportunities there, so let's think positively about it.'

As an ex-director of public health himself – for the London borough of Southwark – does he feel the worries that drug and alcohol services won't be a priority for many of those directors, when it comes to dividing up the money, are justified? 'Yes,' he says. 'I was chairing a seminar just the other day where there was great concern about how much would be left for drug and alcohol services after various other big bites are taken. People were concerned about the patchiness across the country, because while there may be some guidance coming from the centre, a lot of it is down to local determination now.'

Given that, how should services be making their case at local level? 'The case has been made many times, but they should be basing their appeals on the health harms and longer-term costs of not dealing with problems, and there's also, to some extent, the criminal justice impacts. The trouble is, of course, that you've got short-term budgetary concerns and these massive cuts in local government funding that are going to continue for the next few years – there's not much light at the end of the tunnel.'

Despite the 'very strong' arguments, many councils are now making those big cuts, 'not only to the directly-provided services, but also to their funding of voluntary services, which is going to have an impact on drugs and alcohol', he continues. Alongside this is the huge NHS restructuring programme instigated by Andrew Lansley – 'a very unfortunate, not to say potentially highly risky manoeuvre, the wrong policy at the wrong time,' Maryon Davis states. 'But it's happening so there's no point crying over spilt milk. The important thing now is to try to make best use of it, for the health of the people. I think moving public health into local government is a good idea, because it does link up with the wider determinants like housing, employment, education, social care and all of that.'

While he sees Public Health England as a potentially useful organisation, as a long-term public health practitioner he's mystified by the decision to dismantle and merge the Health Protection Agency (HPA). 'That was a great success, very highly regarded nationally and internationally, and now it will be absorbed into this new body, which of course won't be a quango but a branch of the Department of Health. So all of these people are being pulled into the civil service to be part of this massive government department.'

Where the 'glass is also potentially half full', however, is that the Department of Health will be connected with what's going on at local level and 'the whole health protection machinery in a very direct way', he says. 'But the downside of course is that they're civil servants, and it will be politically driven as well as based on the science.'

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Before making the move over to public health, Maryon Davis trained at St Thomas's Hospital. 'I was one of those nerdish kids that used to pore through encyclopaedias

thy attitude

and books about human biology,' he says. 'I was interested originally in being a hospital doctor, a rheumatologist.' That was before his 'light-bulb moment', however. 'I was cycling along the Walworth Road and I saw a plaque on the wall of a local government building that said "the health of the people is the highest law" – a famous quote from Cicero, although I didn't know at the time. I got interested in public health and the whole business of prevention, so I switched from clinical medicine to social medicine, as it was then called.'

After ten years at the Health Education Council he helped to set up the National Heart Forum and Heartbeat Wales, before going on to head up public health in Southwark. He's also well known for his appearances on TV, Radio 4 and LBC, as well as the weekly doctor's column he wrote for *Woman* magazine for 17 years and several books on health issues.

These days he chairs a charity called Best Beginnings that works to reach underprivileged parents through social media – 'obviously alcohol and drugs are very relevant to that,' he says – and is a trustee of Alcohol Research UK, which gives out around £500,000 every year to fund research into reducing alcohol harm.

On that note, the government's consultation on minimum pricing closes this week – despite opposition in the cabinet and threats of a legal challenge from the industry does he think we'll see a minimum price implemented in England? 'I think we will – there are ways around the EU rules and regulations, and I think a pressing public health benefit is an important aspect that might let us get round the legal objections. The Scots are pretty optimistic that they can see this through, and I think England and Wales will follow pretty quickly, with Northern Ireland interested too, but obviously there's a big issue about the price.'

Would he be happy with the 45p the government seems to favour? 'I think 50p's more sensible, and a key issue is obviously to try to prevent cross-border differences. It would be kind of crazy to have Scotland at 50p and England and Wales at 45 – it just wouldn't make sense. The objection that's often been raised is that it would be penalising sensible drinkers who are less well off, but the difference between 45 and 50p would be pretty small in that respect.'

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According to the chief medical officer's annual report, deaths from cirrhosis and chronic liver disease rose by 20 per cent among under-65s in England between 2000 and 2009, at the same time as they fell in 14 other EU countries (*DDN*, December 2012, page 4). Is part of the problem simply that there's an ingrained drinking culture here that will be very hard to change, no matter what legislation is imposed, and the industry will always do its best to exploit that?

'There certainly is a culture that will be hard to change, but people focus on the drinking culture among the young – there's also a pretty big marketing exercise aimed at older, more staid people tippling quietly in front of the telly with a bottle of wine,' he says.

'At the moment the government proposes "working with" the Portman Group or advertising standards, all very loosely worded, all sort of cosy and not making any real impact. Although there's some self-imposed regulation around TV advertising, that's not great and there's still ways to get through those loopholes, but there's really nothing much at all around social media. That's where the big growth area is in marketing – along with all the sponsorship and partnership stuff around music venues – pushing the brands, creating the image that alcohol makes you glamorous and sexy and successful and all the rest of it. We need to find ways of getting into that.'

'People focus on the drinking culture among the young – there's also a pretty big marketing exercise aimed at older, more staid people tippling quietly in front of the telly with a bottle of wine.'

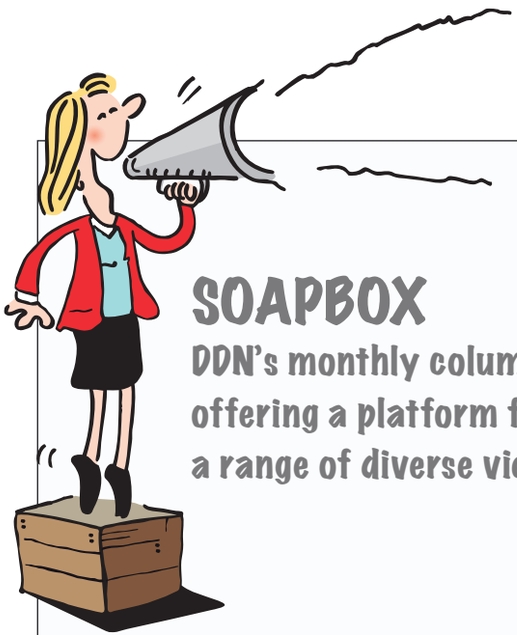
Speaking of marketing, what did he make of the 'responsibility deal' with the industry? (*DDN*, April 2011, page 4). 'Too slow, too soft, and they're only negotiating with part of the industry, anyway – OK there are quite a few big players in there, but there are quite a few who aren't in that negotiation. I don't think it's the right way to go about it.'

Does it help that the media can often misrepresent the issues, as happened to some extent with minimum pricing? 'The difficulty is getting the balance in there, and getting the press to cover the boring facts,' he says. 'The journalists who do actually take an interest on the whole try to look at it as responsibly as they can – the problem then lies with the editors who decide what stories they're going to give prominence to. It's very hard to get them to change their tune because obviously they're trying to sell papers and get the online hits.

'What the health lobby can try to do is get the stories out – from research, conferences and seminars, reports and reviews – which do provide the balance and the evidence to counter the other stuff. You just hope that it gets picked up.' **DDN**

alcoholresearchuk.org

www.bestbeginnings.org.uk



SOAPBOX

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

ROAD TO RUIN

The puritanical recovery agenda is stigmatising, marginalising and endangering the health of people who use drugs or have a maintenance script, says Dr Eliot Ross Albers

For some time now the drug using community in the UK has been in a state of heightened alert and significant concern triggered by the government's 'recovery agenda'. This was first heralded by the launch of a document last year, bearing the logos of eight the major interior ministries including the Department of Health and Home Office, entitled *Putting full recovery first* – a document that has come to be known as the 'recovery roadmap', given that it described itself as a 'roadmap for building a new treatment system based on recovery.' Notable too is that the document not only insists on abstinence from substances that are causing the individual problems, but is also explicit in defining recovery as abstinence from all psychoactive substances – including substitute prescriptions.

At a recent conference I asked Duncan Selbie, the head of Public Health England, if he could provide any guarantee that those of us who are in receipt of maintenance prescriptions of opiates would not be arbitrarily forced to come off them (*DDN*, November 2012, page 12). In spite of insisting that drug services will 'follow the evidence', Selbie kept on insisting that: 'Methadone support is a well-established contribution to recovery. What I would like to have is a broader contribution about how we can help people go beyond that... We will be concerned about rehabilitation, which isn't the end point, being maintained on methadone.'

This, to say the least was not reassuring, but was entirely in keeping with a dominant theme of the government's recent rhetoric in which 'recovery' has been conflated with full abstinence and in which an 'urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another' has been identified as the key objective.

Indeed, the only indicator of success that drug treatment services will have in the new Public Health Outcomes Framework is the number of people exiting services: 'ultimately payment will be made for full recovery only.' They will lose these payments if people relapse and re-enter services within a given time period. In other words, the metric by which the success of future drug treatment services will be measured will be the speed with which they can get people off prescribed medications.

Furthermore, under the new Payment by Results (PbR) system which relates to the ring-fenced treatment budget, boroughs will only receive 100 per cent of their budget if they maintain steady levels of clients exiting services over a 12 month period; failure to do so will result in a budgetary cut. These moves trivialise the complexities of drug dependence and completely overlook the frequently attendant co-morbidities. Such a financial incentive could very well lead to the exclusion of people who are neither ready for, nor seeking, abstinence. This approach furthermore minimises the importance of such proven public health measures as needle and syringe programmes (NSP), HIV treatment and testing, comprehensive hepatitis services, and overdose prevention.

Whatever one's views on the value of the use of the term 'recovery' (I personally do not find it helpful, as I do not see habitual drug use as an illness to be recovered from, but rather a behaviour that people engage in), the insistence that the only satisfactory or successful outcome of an engagement with drug dependence services is abstinence is unrealistic and contrary to the well established evidence enshrined in all internationally accepted guidelines, including the UK's own clinical guidelines. These documents all recognise that opiate maintenance programmes

may need to be continued indefinitely – for as long as the individual concerned finds it helpful. You can search the literature for as long as you like, but nowhere will you find a clinically valid argument suggesting that OST only be provided for a time-limited period.

Since the release of the 'recovery roadmap' there has been a slew of further publications, with varying degrees of government backing, many of which have sought in various ways to disavow some of the more extreme positions taken by the former. Notable among such documents is *Medications in recovery: re-orientating drug dependence treatment* by John Strang and colleagues, which back-pedals considerably from some of the more blatantly ideological positions taken by the 'recovery roadmap'. It disavows the notion that OST should be arbitrarily time-limited, instead insisting that services 'ensure exits from treatment are visible to patients from the minute they walk through the door.'

Because of the crucial indicator embedded in PbR, as discussed above, many will be discouraged from entering into OST programmes. For many people who are experiencing problems with their drug use, knowing that they can access OST has long provided a crucial life raft of stability. This new agenda punches holes in the life raft and seems to be predicated on the notion that one has to jump, or be pushed, off of it as quickly as possible. The risks of doing so are enormous, not least of all in terms of the dangers associated with relapse, notably overdose, destabilisation, and increased vulnerability.

The consistent messaging has been that, as Duncan Selbie put it to me, 'being maintained on methadone' should not be seen as the end point. However, for many of us, all that we want, all that we need, is to be secure in the knowledge that our scripts will not be terminated on any grounds other than that of a mutual agreement to do so, and even then only in a carefully managed reduction schedule. Those of us who want and need nothing more from our drug services than respect, dignity and a maintenance script are being told very clearly by this government that our lives are less valid, that our choices are less legitimate, and that unless we knuckle under the cosh of a state-imposed notion of sobriety, abstinence and temperance, that we will have our benefits taken away, our children removed, our housing and employment threatened.

Selbie's comments reiterated the moral imperative contained in the *Putting full recovery first* document, which, prefaced by Lord Henley, was guided by the notion that 'our ultimate goal is to enable individuals to become free from their dependence fully and live meaningful lives.' The notion that those of us on pharmacotherapies cannot live 'meaningful lives' is an insult to the many tens of thousands of us who are on long-term maintenance scripts, who are accessing harm reduction services, and are, at the same time, succeeding professionally and personally. Equally this agenda does nothing to give confidence to those who rely on them that friendly, comprehensive harm reduction services will be available and properly funded.

The agenda is highly irresponsible in its attitude towards needle and syringe programmes, stating that 'it is self-evident that the best protection against blood-borne viruses is full recovery.' This statement flies in the face of the well-developed, internationally accepted evidence base that shows that the provision of comprehensive needle and syringe programmes is the most efficacious means of preventing blood-borne virus transmission among injecting drug users. Equally, the same evidence base demonstrates that for many, accessing NSPs is often the route out of illicit drug use and into pharmacotherapy programmes.

The new recovery agenda – with its marches, boat rides, right-wing Christian overtones, Russell Brands and happy-clappy 'recovery champions' – silences, stigmatises and further marginalises those of us who are either active drug users or are stable on maintenance scripts. It demeans our choices and denigrates our successes, and it does so on the basis of a disregard for the overwhelming body of evidence that recognises the complexity of drug dependence, and demonstrates the vital need for comprehensive harm reduction services. These services must cater for the drug-using community in all of its diversity, and not through a 'one size fits all' puritanical agenda. If there has ever been a time for the drug-using community to come together in defence of harm reduction, it is now.

Dr Eliot Ross Albers is executive director of the International Network of People who Use Drugs (INPUD)

POLICY SCOPE

Is recovery pushing harm reduction off the drug policy radar, asks Marcus Roberts

OFF THE AGENDA?

I attended a roundtable meeting on HIV and injecting drug use at City Hall in London in January. It was hosted by the National Aids Trust (NAT) and I was struck by an observation from the chair at the beginning of the meeting. He said that he had yet to receive an invitation to a discussion of the future of harm reduction hosted by the drug sector, as there didn't appear to be much activity around this agenda.

Leaving aside the specific debate about the role of opiate substitution treatment, I can see how someone external to our sector could get the impression that 'harm reduction' is slipping off the drug policy radar. Has an increased focus on 'recovery' been at the expense of 'harm reduction' perhaps? This is too simplistic. For example, the second of eight 'recovery outcomes' in the *Drug strategy 2010* is the 'prevention of drug-related deaths and blood-borne viruses'. The lack of discussion of services like needle exchange may actually be because their role in treatment systems is all but universally accepted. There may be a Maslow's Pyramid effect – the harm reduction legacy appears secure and so we move on to other kinds of needs, like relationships, housing, education and employment.

Two of the main messages from the NAT meeting should help to put harm reduction more firmly back on the drug policy agenda. First, there are new harm reduction challenges. For example, there is growing concern about high-risk drug use and sexual activity among some sections of the gay community, including injecting of drugs like methamphetamine. This is not a group who would necessarily access traditional drug services, including needle exchange. Similarly, DrugScope's annual street drug survey identified a growing cohort of people injecting mephedrone. Steroid use remains an issue, as, apparently, does the sporadic phenomenon of young women injecting melanotan, reported at the NAT event.

Secondly, what will be the impact on harm reduction of radical changes in commissioning structures in a period of austerity. While it was recognised at the NAT meeting that harm reduction could be a good 'fit' within a public health framework, the rise of localism raises some fundamental issues about mechanisms for ensuring an adequate level and standard of potentially life-saving services for people with drug and alcohol problems.

Bluntly, as someone asked at the NAT event, what are the safeguards to prevent a local authority from discontinuing or rationing access to needle exchange services? Hopefully this won't arise, but what if something like it did? One possibility, incidentally, is that the decision could be challenged using the NHS Constitution. DrugScope has just submitted a response to a consultation on strengthening the NHS Constitution. But how many users of drug services (or staff) would realise the NHS Constitution was relevant to them?

DrugScope's response to the Department of Health's consultation on *Strengthening the NHS Constitution* is on the DrugScope website at www.drugscope.org.uk

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

swanswell

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We're looking for talented and motivated people to work with our managers and workers in Leicestershire and Rutland, covering Loughborough, Coalville and Hinckley. The most important thing you'll bring to this role is your desire and ability to make a positive difference to people's lives. You'll also have the opportunity to contribute to the strategic aims of the organisation by managing projects across the whole organisation.
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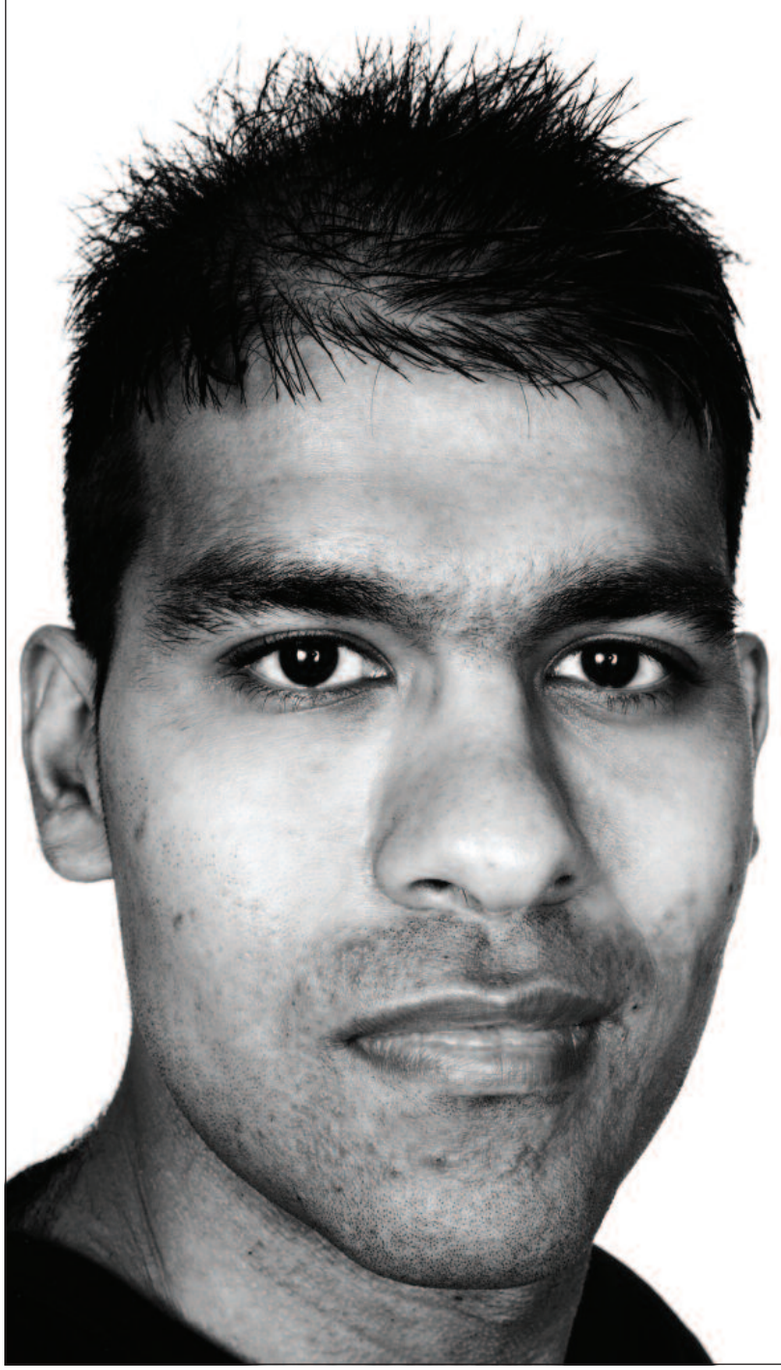
MY TURNING POINT

"It was when an outreach team came right to me to provide the help I needed."



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