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Death of a service *How a pioneering agency went to the wall*



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Druglink

All change

As we announced in the last issue, *Druglink* editor Max Daly has left DrugScope, leaving me in the hot seat as the new editor. But as you will see in this issue, Max will continue to write for the magazine on a freelance basis.

The new arrangements and the New Year give us an opportunity to try out some new ideas. So in this issue, we are introducing a feature called *The Druglink Interview*. We kick off with former drugs minister Bob Ainsworth MP. If you have any ideas for people you would like to see interviewed by *Druglink*, please let me know.

Also in this issue, we are starting a research feature in association with Drug and Alcohol Findings, of which DrugScope is a founding partner. The idea is to feature new research around a topic as well as reminding us of research which although published maybe years ago, is still relevant today.

Starting this month, we begin the process of making the *Druglink* archive available on the main DrugScope website, although the previous six issues (a year's worth) will remain only accessible by DrugScope members. Over time, we aim to have a complete digital archive going back to the earliest days of *Druglink* with an enhanced search facility. Finally, substantive articles by DrugScope staff are now available as free downloads.

Which just leaves me to wish all our readers a peaceful and healthy 2012.

Harry Shapiro

Editor and Director of Communications/ Information

Cover illustration: Kelly Dyson

DrugScope

DrugScope
Prince Consort House
109–111 Farringdon Rd
London EC1R 3BW

Telephone
020 7520 7550

Email
info@drugscope.org.uk

Web
www.drugscope.org.uk

Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

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DRUGLINK STAFF
Editor Harry Shapiro
Editorial Assistant
Ruth Goldsmith
Online Jackie Buckle
Book Reviews Editor
Blaine Stothard
Director of Communications and Information
Harry Shapiro

ADVERTISEMENTS
Email:
harrys@drugscope.org.uk
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CONTRIBUTIONS
Druglink welcomes letters and other contributions. Send direct or contact Harry Shapiro
Email:
harrys@drugscope.org.uk

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■ Danish reform moves

Copenhagen's City Council recently voted to launch an investigation as to how cannabis could be fully legalised and then sold and taxed like alcohol. A similar proposal received the backing of the city's mayor in January 2010, but was blocked at a national level. However, this time, there appears to be enough parliamentary support to take the proposal a step closer by a rewriting of Denmark's current drug policy. The idea is still likely to meet with stiff opposition from many of the country's ruling centre-right Venstre party, like Martin Geersten who told the Jyllands Posten newspaper, 'we strongly urge Frank Jensen as the country's former justice minister to stop this crazy proposal'.

■ Not so good to talk

Charities who rely on public sector funding fear their independence is being eroded according to a new report, *Protecting independence: the voluntary sector in 2012* produced by a panel comprising academics and senior charity professionals. Following a consultation exercise, the panel found that the charities with the highest level of concerns about independence were those in receipt of most public funding because they were caring for some of the most vulnerable groups in society including those with drug and alcohol problems. The report highlighted the danger of these charities becoming 'not for profit businesses, virtually interchangeable with the private sector'. If that happened, the authors warn, 'the term 'independent voluntary sector' could cease to have any meaning.

To read the report go to: <http://www.independencepanel.org.uk/wp-content/uploads/2012/01/Protecting-Independence-final.pdf>

Drug workers strike threat

Staff at Lifeline's Hackney-based Tudor Grove Centre in east London are being balloted on whether to strike over a radical shake-up of the service. Speaking to *Druglink*, regional trade union representative Jamie Major of Unite claimed that all the staff were being told to reapply for their jobs at lower salaries. In a press release, Unite blamed the funder, Hackney Council, for pulling the plug on the support unit for the children of drug-using parents, the specialist womens' service and a counselling service.

However, *Druglink* has learned that while Hackney Council did ask Lifeline to look at ways in which the various services could be streamlined, it is Lifeline which has come up with the reorganisation. 'This is a provider-led initiative' says Lifeline CEO Ian Wardle.

He acknowledged that the service had become too top heavy, suggesting the need for fewer managers. However, he refuted the claim that services would be abolished, rather reconfigured to be more recovery-oriented.

"In all our communications to staff and to stakeholders, we have made clear that the structure of the service needed to change because a number of barriers to improvement had been identified which arose from the compartmentalisation of the current service structure. Also, we needed to change the structure and culture of the service in order to facilitate a much stronger recovery orientation for our beneficiaries.

"We don't believe that we can transform existing treatment services, with their too strong emphasis on prescription into genuine recovery-oriented services just by a series of nudges. Just changing the names of the existing jobs and calling the service a recovery service is not enough. We are keen to take as many of our existing staff with us as possible. We believe, not withstanding the genuine concerns about job security and conditions, that most of our staff are keen to come with us on this journey."

Russia rejects harm reduction

Despite having one of the world's worst heroin problems and highest rate of drug-related HIV infection, Russia still refuses to allocate funding to substitute prescribing. When UN funding for needle exchanges runs out during 2012, there will be no state replacement monies. Not that Russia is short of money; the budget for HIV prevention in 2012 will be £600m, double the sum allocated in 2010. One reason for an end to UN funding is that Russia is no longer the impoverished country it once was and now is actually a donor to the UN Global Fund to Fight AIDS as well as a recipient. The issue is how the money will be spent.

Speaking to Reuters, Alexei Mazus, head of the Moscow Centre for HIV/AIDS Prevention claimed that rates of HIV had increased in areas where foreign-run needle exchanges have operated. Instead, he said, the health strategy would be to prevent the spread of HIV through anti-drug adverts and counselling. There is much fear and anger among health workers inside Russia that once external funding ends, the problems will just get worse, a view supported by Damon Barrett of Harm Reduction International, who said 'it is a human disaster that Russian authorities are willing to watch unfold'.

Back in the day

On 7 January 1971, the ACMD convened for their first meeting. The original members included Bill Deedes, then a Conservative MP and later Editor of *The Daily Telegraph*, Bob Searchfield Director of Release, Baroness Wooton, whose

1968 cannabis report paved the way for the ABC drug classification and two of the country's leading addiction doctors, Griffith Edwards and Tom Bewley.

They met at the Home Office – in Room 101.

Cut to the chase

In a landmark case, three men were jailed in November last year on charges of conspiracy to supply controlled drugs following a three-year police investigation into the importation and supply of 36 tons of cutting agents for cocaine and heroin. There have been other cases involving cutting agents, but this is the first conviction that the Serious Organised Crime Agency (SOCA) has secured.

Between 2005-2008, Jamie Dale, using his Rochdale-based bio-fuels business as a front, along with John Cawley and Barry Hartley, imported benzocaine, paracetamol and caffeine from suppliers in India and China. These chemicals were then sold onto local dealers through connections of Barry Hartley, who was already a convicted drug dealer. Cutting agents are used, post-manufacture, to bulk out (usually) powder drugs. They may have a mild psychoactive effect in their own right (such as benzocaine), but are not the same as the precursor chemicals used in the actual drug production process.

According to the SOCA, the scale of the operation was so large that it was estimated that Dale and his co-conspirators were importing a substantial proportion of the world's total demand for benzocaine, used legitimately by dentists and vets.

In September 2008, when Dale's operation was in full swing, *Druglink* reported on police attempts to tackle the trade in chemicals used to cut or 'bash' cocaine. At the time, police were having



trouble making cases against cutting agent importers and wanted a licensing scheme to force importers to prove that large quantities of chemicals obtained abroad were for legitimate use. As the chemicals concerned are not illegal, the only charge that can be brought is conspiracy – and then the court has to be convinced that the chemicals would have been used to mix with illegal drugs. This partly explains why the case against Dale and the others took such a long time to come to court as the police strove to make this connection. According to a report in *The Independent*, a barrel that Dale had bought was found during a drugs raid in Bournemouth. From this, the link between Dale and the drugs trade was made by placing tracking devices in future shipments.

Industry revolt over booze pricing

The alcohol industry has reacted angrily to a report in the Daily Telegraph (27 December) that David Cameron has ordered officials to develop a scheme of minimum pricing for alcohol similar to that proposed for Scotland. Drinks giant Diageo claimed there is no evidence that such a move would be effective in curbing problem drinking, while SAB Miller branded the move as potentially

'illegal', as it could fall foul of European price fixing laws – a view shared by the government's Business Secretary Vince Cable. Speaking to the industry magazine *The Drinks Business*, Wetherspoons' CEO Tim Martin went so far as to say that 'should this prove to be an increase in tax for pubs, Wetherspoons will campaign vociferously to get Cameron and Clegg out of office'

■ Foil saga rolls on

In December 2011, the Advisory Council on the Misuse of Drugs (ACMD) replied to a request from the Department of Health (DH) about the dangers of smoking heroin. This was the long-awaited response to the ACMD recommendation of November 2010, that tin foil should be exempted from the provisions of Section 9A of the Misuse of Drugs Act which forbids the distribution of paraphernalia which could facilitate the use of controlled drugs. An exemption would allow drug workers to supply foil as part of a harm reduction programme. However the DH felt that it needed more information on the potential dangers of smoking heroin should foil be exempted. *Druglink* understands that a final decision on this can be expected within the next three months.

■ Dutch ban khat

Following on from the gradual reversal of its traditionally liberal policies on the use of cannabis, the Dutch government has outlawed the use of khat, the stimulant-based plant native to the Horn of Africa (see khat feature on page 22).

In a statement the government admitted that used in moderation, the drug would present little problem for the country's estimated 27,000 Somali population. But the statement went on 'an investigation showed it to be problematic among some ten percent of users' and there had been complaints about alleged anti-social behaviour by men under its influence.

In another development, from 1 May, only Dutch nationals will be allowed to buy cannabis from 'coffeeshops' in the south of the country.

Addiction courses closed

EXCLUSIVE

by Andy McNicoll

A series of university programmes offering specialist drug and alcohol training have been cut or suspended, a *Druglink* investigation reveals, with experts warning that the closures could widen skill gaps among new substance misuse workers and hamper the sector's workforce development ambitions.

A series of university programmes offering specialist drug and alcohol training have been cut or suspended, a *Druglink* investigation reveals, with experts warning that the closures could widen skill gaps among new substance misuse workers and hamper the sector's workforce development ambitions.

Degree programmes offering specialist drug and alcohol training to future drug treatment workers, social workers and nurses, have been suspended at a number of universities across England and Scotland. Universities and academic sources attributed the moves to a range of factors, including university budget pressures; cuts to student support grants; falling spend on courses as Continuous Professional Development (CPD) budgets dry up; changes to nursing education structures; and a lack of demand.

Drug charities and workforce leaders involved in the Substance Misuse Skills Consortium warned that cuts to specialist drug training courses could undermine the Consortium's efforts to boost the sector's skill base.

Carole Sharma, Chief Executive of the Federation of Drug and Alcohol Professionals and a member of the Skills Consortium, said:

'The Skills Consortium is looking to get a skills framework that will require people to have quite high level skills for parts of it, yet we seem to be losing some of the courses that will help provide that. We'll need people with differing skills and it's going to be really difficult if we end up losing university courses, and the skills of the tutors, along the way.'

Martin Barnes, DrugScope Chief Executive and Skills Consortium member, warned that drug workers are being asked to develop skills in 'recovery-focused' treatment at a time of intense budget pressures.

'It is therefore a matter of real



concern that much of the expertise built up over recent years in delivering addictions within higher education settings, along with the benefits these courses bring to the field and, in turn, to service users, will be lost due to the closure or suspension of these programmes'.

Academics have also expressed grave concerns at course cuts. Rowdy Yates, Senior Research Fellow in Scottish Addiction Studies at Stirling University said, 'we have this mythology that non-specialist professional training prepares people to work in the addictions field. But the truth is that in areas like social work, nursing and medicine, the amount that is taught in terms of addiction is miniscule. So it means we have a whole group of workers entering the field, entering practice, with no capacity to deliver good drug treatment outcomes.'

Druglink's investigation uncovered a series of course closures. At Stirling University itself, two nursing modules offering specialist substance misuse training were withdrawn in 2009/10. A University spokesperson told *Druglink* 'the course was discontinued due to low take up'. Sources close to the programme however disputed the University's view and told *Druglink* that the modules had exceeded their 'ceiling target' of recruiting 55 students every year. They

felt that 'financial reasons' lay behind the closure.

The University of Sussex has suspended its MSc in substance misuse after nine years. A University spokesperson said the course had become unsustainable after dwindling numbers of students signed up due to cuts in funding grants to support postgraduate study. Four students enrolled in the course in 2010, compared to 13 in 2008 and 10 in 2009.

The University of West London, formerly Thames Valley University, has slashed the number of substance misuse courses it offers from five to one in recent years. The University now only offers a 'final year top up' course in substance misuse to undergraduate students. Foundation degree, Masters degree and CPD level courses are no longer taught. A University of West London spokesperson said: 'We made the decision to incorporate all individual courses on this issue into one simpler course for all relevant students.' *Druglink* understands at least one specialist tutor has been made redundant in the process. A source close to the courses said: 'Our programme has been reduced to a skeleton.'

■ **Andy McNicoll** is a freelance journalist

The Recovery Partnership

The **Recovery Partnership** was formed in May 2011 by the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope, with the aim of providing a new collective voice for the drug sector to Ministers and Government. Building on the work of sector membership and umbrella bodies, the Partnership is able to draw on a broad range of organisations, interest groups and service user voices. A 'Statement of intent' for the Partnership's work can be found here: <http://tiny.cc/Rec-Par-Update-August>

In just seven months, the Partnership has demonstrated that there is real benefit in working together to overcome some of the deep divisions which exist within our sector. Having developed a credible and coherent collective voice through consultation and discussion with the sector on a number of key policy matters such as housing and recovery, Payment by Results, residential rehab and the Work Programme, the Partnership has put these views directly to government via meetings with the Inter-Ministerial Group.

Ministers have welcomed this work; in December 2011, the Partnership received a letter from the Group "to record the IMG's appreciation for [the Partnership's] contribution to IMG discussions following [the Partnership's] formation in May." The letter goes on to feed back on the impact of the Partnership on specific policy areas, and concludes that "the IMG are particularly interested in receiving reports that reflect the honest views and opinions of those working on the 'front line'." The letter is available to view here: <http://tiny.cc/IMG-letter-Dec-11>

Into 2012, the Partnership will continue to focus on the issues that matter to the sector, as we move towards the creation of Public Health England against the backdrop of an ever-changing policy landscape. Our sector will be stronger if we are united to greet the many challenges – and hopefully opportunities – that will come our way this year.



DrugWatch is a new network of UK agencies – including DrugScope – looking to establish an early warning system for drugs (see also the Factsheet on page 30). So what is the rationale?

Front-line staff who work with drug users often receive 'warnings' about drugs that are passed on by the police, hospitals and from one service to another. A warning could be about alleged 'rogue' batches of existing drugs like heroin or ecstasy or could be concerning new, often still legal substances about which little is known.

Although well-intentioned, these warnings are sometimes inaccurate and are nearly always unverifiable. Increasingly in this age of instant communication, warnings are supplemented with information cut and pasted from user forums or news outlets, without any way of checking the accuracy or appropriateness of the message. Also staff pick up information from drug users about new, 'bad' or adulterated drugs without any clear and consistent mechanisms for reporting this to other professionals or the clients themselves.

DrugWatch was set up to find a way of creating a system of practical use to drug workers and drug users. We are not aiming to supplant other, more official 'top down' early warning systems; rather the main aim is to provide information about new or adulterated drugs in a standardised, verifiable format that comes from a variety of sources: drug workers, drug users, drug forums, hospitals, police, drug analysis etc, as well as existing early warning mechanisms. We are also looking at ways of weighting and distributing this information and providing advice to the appropriate target group. A website is currently under construction, but for example *Druglink* will also carry information (mainly) on new substances that appear on the drug scene based on information collated and analysed by DrugWatch.

For information on the Recovery Partnership email Martin Barnes at martinb@drugscope.org.uk
For information on DrugWatch email Harry Shapiro at harrys@drugscope.org.uk

Long day's journey into night

How did a drug agency with a turnover of £5m go bust leaving less than £20k in the bank? Harry Shapiro investigates.

During the early afternoon of Friday 4 November, Nigel Eggleston, Service Manager at TH@W, a young person's project based in Clapham, south London took a call in his office. On the end of the line was a trustee from In-Volve, the charity which managed the project. The news was devastating. "I was told that the company had gone under," Nigel recalls, "and that I had to go and dismiss the staff and send them all home. We were all out of a job with no warning, no notice. I couldn't believe it, we were doing so well, hitting all our targets and building up really good relationships with all the other providers in the area."

The story was the same for an estimated fifty staff at In-Volve projects across the country, from the adult service in Newham to the young peoples' service in Trafford. Commissioners were left to put emergency plans into place to ensure that clients were not left unsupported. Thankfully, it would seem that interim measures were executed swiftly and responsibly to minimise the disruption.

One local authority did have strong indications of impending trouble however. In-Volve's jewel in the crown was the adult shared care scheme in Newham, east London, where the head office of In-Volve was based. Commissioners were sufficiently concerned about local rumours of problems to write formally to In-Volve in September asking for a copy of the latest accounts. What they read rang alarm bells, and they asked In-Volve for clarification of their game plan to

stave off what looked like impending insolvency. In-Volve replied that Plan A was merger, Plan B was closure. Soon after, however, and with only twenty four hours notice, In-Volve informed the commissioners that it was going into voluntary liquidation. By then, commissioners had alternative arrangements in place.

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In a letter to the charity's staff, the chair of the trustees, Alan Ruyten, laid the blame for the collapse squarely on external factors: "You will be well aware that the economic environment we operate in has seen dramatic changes. Despite the best efforts of Teresa Pointing and the...team, we have not been able to protect the charity from these changes. In-Volve has been struggling in the face of severe cuts in government funding, which have led commissioners to review all service provision and, in some cases, take services in-house. Some funding authorities and grant-making bodies have altered the way they administer their funds, leaving us unable to maintain the level of cash flow required to sustain our organisation. And what service providers are expected to deliver has also changed, making us increasingly

vulnerable to being underbid by larger organisations that are able to operate at minimal margins or even 'loss-lead' on contracts."

But while it is clear that the changing landscape for delivering drug treatment in England has made life increasingly difficult, especially for the smaller agencies, Druglink has learnt that staff had more long-standing concerns about the internal management of the organisation.

In-Volve began life in 1990 as the Newham Drugs Advice Project, focussing on work with young people, a dynamic and pioneering agency which one former staff member describes as being an 'exciting and supportive environment in which to work'. Under the leadership of Viv Ahmun and his deputy Colin Cripps, there was a willingness to be innovative and unconventional.

Over the years, the agency expanded from its east London base to other parts of the south east, the south west, Birmingham and Greater Manchester, while Viv Ahmun was also looking to diversify the agency's activities, at least in London, into areas such as tackling gang culture and gun crime. In 2008, he proposed that the agency, by then renamed In-Volve, should merge to increase turnover and also proposed selling their building to help build a war chest against what he saw as an increasingly challenging climate, in which In-Volve were already beginning to lose contracts. The most significant loss came when the young people's



service in Birmingham went to Lifeline. In-Volve had held the contract for nearly a decade. None of Viv Ahmun's proposals for the future of the organisation came to fruition and tensions built up between him and the Board. Ahmun resigned in 2008. The expectation was that Colin Cripps would take over as CEO. Instead however, the board appointed Dr Teresa Pointing, who had previously been brought in by Colin to oversee the agency's clinical governance obligations.

While Dr Pointing certainly ticked all the right boxes by boosting the agency's credibility among GPs in the Newham shared care scheme, senior staff had concerns that overall those at the top lacked the necessary strategic, managerial and financial experience for an agency whose turnover was now in the millions. One senior manager told *Druglink*, 'the managerial infrastructure

WE DIDN'T HAVE ANYBODY WHO COULD WRITE GOOD TENDERS, SOME OF THOSE THAT WERE GOING IN WERE NOT UP TO STANDARD... FROM A PROFESSIONAL POINT OF VIEW, IT FELT LIKE A MESS

was not good, managers had come up through the ranks and were resistant to change; we didn't have anybody who could write good tenders, some of those that were going in were not up to standard. And I gave up trying to understand the budgets across the different projects. From a professional

point of view, it felt like a mess.' This staffer suggests that there was an air of complacency within In-Volve derived from a belief that their long-term contracts were a shoo-in for renewal. However, the organisation came smack up against the new era of commissioning, with a fire-breathing NTA pushing hard on national targets.

All providers are at the mercy of the slings and arrows of outrageous commissioning – although where there are genuine concerns about performance and delivery, the decision not to re-commission a provider might not be so outrageous. But exactly who gets commissioned and why remains one of life's great mysteries. A new commissioner might come in and, just on a matter of principle, refuse to award a contract to a long-standing provider. The larger providers frequently lose

CLOSED

several long-term contracts in one city or area only to pick them up somewhere else at the expense of another provider. Smaller agencies like In-Volve are less likely to be able to stand such losses, although given the recent successes, for example, of Blenheim CDP and the Westminster Drug Project, being relatively small does not automatically put an agency at a disadvantage. That said, it can be especially galling to lose a contract when you know you are providing a good service. This happened to In-Volve in the London Borough of Merton. Nigel Eggleston, who had previously managed In-Volve's Merton-based Youth Awareness Project, explains. "We were so over-achieving it was ridiculous. We had our own building, about eleven counsellors, volunteers, outreach. They took it down to a tiny team with no office who had to go and beg a room so they could do some one-to-one work. It was only about £40k cheaper than what we were providing. It was a big contract; if it was about money, all they had to do was come to me and say 'save £40k' and I could have done it. Who knows why we lost that contract, although I think they were only interested in dealing with young people already in the system, those in care, being seen by youth offending team and so on."

In the words of one manager, in recent times, In-Volve were losing contracts, 'left, right and centre', but crucially without winning new ones. None were more important than the adult service in Newham, which appears to have been their biggest contract worth over £1m. In-Volve were one of seven providers delivering adult drug treatment in Newham when the tender came up for renewal at the end of 2010. The new commissioner, who had come in about a year earlier, was determined to shake the system up because the service was performing poorly against NTA targets. In particular, it was felt (rightly or wrongly) that too many patients were stuck in the shared care system for too long.

To try and address this, it was decided to reconfigure the service, adding two new elements; firstly a 'care navigation

assessment service' at the start of the treatment journey (essentially a key worker system) and a 'move-on' element at the end. In-Volve and other existing providers tendered for these extension services, but the contract went to a new provider, Foundation 66. So In-Volve kept their shared care contract, but its value was apparently almost halved, because there was no new money for the extension services – it had to come from existing funds. Inevitably, In-Volve lost staff: around twenty five transferred to Foundation 66 under TUPE arrangements.

THE NEW COMMISSIONER, WHO HAD COME IN ABOUT A YEAR EARLIER, WAS DETERMINED TO SHAKE THE SYSTEM UP BECAUSE THE SERVICE WAS PERFORMING POORLY AGAINST NTA TARGETS

Perhaps as a result of the bad news from Newham, or general concerns about the worsening state of affairs, in 2010 In-Volve took up again the idea of merger with a major provider. Talks collapsed early in 2011; another partner was sought, but talks again foundered, ultimately pushing the agency over the edge. *Druglink* has been unable to formally confirm who the merger partners were or why talks failed, but it would be a reasonable to surmise that with their backs to the wall, In-Volve were in no real position to dictate terms or even have discussions on an equal footing – and that any merger would in fact be a take-over. At the time, one senior manager expressed concern that a much larger provider would come in cherry-pick what was left and dismantle everything else. The manager was reassured otherwise, but in any case had become totally disillusioned with the organisation and resigned in mid-2011.

By this time In-Volve were reduced possibly to no more than five or six projects nationwide.

Presumably, the major providers engaged with In-Volve in talks thought that if agreement could not be reached, they could simply wait until In-Volve went bust and then tender for the services. In the commercially bruising environment in which service providers now operate, this is precisely what will happen during 2012.

A look at the latest set of published accounts for 2009-10 tells at least part of the story. *Druglink* asked the financial manager of another treatment provider to look at the accounts and imagine he was considering joining the board. What concerns would he have? He thought that there were too few trustees, suggesting a potential lack of the necessary skillset for an organisation with a turnover of £5m (a number of trustees left when Viv Ahumn resigned). He also noted that a number of projects were running at a loss, and that the head office building had been remortgaged presumably to raise funds, because it was clear from the accounts that cash reserves were dangerously low. In-Volve closed with debts approaching £350,000 and from the Statement of Affairs listing all their creditors, less than £20k in the bank.

By the cruellest of ironies, *DrugScope* had visited TH@W in Clapham almost four weeks to the day before closure. We were there for a media visit with actress Tanya Franks from *EastEnders* and the Robin Hood Tax Alliance, to show off TH@W as the sort of beacon project that could benefit from such a tax. TH@W was so successful that the local council had re-allocated money from other projects to boost its support. *Druglink* commissioned Nigel Eggleston to write a *Drug World Diary* to celebrate their success. Sadly, the story he would be telling now is very different.

Note: *Druglink* sent an email, left a phone message and wrote to the Chair of the trustees and also wrote to the CEO and former trustees. Nobody responded to the request for comment.



Substance Misuse Skills Consortium second national event

Building recovery in the workforce: developing an inspirational, recovery-orientated drug and alcohol workforce

14th February 2012 9.30am - 4.30pm

After the success of the Consortium's first national event, service managers, team leaders and other key treatment service staff are again invited to hear and share practical experience on how to deliver an inspirational recovery-orientated workforce.

There will be workshops on developing the recovery-orientated workforce that will deliver the aims of the 2010 Drug Strategy and support more drug and alcohol users to recover.

The one-day conference will explore the evidence base for treatment and recovery, and will also look at:

- How to translate evidence into practice
- How to implement new interventions
- How to ensure keyworkers have the skills to support recovery
- How the Skills Hub can support services in delivering a recovery-oriented service.

Speakers will include:

- Dr Ed Day (Senior Lecturer and Honorary Consultant in Addiction Psychiatry, Queen Elizabeth Psychiatric Hospital, Birmingham)
- Ian Wardle (Chief Executive, Lifeline)
- Christopher Whiteley (Consultant Clinical Psychologist, East London NHS Foundation Trust)
- Peter Burkinshaw (Skills and Development Manager, National Treatment Agency)

Practical workshops with leading experts will cover:

- Recovery focused keyworking
- Families and social networking
- Safeguarding the children of drug using parents
- Supervising staff for effective recovery.

The member's discounted rate is available to organisations who apply to become a member of the Skills Consortium. Please check that your organisation is not already a member before you apply – see the Skills Consortium website for an up-to-date list of members: www.skillsconsortium.org.uk

**Tuesday 14 February
2012**

Venue: Skipton House,
80 London Road,
London SE1 6LH

**£69 (plus VAT)
Consortium members
£92 (plus VAT)
non-members**

Supported by:


**National Treatment Agency
for Substance Misuse**



For booking form see:

www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/SkillsConsortiumConferenceBrochure.doc

Bob Ainsworth



In December 2010, former Defence Secretary and Drugs Minister, Bob Ainsworth, astonished party colleagues by declaring his support for a fundamental reform of the Misuse of Drugs Act 1971.

In a Parliamentary debate, he advocated a regulated market. He said he felt that the system of strict prohibition had **“built up international criminal organisations that dwarf the mafia,”** and added **“we have not dented the huge apparatus that supplies drugs”**. Here, Ainsworth discusses his tenure in government and his views on how we should move toward a more liberal regime for controlling drugs with Jeremy Sare.

When exactly did you change your views on drugs?

When I became Drugs Minister (2001-3) I held a traditional enforcement-centred view – just a “try harder, be smarter” approach. My views changed in office as a result of talking to people in treatment, in policing and simply reading a lot and thinking about the policy we had.

Can you describe a specific moment as Drugs Minister when you realised prohibition was not working?

One trip to Jamaica was significant to me. I witnessed first hand the failures of the current system and the resultant drug-funded corruption that threatened to create a failed state.

How would you describe the main features of your period in office?

We certainly used the Home Affairs Select Committee, whose membership famously included Chris Mullin and David Cameron, to broaden our support. We also opened the door for heroin prescribing and tried to oblige, encourage, cajole, force the practitioners into accepting it.

By the time I left the job, we had moved the policy a bit toward harm minimisation. We had rowed back from populist Hellowell [former Drug Czar] type of ideas and we parted company with him after introducing more harm reduction, more treatment and reclassifying cannabis from Class B to C.

I was very annoyed when No.10 imposed a target to halve poppy production in Afghanistan on us, because it was a ridiculous ambition. Ultimately it was more of a headache for the Foreign Office.

What was it like working with Keith Hellowell?

The relationship was very difficult. He had been at war with Mo Mowlam for some time and both were pretty bruised by it. At the same time, David Blunkett wrested control of drug policy back to the Home Office and effectively sidelined him. It was part of my job to handle him and see him off without the Government suffering too much political damage. He left a parting shot over cannabis reclassification, but nothing serious.

So what was it that prevented you from revealing your misgivings?

It was because of the collective responsibility you sign up to when in Government. We were making some progressive improvements, but David Blunkett, as Home Secretary, was prevented by Tony Blair and the No.10 machine from going any further. More than anyone, they acted as our brake.

What conversations did you have with colleagues?

A big influence on me was Lewis Moonie (now Lord), a Defence Minister and a doctor, who showed me we should be moving to a properly evaluated response to the drug problem. But I have lost friends in Parliament who are extremely angry and think I am undermining the fight against drugs. They think ‘bear down, press on’ and it will just work. I have had family members who have asked to speak to me because they were so upset with my position.

For parliamentarians, is it less about the rights and wrongs of the issue and more about how their views are perceived?

It is certainly a big part of it, particularly for party leaders. Tony Blair was really not of my view fundamentally and had a pretty conservative take. But David Cameron on the other hand, I'm pretty sure, is a liberal at heart and would be in a private conversation. He only recanted at the point he became Conservative leader because of the inevitable electoral consequences.

The drugs issue can never get to the top of the political agenda like it ought to. We are over-centralised, decisions are made almost exclusively by No.10 and that is a big problem. As a political issue, it is completely parked.

Six months before the speech, you held one of the most senior posts in the cabinet. After the speech, the top of the party were whispering about how you had seemingly lost all sense of reason.

The only bit which annoyed me was the "senior sources" who told the papers I was "irresponsible". The attack dog was unleashed, which in my case was John Mann MP. I know how it works – I used to do it when I was Deputy Chief Whip! I had been liaising with Transform who thought a former Drugs Minister advocating regulation would make the difference. I never had any illusions about that. I knew the system would easily absorb anything I had to say.

There is a policy review within Labour party now.

There is. But don't expect anything. The fact is, Labour has lost power and the purpose of the review is to regain power. The shadow cabinet are simply seeking the platform which will lead us to electoral success, which won't include drugs. So, on this issue, I would say politics is not serving the people.

The British Crime Survey figures show dramatic falls in the last 10-12 years for many drugs, particularly cannabis. So why do Governments take such a hard line rather than champion their successes?

Gordon [Brown] re-classified cannabis, I think, simply because Paul Dacre [Editor of *The Daily Mail*] wanted him to. The political fear about drugs is derived from a lack of knowledge. There are MPs who took some of these substances when they were young – they could bring some wisdom to the public arena, but don't. And then there are MPs and peers who have had family problems and they have some knowledge, albeit hugely distorted by their own personal tragedy.

How are we going to make progress on reforming the policy?

Strip out all this baggage. Have a conversation where we could consider the potential increase in usage which might flow from a more liberal regime. Then we could measure whether the increased harm was equal to the harm caused by the war on drugs, and determine what is the balance of good. If you could have that conversation, then we could work out the correct regulation for heroin, cocaine and cannabis and all the new substances which are being invented every day of the week.

You have advocated an incremental approach rather than a 'big bang'. Could a pilot be set up to test decriminalisation, like we did with cannabis reclassification?

Yes. But there are pilots which we refuse to study and learn from such as decriminalisation in Portugal or heroin prescribing in Switzerland. By the UN Conventions, which we are signatories to, we try and crush these projects rather than study them.

Legal highs are a huge change and a new path to drug use for young people. Do you think the imposition of temporary bans will help reduce use?

I don't know. It is certainly not a bad thing for the law to be able to react more quickly but the basic problem is the lack of logical thought applied overall.

Will you continue to work with Transform?

I have certainly tabled questions and will continue to do so. But I am a constituency MP and I don't want to be the 'Member for Drug Reform'. I have said to many other MPs that when you speak your mind, it's not that bad. You may think you are going to get murdered. My local paper ran a survey; 56 per cent were against and 44 per cent were for my stance. Paul Flynn thinks his independent views on drugs actually add to his popularity locally. The public will give a much more thoughtful response than you ever get from the media or in the House.

Do you think there is much to be optimistic about, for example the Global Commission on Drugs led by George Schulz and several former Presidents?

I still hold an optimistic outlook. Once the regime of prohibition falls, it will collapse like a house without foundations, which is effectively what it is. There is an awful lot going on already signalling change, referendums in California and big changes in policy in Latin America. At some point, somebody must seize the moment and the whole rotten edifice will fall over. We will end up with a proper international debate recognising the current situation is unsustainable. Policy will shift, just like it did with alcohol in the 1930s, and finally it will become a health issue and not simply one of enforcement.

■ **Jeremy Sare** is a freelance journalist.

Dragon's den

According to the official statistics, the number of problematic heroin users has fallen for the first time across the UK. Yet Swansea appears to be bucking the trend, where according to one user, it's 'more hassle to buy a packet of fags' than heroin. Rebecca Lees investigates.

In a move reminiscent of the mid-1980s, a hard-hitting poster campaign featuring a grainy black and white image of a tombstone was launched recently in Swansea. *Heroin Ruins Lives*, led by South Wales Police, aims to raise awareness of the impact of the drug on users, their families, friends and communities, and encourages people with information about dealers to talk to police. But why has this campaign been considered necessary at a time when the national picture suggests that heroin use is declining?

The National Drug Treatment Monitoring System (NDTMS) data for 2010/11, published by the National Treatment Agency for Substance Misuse, reveals that the number of people accessing treatment for heroin and crack in the last two years fell by 10,000, a statistically significant figure. Other research supports this downward trend, with figures from the University of Glasgow suggesting an overall decrease in the numbers of people using those drugs problematically. NTA Chief Executive Paul Hayes welcomed the figures, but recognised that "addiction remains a serious problem for many communities," adding, "We need to remain vigilant, particularly in a tough economic climate."

Vigilance is undoubtedly a priority for police in Swansea. Since 2007, there have been 61 drug-related deaths in and around the city, while more than £500,000 worth of Class A drugs have been recovered since April 2010. Drug trafficking offences detected in the city rose to 188 between September 2010 and 2011, an increase of 100 per cent on the same period for the previous year, and 13 organised gangs were disbanded after

being caught attempting to establish heroin supply networks in Swansea.

Detective Inspector Jason Davies of South Wales Police is leading the *Heroin Ruins Lives* campaign. "Swansea is recognised nationally as having a significant heroin misuse problem. This makes the area vulnerable to infiltration by organised crime groups intent on supplying heroin on our streets," he says. "The focus has been on groups from London, Liverpool, Manchester and Birmingham. They're housed in Swansea by local people who deal for them in return for free bags of heroin".

The campaign poster, illustrated with the headstone of a heroin user, has been described by some as insensitive. But it's seen by agencies and users' families as essential in underlining the problem facing the city. One former heavy user says, "It's probably more hassle to go to the shop to get a pack of fags than heroin, to be honest. You just phone someone and they drop it off at the house." The 30-year-old started using the drug about 10 years ago. "Now and again, me and my mates would go clubbing and take some pills. Then my best mate got into gear and it was easy to follow him," he says. "In 10 years, it's got much easier to get hold of it. It's rife in Swansea. It's cheap too."

This man is one of the city's success stories. His use is now occasional, and he is planning a future after accessing support at Swansea Drugs Project, a flagship treatment service which recently moved into new £2m premises. "The staff are brilliant. I have done lots of courses," the client says. "It keeps me busy, which is essential to my recovery, otherwise I'd be at home twiddling my thumbs." The project has seen a 40%

jump in referrals in the last year alone.

Director Ifor Glyn said: "Heroin misuse is one of the biggest problems facing communities in Swansea. The number of deaths over the years is shocking and the cost to families and friends unbearable. You can't avoid it – it's a problem that's there on the streets. It's the usual mixture of alcohol, homelessness and heroin and it's quite visible in the city centre".

"Fifteen years ago this wouldn't have happened. When I came to Swansea there was no heroin at all. I went away for about three or four years to work in the valleys and when I came back about five years ago, the place was awash with it. I think once it gets a grip, it tends to spread like wildfire when there is a lack of jobs and prospects."

Jobs and prospects are certainly an issue in Swansea. The four wards where heroin use is most prevalent, including the Castle ward in the city centre, are among the top ten most deprived areas in Wales. But Swansea's problem doesn't stem solely from poverty, according to DI Davies. "Recent demographic analysis highlights a number of key areas that are being looked at," he says. "For example, Swansea does not have a gang culture, turf wars or gun crime issues, thus making the threat to organised crime groups limited when they infiltrate the area. This is opposed to the situation in Liverpool, for example, where to supply heroin brings severe risk to life from other suppliers who fight for territory."

Another theory is that Swansea is, to some extent, a victim of its own success. Previously, those seeking help had a confusing number of agencies to choose from. The Abertawe Alcohol and Drugs Assessment Service (AADAS) is now the

Photographer Adam Patterson also co-produced a documentary about the city's drug problem called *Swansea love story*.

View it at www.vice.com/rule-britannia/rule-britannia-swansea-part-1-of-6



ADAM PATTERSON

first point of contact for all enquiries. The service was the first of its kind in Wales when it launched in 2010. The city was also the first place to make available the heroin antidote naloxone, which has since been rolled out to other parts of Wales.

"In the last five years there has been a year-on-year increase in people coming to the centre, but it's difficult to say whether it's become a bigger problem or whether there is more success in getting people into treatment," says Mr Glyn. "There is a shift in what we are doing. Before, we were just putting a plaster on the problem. Now it's about taking people from basic overdose prevention to working with them and supporting them back into work."

Cyrenians' Chris Skelton agrees. "There are definitely more people using heroin but we have a one-point-of-contact referral system, so it might be that the figures we are producing are more accurate. We also have a high number of people with hepatitis C, which could be because we do more screening and we target people who inject. We tackle substance misuse from all angles, including health, psychological and physical."

"The recognition of the problem 18 months ago brought it out from hiding into the public arena," says DI

SWANSEA DOES NOT HAVE A GANG CULTURE, TURF WARS OR GUN CRIME ISSUES, THUS MAKING THE THREAT TO ORGANISED CRIME GROUPS LIMITED WHEN THEY INFILTRATE THE AREA

Davies. "Also we have seen a 50 per cent reduction in heroin overdoses since 2008. This is based on effective partnership working and the roll-out of naloxone." This partnership work also includes the Safer Swansea Partnership, which works with police and other agencies to reduce crime and anti-social behaviour.

All this, of course, requires funding. With the possibility of a double-dip recession looming, there are concerns as The Cyrenians' base in St Matthew's Church, High Street, is facing an uncertain future, while staff at the Swansea Drugs Project are all too aware of the demands on the public purse.

"Future funding is in question because of the pressure on governments," says Mr Glyn. "But they need to look at what would be happening without all this

money being spent. There would be an increase in costs from hepatitis and more children would be taken into local authority accommodation. There are loads of practical costs that people need to think about."

Above all, according to DI Davies, is the need to appeal to those communities where the drug is most conspicuous. "The purpose of the project is to raise awareness of the impact heroin has on the user, those closest to them and the community as a whole," he says. "Without the support of the community we are often one step behind in the fight against heroin supply and those closest to the user are often best placed to provide information on the supply networks. With the public's support, together we can respond to the needs of the community by acting dynamically on this intelligence. We can improve the quality of life for users' families by reducing heroin availability, which in turn offers opportunities for them to support the user to engage in rehabilitative programmes. Unless we strategically target the groups and change the mindsets of the locals who house the groups, then we will never succeed in the battle to save lives."

■ **Rebecca Lees** is a freelance journalist.



In from the storm

Most rough sleepers are men, but the true number of women who are homeless is unknown. And getting them to come forward for help is difficult. Esther Sample from St Mungo's on a new initiative to protect vulnerable women

When most homelessness charities developed in Britain in the 60s and 70s, they were set up with homeless men in mind. Men have traditionally formed the majority of rough sleepers and hostel residents. Official figures suggest, however, that while far fewer women than men become homeless, women still make up a quarter of the homeless population.

Statistics do not record the extent of women's hidden homelessness, however. Rather than sleeping on the streets or coming forward to support services, women are more likely to sofa surf between family and friends, stay in abusive relationships, squats or insecure housing situations. Why? The dangers of being female and sleeping on the streets are obvious, but reasons for not coming to services include the fear of children being taken into care, support services which are male dominated and stigma. These same reasons throw up barriers to presenting at a whole range of services including those which support people with drug and alcohol problems.

When women do resort to sleeping rough, they often choose hidden shelters or areas that feel safer away from public

view. Perversely, these are often more dangerous due to their isolated nature. Women also often sleep in the day, staying awake at night for safety. Women who sleep rough in this way would not necessarily show up on official street count figures which cover people 'bedded down' on the streets on a particular night each year. It is also common for women who do sleep on the streets to do so as part of a couple. Unfortunately, relationships can become unbalanced and abusive if the woman is dependent on a partner for protection, particularly when substance use, alcohol and mental health issues are involved. Women are also at risk of becoming involved in prostitution.

STATISTICS DO NOT RECORD THE EXTENT OF WOMEN'S HIDDEN HOMELESSNESS

Our research report, *Battered, Broken, Bereft, Why People Still End up Sleeping Rough*, published in October last year,

asked outreach workers nationally about who was still sleeping rough and why. In addition to outreach responses, we also included the results of our latest annual survey of our clients. This found that 35% of our female clients who had slept rough did so after escaping domestic violence. It also showed that it is women with the most complex needs that are not being picked up by services. Of those women who had slept rough because of domestic violence, 90% used drugs or alcohol problematically or had done in the past, compared to 58% for those that had gone straight into services and not slept rough. They were also much more likely to have a significant medical condition.

More broadly, we have found that women in our services, whether they have slept rough or not, have different and often higher levels of support needs (such as substance use and mental health) than men. Data from 2008 showed that overall, female clients were coming into services with higher support needs (and at a more pre-contemplative stage of recovery), and were also progressing more slowly than the men in projects.

THE MAJORITY OF HOMELESS SERVICES HAVE BEEN, AND STILL ARE, BOTH DESIGNED FOR AND DOMINATED BY MEN. IF WE ARE TO TRULY MEET THE NEEDS OF HOMELESS WOMEN AND GIVE THEM THE SUPPORT THEY NEED TO MOVE FORWARD, THEN THIS NEEDS TO BE URGENTLY RE-THOUGHT

So how do we make homelessness and related support services more accessible, appealing and effective for women who need them?

If women feel that services cater for their specific needs and that they will not be judged or isolated as a female client, they are more likely to come forward for support. Since 2008, St Mungo's has been working to improve services for women, and conducting extensive peer research with female clients through our client representative group, *Outside In*, as to the specific issues they face.

What became clear is that, although some routes into homelessness are shared by both genders, women do have different routes into homelessness to men, and can need different support to move forward. The research found that the profound emotional trauma experienced by women through issues such as domestic abuse, sexual exploitation and loss of children and family is key to their not being able to progress out of services and move on from issues such as substance use.

St Mungo's Women's Strategy aims to ensure all services are meeting the personal, emotional and social needs of women, as well as the potential for housing, health and work. Partnerships with the drug and alcohol sector on these issues, together with domestic violence services and especially social services will be key to the success of the project.

Although the women we work with are seen as 'single homeless', 50% of our female clients are mothers and 60% of those children are in care. We want to support women to regain contact with children or if this is not possible, provide support to grieve the loss of

SARAH'S STORY

When Sarah arrived at one of our hostels, she had recently had a baby and had been violently assaulted by the baby's father. The baby has since been adopted. The father is in prison.

During her childhood, Sarah's step-father was extremely violent and she went into care. Her alcohol use was so concerning that she went to detox and then rehab in her late teens. Although she stayed eight months, she didn't complete due to feelings of loneliness.

Sarah has had unstable housing and periods of homelessness throughout her life. She has four children in total, none of whom have stayed in her care. She feels terrible guilt about these children, particularly her daughter as she was subsequently subjected to assault from a step-mother.

Sarah has had few opportunities to learn and benefit from loving relationships, either as a child or as a partner of anyone. She has always been subject to assault. Her substance use and alcohol consumption continue to provide an escape from overwhelming emotions, and at present, St Mungo's staff are working to help her feel settled and cared about.

North London Women's Project: enabling contact with children

St Mungo's North London Women's Project is a 29 bed hostel for vulnerable single homeless women with support needs such as physical or mental health problems, drug or alcohol issues, prostitution and domestic violence. The project supports residents through assessment and planning to meet their individual needs, and to access other services such as GPs, substance use or education providers. The project encourages women to maximise relationships with their children by liaising with external services, as well as enabling contact in the project. Keyworkers provide emotional support to the women around their relationship with their children.

children, something our clients say is rarely acknowledged by services. Fear of losing children as a barrier to accessing services also needs to be explored.

The majority of homeless services have been, and still are, both designed for and dominated by men. If we are to truly meet the needs of homeless women and give them the support they need to move forward, then this needs to be urgently re-thought.

To that end, in 2012, St Mungo's will focus on women's homelessness. The views and experiences of the drug and alcohol sector will be invaluable to finding better prevention strategies and homelessness support for women.

Chrysalis: Psychologically Informed Environment

The Chrysalis Project, a partnership between the London Borough of Lambeth, St Mungo's and Commonweal Housing, provides housing and support for women who are homeless and have support needs related to substance use, trauma, abuse and sexual exploitation. The service offers 31 beds for women. All clients have access to formal psychotherapy and personalised support. St Mungo's runs the hostel and Commonweal Housing provides a mix of self-contained move-on flats. The hostel has become one of St Mungo's Psychologically Informed Environment (PIE) pilot schemes. With the support of clinically trained psychotherapists, staff are given the opportunity to reflect and develop skills that are psychologically informed. This helps build resilience in coping with the emotional impact of their work and encourages a reflective way of working. For the clients, it fosters an emotionally safe environment, supports understanding of behaviour and relationships with others, and helps to encourage a sense of community.

The photographer Georgina Cranston runs a multimedia project exploring women's homelessness in London at www.wherfromwherenow.org/the-project

■ **Esther Sample** is St Mungo's Women's Strategy Coordinator

CURIOSITY LIES IN WAIT FOR EVERY SECRET

Jennifer Holly reminds drug workers of the high incidence of violence in the background of women with substance misuse and mental health problems.

Most drug workers know that the majority of those people with serious drug and alcohol problems also struggle with their mental health and the impact of trauma often going back to childhood. Workers know this instinctively, but don't always make the day-to-day connection between a client's lifetime experiences of trauma and current behaviour which may be challenging or frustrating. Clients may repeatedly put themselves in situations which are clearly risky. And this seems a particularly acute problem for women service users. As one alcohol worker recently told me: "clearly there's a history of abuse, from childhood, and now she goes from relationship to relationship. Each time there's abuse. I don't know how to help her out of the situation." So what is the psychiatric fallout for women drug and alcohol users whose lives have been blighted by sexual and violent trauma? Why can it be so difficult to break the cycle of abuse?

It isn't hard to imagine that being physically assaulted, being raped (sometimes in front of your children), being told you're fat, ugly, stupid,

worthless or pointless, being isolated from friends and family and having your whereabouts constantly monitored, could leave a survivor feeling – among other things – sad, terrified, on edge, ashamed, lacking self-esteem, confused and angry.

It also translates into above average psychiatric diagnoses. Women who have experienced abuse or serious sexual assault are roughly three to five times more likely than non-abused women to experience depression, anxiety and suicidal thoughts. Around 64% of abused women also experience post-traumatic stress disorder (PTSD), significantly more than the 1-2% lifetime prevalence in the general population.

Prolonged abuse over months and years may also be followed by another syndrome known as complex PTSD. In addition to the symptoms of regular PTSD, i.e. intrusive memories and flashbacks, avoidance, feelings of numbness and extreme edginess, complex PTSD is also characterised by difficulties in regulating emotions, explosive anger, inhibited sexuality, feelings of 'unreality', changes in

view of self, feeling helpless/defiled/violated, having a belief that no-one can understand, difficulties in intimate relationships, distrust, repeated failures of self-protection, experiencing hopelessness and despair.

It's worth considering the overlaps between the symptoms of complex PTSD and those associated with borderline personality disorders (BPD). There is a question mark around BPD diagnoses and whether, in some cases, it is a misdiagnosis of complex PTSD. Taking into consideration that up to 90% of people diagnosed with BPD have experiences of severe childhood trauma, and around half meet the criteria for co-morbid PTSD, there is certainly reason to consider whether service users who have a BPD diagnosis are actually responding to a childhood trauma which may have been compounded by abuse in adulthood.

Survivors of domestic and sexual violence frequently describe feeling scared, anxious and/or depressed for years after the end of an abusive relationship. PTSD symptoms last, on average, for twenty years. For some

survivors, it may become the 'norm' to live with psychological distress, compounded by the resulting effects of abuse such as poor physical health, poverty and a lack of safe affordable housing. It may not be obvious to them that being the victim of abuse, possibly decades previously, could be the source of their current mental ill-health and substance use. They may be left to simply cope and survive alone.

Self-medicating, to cope with experiences of abuse and to relieve some of the physical and emotional pain caused by domestic and sexual violence is commonplace. Women who have experienced domestic and sexual violence are just over four times more likely to have a lifetime substance use disorder than women who have experienced no trauma, with victims of multiple forms of abuse reporting higher levels of substance use than those who have experienced just one form of violence. Women who have experienced more than one sexual assault are 3.5 times more likely to begin or increase substance use. In terms of survivors of violence and abuse, problematic substance use tends to be preceded by mental illness, and is used to manage the symptoms. Alcohol and other depressants, for example, can mediate poor sleep, mask extreme anxiety and cope with the intrusive symptoms associated with PTSD.

Considering how many women's substance use may be associated with their experiences of domestic and/or sexual violence and subsequent long-term psychological distress, it is vital that drug and alcohol workers are encouraged and have the confidence to be curious about their service users' experiences of abuse. Not understanding how domestic and sexual violence could be linked to someone's substance use can definitely hamper their ability to stabilise their use or recover. Furthermore, not asking about domestic and sexual violence can leave survivors – and their children – at risk of further harm. The Department for Education's recent publication *Children's Needs – Parenting Capacity* clearly evidences how a combination of parental mental ill-health and problematic substance use increases the risk to children's safety and welfare, but most importantly that "the best predictor of adverse long-term effects on children is the co-existence with family disharmony and violence". So how best to support survivors of sexual abuse and domestic violence?

Fiona (not her real name) told me about her experiences of domestic violence:

"My ex-husband was really quite violent. So were a couple of other exes. One really beat me up, punched me in the nose. Others stole money, managed to raid my bank account. When I was drinking, it was a way to cope with what was going on. I didn't seem to mind so much when I drank. Drinking also gave me the courage to fight back. Leaving the last guy, I was terrified. I thought he would kill me and the kids. He wouldn't let me take both my children when I went out – I guess a way of keeping me coming back. So I had to wait until he'd passed out from drinking before we could all get away together. I got to a friend's house, called the police and eventually got a restraining order against him."

WOMEN WHO HAVE EXPERIENCED DOMESTIC AND SEXUAL VIOLENCE ARE JUST OVER FOUR TIMES MORE LIKELY TO HAVE A LIFETIME SUBSTANCE USE DISORDER

Fiona is clear that the first thing a survivor needs "is to be treated like a human being, like you're worth treating. Asking for help is the most difficult thing you can ever do, especially for women who tend to have lower self-esteem than men. It's really difficult to tell someone you're an alcoholic, a drug addict, or your husband beats you up. It makes you feel worthless. When you do say something, you just want someone to say, 'Look, it's not your fault, you are not a worthless human being. You do deserve to live, you deserve to be a mother, you deserve to be happy, you don't deserve this man smacking you round the face'. That's the first thing you need. And then you need the practical help."

In terms of practical support, agencies should support workers to effectively assess the risk of further violence. There is a standard risk assessment – the DASH (Domestic abuse, stalking and harassment) Risk Identification Checklist – which is widely used by the police and specialist domestic violence services. The risk assessment form can be downloaded from www.dashriskchecklist.co.uk or contact your local domestic violence service/forum for a local version as well as risk assessment training for staff.

If your client is assessed to be at high risk, s/he can be referred to the

MARAC (multi-agency risk assessment conference) where the case is discussed by a range of agencies such as the police, housing, specialist support services and actions will be agreed.

The next step requires more curiosity – asking survivors what they want. Survivors will be at different stages of change. Some survivors will want to stay in the relationship (for many different reasons), or won't be ready to leave. In such cases, you can support a survivor through safety planning. You can find out about safety planning from your local domestic violence service or in the *Survivors Handbook* on the Women's Aid website: <http://tinyurl.com/7w4hye5>. You can provide information about local services in case she later decides to access support.

Other survivors will want the relationship to end and to remain in their home. Safety at home can be increased through occupation orders (which remove the perpetrator from the property) and non-molestation orders (which require perpetrators to have no contact with the victim), and the use of Sanctuary Schemes (security measures for a property). Your local domestic violence service can advise survivors on what measures are available locally and how to access them, as well as offering other practical and emotional support.

For some survivors, it may not be possible to stay in their home. Depending on your client's level of substance use, you may consider referring her to a refuge (the National Domestic Violence Helpline on 0808 2000 247 can provide details of which refuges have spaces at any time). Many refuges are unable to support women with complex needs such as substance use problems. If you cannot find refuge space, domestic violence advice or outreach services should be able to support your client to access local authority accommodation.

The good news is that, in many ways, we already know the answer to the problem. There is no magic wand, no new whizz-bang model of working. We simply need to do what we are already doing, just a little bit better. And with a tad more curiosity.

■ **Jennifer Holly** coordinates the Stella Project Mental Health Initiative, a three-year project developing models of responding to survivors and perpetrators of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health.

For more information, please visit <http://www.avaproject.org.uk/our-projects/stella-project.aspx>.

RAISING THE BAR

Gary Ward takes a look at how one local authority tackled the problem of repeated alcohol-related hospital admissions.

Carl Roberts was an accountant for more than 20 years before a mixture of wine, port and vodka took its toll and he had to give up his job. The 45-year-old attended St Richard's Hospital in Chichester nine times in nine months to have his stomach drained because of his excessive drinking. After the last visit he was told that without change he had three to six months to live. "If I didn't do something about it, I was going to die," said Carl, who underwent a fifth detox after hospital treatment. Carl's story was not unusual in the life-cycle of those with serious alcohol problems who were discharged from hospital in Chichester only to return soon after. But what to do about it?

Chichester probably wouldn't be anyone's first choice as a hotbed of alcohol misuse, but things aren't always what they seem. For while the picturesque city centre, in the shadow of the 11th century cathedral, doesn't resemble the battleground of some towns on a Saturday night, alcohol problems still run deep.

Figures from the Public Health Observatory show that out of 326 local authorities in England, Chichester is in the top ten reporting alcohol use at the level of 'increased risk'. This is defined as consumption of between 22 and 50 units of alcohol per week for men and between 15 and 35 units of alcohol per week for women, or more than double the recommended levels at the higher end. The city is also pretty near the top of the chart for the number of employees working in bars as a percentage of the local workforce: no doubt good for the local economy, but suggesting that Chichester has more than its share of drinking venues.

Previously, patients were treated for the medical problems associated with their drinking, but with no link-up between the hospital and local treatment services, repeat admissions were

common. Hospital staff thought a few patients might have tried AA, but nobody was addressing chronic drinking beyond primary care.

An idea was formulated to have an alcohol liaison nurse who would engage with patients about their drinking, work with other hospital staff and external providers and establish clear pathways for people to help them into community-based treatment services.

In 2011, NHS Sussex and the Western Sussex Hospitals Trust secured £15,000 from the government's alcohol innovation programme and ran a three month 'frequent flyers' pilot. The approach identifies and follows up patients whose alcohol problems tie up a huge amount of time and resources through repeat hospital admissions.

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Seconded from her post in gastroenterology, Staff Nurse Catrina Gooderham was redesignated as the Alcohol Liaison Nurse. Her brief was clear: begin with a blank slate, talk to people, make yourself known, and improve the quality of care and treatment for those making repeat visits to the hospital as a result of their heavy drinking. "I knew we could do more," she says.

But before she could make a difference, she had to overcome scepticism among other staff. "I found I couldn't just stride in and say 'ok, who

have you got to refer to me,' because the answer was usually 'no-one'. It took time to build bridges and rapport so that other staff could see the benefits."

And the benefits of taking the issue seriously are enormous, according to consultant gastroenterologist and hepatologist Dr Mohammed Rashid. "The quality of care has vastly improved and we're saving beds. Considering how much we spend on the NHS, this is not an expensive service, but at the same time it's impacting on one of the most important problems we see in the region."

With support from Dr Rashid, Catrina developed an alcohol care pathway group, involving doctors, nurses, administrators and for the first time reached beyond the hospital to involve local GPs – visiting every surgery in the area – and the local Alcoholics Anonymous group and Clockwalk, an external alcohol treatment provider.

Once underway, identifying the most regular 'frequent flyers' proved difficult because the data was patchy. So the project was extended to support anyone presenting at the hospital with severe alcohol-related problems.

Gooderham's approach was to deliver a 'brief intervention'; talk to patients about their drinking, take a history and support them into a range of further treatment options that would focus on their misuse of alcohol. The approach soon began to yield results, with a number of quantifiable outcomes: patients reduced their drinking; took up less bed space and were moved on quicker; referrals to alcohol services from wards across the hospital shot up; co-ordination of treatment and care between acute and community services greatly improved and awareness of the impact of alcohol on admissions across the acute trust increased.

During the pilot, Catrina saw 116 patients, 56 whom were referred on to

further treatment; 40 of these engaged with community services. Such was its impact that the public health department is continuing to fund Catrina's post in Chichester, plus two other specialist nurses in Redhill and Worthing, adapting the model to suit local needs.

Catrina has now trained more than 60 nurses to deliver brief interventions across a number of wards and the whole project is supported by the Chief Executive, the Chief of Medicine and the Trust's Board.

All of the indications are positive so far. An independent evaluation found that, if successfully implemented across the four hospitals in the area, the project could save around £252,000 a year on A&E and admissions costs.

In Chichester, the project is now part of the West Sussex Quality, Innovation, Productivity and Prevention (QIPP) initiative which identifies those programmes giving most bang for buck in terms of cost saving and health improvement – a significant mark of the respect in which this programme is held.

Catrina says; "I'm incredibly proud of our achievements and that our patients now have a much greater opportunity to address their problem drinking. But I'm under no illusions. This is a serious problem and it needs ongoing work."

Dr Rashid added: "When we started this pilot, our medical treatment was good, but we had zero alcohol services to speak of. Now we've seen a massive transformation, and a comprehensive approach to alcohol problems across the whole hospital, which is being expanded across the county."

And Carl? "I can't say anything bad about my treatment at St Richards. Catrina was very forceful, and while I didn't want to listen at the time, afterwards I realised she was right. The fact is, you have to make a commitment, and no-one else can do that for you."

Dry since May 2011, Carl has immersed himself into a service user group and has the support of his long-term partner. He struggles with agoraphobia and a dependency on sedatives, but is positive about his recovery.

"I used to sleep all day and drink the rest of the time. I don't do that anymore. I'm involved in my group and feel confident enough to have a short holiday to visit friends. I listen to audio books and my attention span is much better. I have to go back to see Dr Rashid, but if the results from my liver are good, I can be discharged."

■ **Gary Ward** is a freelance writer



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Innovating to reduce alcohol-related harm

During 2010-11 the former Government Office for the South East funded 26 local projects to tackle alcohol misuse and measured their success. The five most successful approaches were then tested again the next year, with a further ten projects awarded a total of £118,750. The Chichester project received £15,000.

The programme was managed by the Centre for Public Innovation (CPI), a social enterprise that specialises in supporting innovation to tackle some of society's most intractable problems.

The five most successful models were:

1. 'Frequent flyers' – intensive work with a small group of patients with the highest levels of repeat alcohol-related hospital attendances and admissions. The model drew on learning from a drugs approach.
2. Pharmacy brief advice – helping community pharmacy staff to provide pro-active advice to low and increasing risk drinkers.
3. Hostel clinical nurse – targeting a group for whom inpatient detox has not worked, increasing the opportunity to address alcohol problems in hostel accommodation.
4. Supported housing self-help group – using workshops to address reluctance to attend specialist services and provide support and advice.

5. Hospital healthcare workers identification and brief advice – training support staff in A&E and other departments to screen patients for problematic alcohol use.

An independent evaluation by the pharmaceutical company, Lundbeck, found that five of the ten projects, including Chichester, had the potential to make significant cost savings.

Mark Napier, Managing Director of CPI, said: "This programme has shown that innovative, locally-based approaches to tackle the health and social harm caused by alcohol can succeed. If replicated nationwide, some of these projects could save a substantial amount of money and improve health and well being.

"With huge pressure on the NHS to save money, innovation may appear risky, but without a commitment to try something new, patient outcomes are unlikely to change for the better, costing more in the long run. The Chichester project is a great example of trying something for the first time and engaging with services across the community."

For more details, and to read the full evaluation of the alcohol innovation programme, see <http://www.publicinnovation.org.uk/southeastalcoholinnovationevaluation.html> or contact Mark Napier on 020 7922 7820



Burden of proof

Prison drug treatment programmes can cut re-offending but, claims Gail Jones of Rapt, the lack of a solid evidence base is putting their future at risk.

The world of recovery is full of individually inspiring stories. Duwaine's is no exception. A tough gang member, he had been using and offending for 15 years. Until he encountered the Rehabilitation of Addicted Prisoners trust (RAPt) team at HMP Coldingley, in Surrey, Duwaine saw his drug use inside as a way of keeping his head down and getting through his sentence.

It's now a year since Duwaine reluctantly agreed to move into the RAPt recovery unit, mainly for the exclusive en-suite toilet and shower facilities. A year on, the gangster swagger has been replaced with a light, hopeful step, and Duwaine says he now feels free, despite being in prison.

He says the turning point was seeing his life story written down – writing about and sharing your experience with fellow users is one of the foundations of the 12-step recovery model used by RAPt.

The process made him see what his life was really like, as opposed to the more palatable edit he had previously chosen to see. He finally grasped the impact of taking drugs in front of his young children, and the string of broken promises he had made to people who loved him.

Six months later he is not only drug-free, but also a changed man. He has secured “the privilege” of being transferred to High Down prison to work as a peer supporter on the RAPt ‘Bridges to Recovery’ programme. He has gone from being a ‘person of interest’ – criminal justice speak for big trouble – to a model of successful rehabilitation, given the freedom to walk the corridors across the prison as he goes about trying to persuade his old partners in crime to join him as a peer in recovery.

The key to his current stage of recovery is winning trust – of both those close to him and authority figures – which in turn is giving him hope that he can build a drug and crime-free life. He hopes to continue training to work with young people on crime diversion schemes when he gets released in about a year's time. Duwaine has already been approached by police forces and others keen to work with someone who can speak to young gang members in language they understand – especially in the wake of the 2011 summer riots.

Duwaine's chances of starting a new life on release, and avoiding sliding back into old using and criminal habits are now much higher, thanks

to RAPt's intensive abstinence-based approach, than if he had completed a lower intensity programme. RAPt can say this with confidence because we have conducted robust analysis of our programme data. We realised that though individual stories can be compelling, interventions need to be able to use the rigour of science to demonstrate their impact.

For some years, RAPt has collected data on all offenders who have engaged with its treatment programmes. The data measures changes in criminal thinking and behaviours that have been shown to be associated with post-release offending.

An analysis of the data shows the programme is able to bring about positive changes in participants and reduce their likelihood of re-offending.

While these proxy measures were encouraging, we wanted to go one step further and analyse the re-offending rates of service users when they were back in the community. In order to compare results with a matched group of offenders, RAPt submitted details of men who had completed its programme, and a comparison group of offenders who had undertaken a low intensity CBT

programme run by the Prison Service.

This analysis showed that less than a third (31%) of the group who had completed the RAPT programme had re-offended within 1 year of release compared to more than half (51%) of the matched comparison group, based on analysis of re-offending using the Police National Computer database.

It also highlighted a significant difference between the two groups' volume of offending. The comparison group committed over twice as many offences per person than the RAPT group (2.3 and 0.8 respectively) and received twice as many custodial sentences (2.6 and 0.7 respectively).

RAPT's efforts to provide an evidence base for its programmes, which were recently validated by Manchester University, are a rarity, despite the heavy government investment in prison-based drug treatment over the past twelve years.

This policy of focusing on problem drug users, whose offending was in some way related to their drug use, was based to some extent on an act of faith – that prisoners would be willing to engage in treatment during a stay in prison, that the programmes offered could be effective, and that post-release reoffending rates would consequently be reduced.

While these assumptions have broadly held true, it was also fair to assume that, as a wide range of interventions were rolled out over the years, their expansion would be accompanied by a growth in the evaluation and evidence base. This, in turn, could guide understanding of impact and effectiveness, and therefore what services should be commissioned in the future. But twelve years on, in an important period of review of prison based needs, strategy and commissioning, the level of research conducted in this field, and the extent to which service evaluations are conducted and discussed in public, has been disappointing.

Lack of research into the effectiveness of prison based interventions may be damaging to the sector when the Home Affairs Committee reviews the extent to which the Government's 2010 drug strategy is a 'fiscally responsible policy'. It has made clear that one of the ways in which current interventions will be judged is the extent to which they are grounded in science.

The previous government asked The Patel Committee to look at the

LACK OF RESEARCH INTO THE EFFECTIVENESS OF PRISON BASED INTERVENTIONS MAY BE DAMAGING TO THE SECTOR WHEN THE HOME AFFAIRS COMMITTEE REVIEWS THE EXTENT TO WHICH THE GOVERNMENT'S 2010 DRUG STRATEGY IS A 'FISCALLY RESPONSIBLE POLICY'

available evidence base for prison-based treatment as part of its wider review of drug policy. It had to rely largely on studies conducted in other countries for its analysis. The Committee was able to state with some confidence in its final report that there were a few interventions that were effective and cost-efficient – opiate substitution programmes, intensive abstinence-based therapeutic programmes, and contingency management. However it was forced to conclude that there was insufficient evidence of the impact of many services which had received heavy investment, including lower intensity programmes and pharmacological interventions for substances other than heroin.

A review published in 2008 by the UK Drug Policy Commission (*Reducing Drug Use, Reducing Reoffending*) came to broadly the same conclusions, although the authors were only reviewing UK-based treatment for offenders in the community and in prison establishments. The review reported that there was reasonable evidence on the effectiveness of opioid detoxification and maintenance (although long-term outcomes are unknown), therapeutic communities and, specifically named, the RAPT 12-step programme.

Again, several interventions – CARATs, short-duration CBT-focused programmes such as Addressing Substance-Related Offending (ASRO), and drug-free wings – were found to have no published evaluations of their effectiveness. The authors note that considering the investment into CJS interventions, there is very little published evidence on which programmes works best for whom, and what individual features of programmes are key to successful outcomes. Even information on basic areas such as

'throughput and output' of programmes are widely inaccessible.

RAPT has made several attempts to help fill this evidence gap. After the last round of service restructuring, we tried to persuade the Home Office and Ministry of Justice to commission a national comparison study on a cohort drawn from the 70,000 prisoners per year receiving some sort of intervention, in order to understand the impact of different interventions and pathways.

Then, in 2008/9 we attempted to pull together a consortium of service providers to directly commission some comparative research into our outcomes. We failed to find enthusiastic partners for these studies. Finally, we had to settle for a less ambitious project that compared the reoffending rates of male offenders who had undertaken the RAPT intensive programme with those completing a lower intensity programme.

The finding that intensive programmes are able to achieve a 65% reduction in the volume of crime would suggest that a fiscally responsible policy would ensure that offenders are able to access interventions that match intensity with the complexity of need.

RAPT's research findings clearly demonstrate that if well structured and delivered treatment is available in prisons, significant reductions in reoffending can be achieved. On the other hand, it is clear that many of the services that are currently commissioned have no evaluation evidence. Budget holders need to engage with these issues to make informed decisions on future resource allocation.

RAPT has supported the increase in the number of prisoners entering drug treatment programmes. However, we have cautioned throughout this expansion on the significant threat to the sector if we achieve this goal without being able to demonstrate its cost effectiveness.

The sector now finds itself in a position where the paucity of research puts future funding at risk. If drug treatment programmes are to continue in UK prisons, there needs to be a radical policy shift that insists on funding being linked to reductions in re-offending rates, with all providers gathering and publishing this data. It is vital this guiding principle is now fully embraced by all treatment providers.

■ **Gail Jones** is Deputy Chief Executive of the Rehabilitation of Addicted Prisoners Trust (RAPt)

FOOD FOR THOUGHT

Although khat has been used in Ethiopia for centuries, **Andrew Craig** argues that the rising demand for khat globally from the Horn of Africa diaspora is blighting the famine-ravaged region.



Our bus bumped to a halt at the Harar Gate, at the western edge of the old city walls, after a gruelling nine hours from Addis Ababa. On disembarking, I stepped over the remnants of bags of khat which had been masticated during the journey by my fellow passengers.

The walk through the Gate into the Old Town of Harar was not what I had imagined it to be. My guidebook's account of 'charming people' and 'coffee-scented streets' did not prepare me for the sight of dishevelled men, strewn like litter, along the roadside. Some twitched with involuntary spasms and others lay splattered with their own vomit. With pupils dilated, they clutched bushels of khat tearing off clumps of leaves with their mouths and chewing, languidly. This was the stark reality of khat dependence.

Khat, or *catha edulis*, is a plant native to tropical East Africa. Its main psychotropic ingredient, cathinone, generates a feeling of euphoria, and for centuries East Africans and Yemenis have used the drug as a social lubricant.

Traditionally, consumption was limited to areas in which the plant was grown as only the fresh leaves have a stimulant effect when chewed. However, in recent years, improved transport and infrastructure have made global distribution possible.

The Somali and Ethiopian diaspora are now opening the khat market to an ever-increasing number of consumers. Around seven tonnes of khat arrived at British airports each week in the 1990s; in 2010 this total rose to around 57 tonnes, some of it intended for onward distribution to countries where the drug is illegal. In the United Kingdom, the drug is mainly used by the East African community, but is also growing in popularity among British students.

The impact of consumption in the UK is revealed in a literature review written by two Oxford University academics and published by the Home Office in July 2011. The review asserts that there is no evidence to show a causal relationship between khat consumption in the UK and the social harms for which it is

supposedly responsible. The authors question the legitimacy of the drug's illegal status in other countries such as Canada and the US, on the grounds that such bans were not preceded by adequate research.

However, the main body of research into khat and other drugs focuses on how the trade affects Western populations. Far less attention goes to the social and economic consequences for producer countries such as Ethiopia, where khat growing is linked to the poverty and hunger that affect millions.

In fact, since khat is not considered to be a hazardous drug, the trade is often seen as inconsequential. An article by Susan Beckerling from the London School of Hygiene and Tropical Medicine published in 2007 advocated growing khat as a reliable source of income. However, the consumption of khat has a debilitating effect on many Ethiopians. Unlike in the UK, where its use is purely recreational, in Ethiopia, the drug has an additional value as a hunger suppressant. Several consumers I met in

Harar cited this as their main reason for chewing khat, even though it is relatively expensive in Ethiopia. A dependent user can chew up to half a kilo of leaves per day and bunches of khat cost up to £7 per kilo. In a country where many workers earn less than £1 per day, paying for the drug usually diverts money that might otherwise go towards feeding families.

A further concern is that most illegal drug users in the country began by using khat as their gateway drug. The Ethiopian drug authorities also believe that the infrastructure for the supply of khat is increasingly used to distribute illegal drugs.

However, land use in Ethiopia has bleak humanitarian implications. Land for food against land for khat is becoming a conflict that threatens to menace the country's already deficient food producing resources.

Modern Ethiopia has become synonymous with famine, and the spring of 2011 exposed once again the vulnerability of the region to climatic conditions. Moreover, climate change models predict increased periods of prolonged drought and flooding. Famines of the future are likely to become more frequent and more intense. Ethiopia's fragile ecology and poor infrastructure offer little capacity to adapt in such conditions. Smallholders and pastoralists who rely on regular rains will be most at risk if environmental conditions deteriorate.

However, cycles of famine are not inevitable. Programmes to reform food production in the country include promoting drought-resistant crops such as sorghum (a type of cereal crop) and chickpea, as well as the use of improved seed quality. These schemes can help to reduce the risk of crop failure but the competition for arable land is becoming another obstacle to their success.

Pressures on agricultural land are heightened by the Ethiopian government's own policy of so-called 'villagisation', in which tens of thousands of people are moved from traditional lands into centralised 'village' communities. This relocation enables the government to lease huge areas of fertile land to foreign and domestic agro-companies for the cultivation and export of food crops. Defenders of the scheme claim that it has the potential to improve agricultural techniques, increase local food supply and create jobs. Detractors believe that this smacks of wishful thinking. The programme is more likely to become one more episode in the long history of conflict between production

for profit and human welfare. Private agro-companies often pay low wages, sometimes leaving their employees unable to afford the food that they produce. And, inevitably, the grant of agricultural licences to foreigners raises the spectre of bureaucratic corruption.

THERE IS NO JUSTIFICATION FOR...LARGE SCALE PRODUCTION...WHERE AGRICULTURAL LAND IS SCARCE AND WHERE PEOPLE ARE SO FREQUENTLY WRACKED WITH HUNGER...

As vast areas of Ethiopia are leased to foreign farming interests, the proportion of land used to grow khat becomes ever more relevant. Current estimates are unavailable but in 2003 a total of 94,330 hectares was given over to producing the drug. Since then, khat growing has rocketed. Almost all regions of Ethiopia now cultivate the crop and it has become the country's fourth leading export, yielding ten percent of export revenue (USD\$210 million). Remarkably, in 2010, the revenue generated from khat exportation increased by more than 50% on the previous year. It is a woeful irony, in a country where 7.8 million people are supported by donor-funded food programmes and 13 million receive some form of food aid, that so much land is devoted to a crop that the people cannot eat.

However, if this is an issue that resonates with the Ethiopian Government, I have not been able to find a reference to it in my research for this article. Although the conflict between land for food and land for khat is a visible obstacle to hunger-alleviation strategies, there seems not to be even the beginnings of a debate about it. When asked, the UK Department of International Development said 'land used for khat cultivation is not an issue that DFID is currently working on'.

In a world busting at the seams with narcotics, the pursuit of international markets for the sale of khat is a colossal step in the wrong direction. Khat farmers are thriving under the legal protection of the Ethiopian government but the moral case against the growing of khat is simple and undeniable – there is no justification for its large scale production in a country where agricultural land

is scarce and where people are so frequently wracked with hunger and famine.

It is estimated that the profits from growing khat is 2.7 times higher than those from cereal production. This means that the khat business is having an escalating impact on the Ethiopian economy: moreover there is no doubt that the tax revenues from the trade are making a contribution to the development of country's infrastructure. However, in comparison to the vast sums that are expended on humanitarian aid, the tax revenues from the khat trade are paltry.

In 2009, humanitarian aid to Ethiopia amounted to USD\$3.9 billion. According to the independent research organisation Global Humanitarian Assistance, food aid accounted for 77% of that total. The budget for food aid therefore has the potential to exercise greater influence over the Ethiopian economy than do the tax revenues from khat sales. Research by Jeffrey Sachs, Director of the Earth Institute, reveals that transporting food into famine-hit areas is ten times more costly than sustained food production on the ground. This being the case, it can be argued that aid budgets should be used to incentivise the cultivation of crops that people can eat.

John Dempsey, a senior advisor for the US Institute of Peace, believes farmers in war-torn Afghanistan could be persuaded to give up growing opium and cannabis if Western and Afghan officials introduced incentives for growing food crops. How much easier would this type of trade-off be in the more stable social and economic conditions of Ethiopia? If such inducements could be made, it would be possible to develop food production on a scale that would ease the cycle of famine that has plagued the country for decades. In this respect, the economics of interventionist strategies is self-evident.

Poverty and hunger in the horn of Africa are beyond simplistic solutions, but I would argue that the khat trade is a significant impediment to food production. Aid donors cannot make aid conditional when famine occurs but, in more secure times, it can be used as a negotiating mechanism to discourage the growing of khat in favour of food. Governments should recognise this and act accordingly. In doing so, they will make a positive move to alleviate hunger and might also halt the advance of the vomit-encrusted T-shirt.

■ **Andrew Craig** is a freelance writer and commentator on international drug issues.



In this new regular feature, Mike Ashton, editor of *Drug & Alcohol Findings* selects evaluation research highlights on subjects of topical interest

Harm reduction flood needed to extinguish the hepatitis C epidemic

In the early '90s an article in *Druglink* alerted Britain's drug workers to the "sleeping giant" of hepatitis C infection. Before a test was available to identify it, the virus had already infected a much larger proportion of drug injectors than HIV ever would. "It may be wise to let sleeping dogs lie, but not sleeping giants," warned the authors. Since then Britain, if not letting the virus lie, has not mounted an attack commensurate to the dimensions of the epidemic.

Consistent participation in methadone maintenance treatment plus adequate access to fresh injecting equipment can impede the spread of the virus, but these and other initiatives (especially early detection and treatment of infection) have not been sufficiently abundant to reverse an epidemic which in 2009 infected over a fifth of injectors within three years of their starting injecting, prompting the Health Protection Agency to warn that "transmission of hepatitis C among younger [injecting drug users] and recent initiates is probably higher than it was a decade ago".

The transmissibility and prevalence of the virus mean that only a flood of harm reduction services can be expected to bring it under greater control. As comprehensively detailed in a four-part Findings series, coverage is the key – leaving no chinks in the form of the sharing of potentially contaminated injecting equipment for the virus to slip through. It has been estimated that to get to the point where fewer than 1 in 10 injectors in London are infected with hepatitis C would require the average injector to cut their sharing of used syringes from 16 times a month to once or twice, and that the impact of even this kind of achievement would be jeopardised unless sharing reductions extended to very recently initiated injectors.

Selected from the Drug and Alcohol Findings Effectiveness Bank project. For the full story with links visit <http://findings.org.uk/DL/DL1.php>

From the latest Findings analyses

Methadone maintenance is the focus for this set of studies newly analysed by Drug and Alcohol Findings for the Effectiveness Bank at <http://findings.org.uk>: how the treatment saves and enhances life, and at the same time limits it.

For the full stories with links visit <http://findings.org.uk/DL/DL1.php>

Methadone improves as well as saves lives

Methadone saves lives – but does it also make those lives better? The first systematic review of research on the quality of life of opiate users finds this generally improves once they start treatment, but few studies have assessed what counts as a good life from the point of view of the patient rather than the broader society.

De Maeyer J., Vanderplasschen W., Broekaert E. "Quality of life among opiate-dependent individuals: a review of the literature." *International Journal of Drug Policy*: 2010, 21, p. 364–380.

Both a platform for and limit on a good quality of life

The implications of this study could hardly be more relevant to UK debates about reorienting treatment to a recovery agenda and the role within that of methadone maintenance. In-depth accounts from opiate dependent methadone patients in Belgium of what for them constitutes a good quality of life reveal themes shared with the population in general: a meaningful, independent life and supportive relationships. Methadone creates the preconditions for such a life, but at the

same time stigma, the requirements of the treatment programme, and the effects of the medication, limit its achievement.

De Maeyer J., Vanderplasschen W., Camfield L. et al. "A good quality of life under the influence of methadone: a qualitative study among opiate-dependent individuals." *International Journal of Nursing Studies*: 2011, 48, p. 1244–1257.

Hepatitis C can be prevented by methadone plus needle exchange

For British harm reduction services and for their clients, the importance of this analysis can hardly be over-estimated. It found recent UK studies consistent with the conclusion that methadone maintenance plus adequate needle exchange has prevented many hepatitis C infections.

Turner K.M.E., Hutchinson S., Vickerman P. et al. "The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence." *Addiction*: 2011, 106, p. 1978–1988.

Counselling not essential to methadone's initial impact

Is regular counselling really essential to the effectiveness of methadone maintenance treatment, or are treatment entry and the power of high-dose methadone enough in themselves for many patients? At least in the first four months, this US study suggests the latter.

Schwartz R.P., Kelly S.M., O'Grady K.E. et al. "Interim methadone treatment compared to standard methadone treatment: 4-month findings." *Journal of Substance Abuse Treatment*: 2011, 41, p. 21–29.

Everything about tobacco rolled up in one book

Designed as a reference book and first published in 2004, this is the second edition, the first having been published in 2004, and is very welcome for such an important public health issue – the preface mentions that tobacco has caused more destruction than wars. This book is extremely useful in the practice of tobacco control in terms of making the case, prioritising interventions and evaluating their impact.

An account of the evolution of knowledge of the smoking epidemic outlines the great studies of the 20th century, notably Richard Doll and Austin Bradford Hill. The wealth and strength of evidence of these studies is undeniable, but they serve to highlight the fact that more needs to be done, particularly in relation to cohort studies testing interventions. The book continues by revealing the practices of the tobacco industry – the use of cigarette advertising, promotion and in some cases blatant deceit. Robertson and Hunt's chapter is an excellent exposé of texts produced by the tobacco companies and their affiliates.

Coverage of the chemical composition of cigarettes focuses on some of the (more than 60) carcinogens in tobacco smoke. Although the compositions have changed, the conclusion is that there is still no safe cigarette. The book describes nicotine and the ways in which tobacco companies manipulate product design to reinforce tobacco addiction.

The next section covers different countries or regions, although the chapters do not appear to be sequential or systematic. Beginning with the European Union, with special attention to new member states, outlining smoking prevalence and tobacco-related harm, this section also describes the epidemic in India, recounting the history of the introduction of tobacco to India, its impact and the government efforts to address tobacco issues.

I expected the chapter "Tobacco – the Growing Epidemic" to describe the world-wide epidemic, or at least focus on continents or group of countries which have swelled the epidemic, but it focuses solely on China. Considering that this chapter is a publication of the largest study ever undertaken to examine the health effects of tobacco, there is a danger that this study specific to China is not clearly identified in the contents.

"The Hazards of smoking and the benefits of stopping" on mortality bridges earlier chapters and those following, which looks at passive smoking, adolescent smoking and tobacco and women. The next group of chapters describes different medical conditions and their relationship to tobacco and smoking. The book ends with an exposition of public health measures, concluding with global

Reviews

■ **Bimpe Oki** is Assistant Director of Public Health/ Consultant in Public Health, NHS Lambeth leads on Health Improvement. Her involvement in Tobacco Control spans more than 16 years.

action to coordinate international tobacco control through the World Health Organisation.

This is a book that one may struggle to read at long stretches, not because it is devoid of interest or substance – quite the contrary. But each chapter is packed with such high quality evidence that some level of reflection is required before proceeding to the next and clear themes linking the chapters would have been helpful in encouraging the reader to continue. Grouping the contents within thematic sections would be an improvement – being a second edition meant there was every opportunity to do this.

That said, the book is an absolute must for anyone with any interest in tobacco or smoking. I look forward to the third edition in the hope that the chapters and titles may be better organised, but more importantly, that it is necessitated by significant future progress in a global reduction in prevalence of tobacco use and its associated burdens.



TOBACCO: SCIENCE, POLICY AND PUBLIC HEALTH: 2nd. EDITION.

Eds.: Peter Boyle, Nigel Gray, Jack Henningfield, John Seffrin, Witold A Zatoński
Oxford University Press 2010
ISBN 978-0-19-956665-5
Hardback
738 pages
£ 70.00

Rethinking Evidence

What does evidence-based policy really mean and how will it play in a new era of local democracy?

Reviews

**EVIDENCE
VERSUS POLITICS
- EXPLOITING
RESEARCH IN UK
DRUG POLICY MAKING**

Mark Monaghan
Bristol: The Policy
Press 2011
187pp
ISBN:9781847426970

In 2008 the Conservative Party announced that it intended to send its MPs for lessons in scientific literacy 'under a plan to strengthen evidence-based policy making', reports Mark Monaghan, in this intriguing if sometimes frustrating book. The notion of reluctant MPs trooping in from the Tory shires to submit to education in science and technocracy – including, one presumes, social science – is testimony to the ascendancy of the idea (one is tempted to say the ideology) of an evidence-based political culture. It is, I think, and for reasons I'll come back to, a moment that may have passed

The commitment to evidence-based policy making was integral to the New Labour project. Why? Surprisingly, perhaps, this is not a question that Monaghan addresses in detail – but he makes some helpful comments. Extrapolating from these, New Labourism was about breaking with a Labour tradition that had (allegedly) conceived politics as a struggle between interests and ideologies – the 'evidential turn' was about stripping the political values (including the traditional Labour ones) from policy making, and replacing them with 'objective scientific evidence' of 'what really works'. Happily, this potentially took the heat out of heavily politicised areas of policy that New Labour hoped to make progress with – in particular, crime and

punishment and drug policy. Who could argue with the motherhood and apple pie notion of policy based on evidence? And didn't evidence lean towards the more 'progressive' approaches to these issues that New Labour broadly favoured?

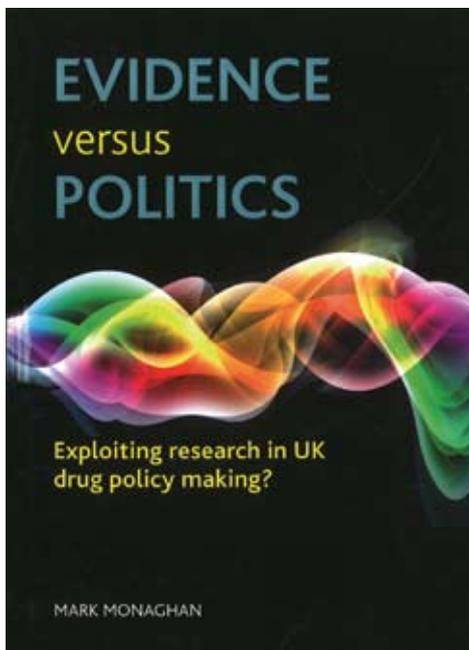
This commitment to 'evidence-based policy' drove a massive and unprecedented expansion in the availability of drug treatment in Britain from the late 1990s, accompanied by significant improvements in the clinical standards of treatment provision and in the availability of data on treatment performance and outcomes (for example, with the creation of the

National Drug Treatment Monitoring System or NDTMS). It also arguably resulted in an increase in 'red tape', an over-dependence on centralised targets, an isolationist (rather than collaborative) mindset from the sector at local level, and a disproportionate focus on 'processes' at the expense of 'outcomes'. The National Audit Office concluded in a 2010 report that the influence of evidence-based approaches on other aspects of Labour's drug strategy than treatment was less clear. It remarked that Labour's 2008 Drug Strategy had failed to provide 'an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes or the value for money provided'. This is equally true of the coalition Government's 2010 strategy.

Disappointingly for me – given that this book is subtitled 'exploiting research in UK drug policy making' – Monaghan has scarcely a word to say about any of this. In so far as he addresses drug policy (and this discussion is largely confined to one chapter), his focus is almost exclusively on drug classification. His starting point is the decision by David Blunkett to downgrade cannabis from class B to C in 2004, which he notes was 'the first instance in the UK whereby an extensively used illicit substance has had penal sanctions lightened', adding – insightfully – that 'with the benefit of hindsight, it is clear that cannabis reclassification was the trigger for the developing interest in the evidence base for UK drug classification and the debates of evidence thereon' (including the hallucinatory decision to place magic mushrooms in Class A in the Drugs Act 2005). Predictably, the 'Nutsack' affair of October 2009 figures prominently.

Monaghan divides the principal interlocutors in the drug classification debate into three camps: 'the radical perspective' (the only evidence-based approach is legalisation and regulation, anything short of this is a shifting of deck chairs), 'the rational perspective' (which accepts the existing framework, including the drug classification system, but looks to evidence to iron out anomalies, such as misclassification of particular drugs) and the 'conservative perspective' (which believes that evidence for abstinence and prevention is routinely marginalised and neglected).

This categorisation is intuitively appealing and helpful. But I was not wholly convinced by it, finding it, simultaneously, too rigid and too loose. For example, many of the organisations identified with the 'rational perspective' (including DrugScope) have publically supported review of the



CANNABIS RECLASSIFICATION WAS THE TRIGGER FOR THE DEVELOPING INTEREST IN THE EVIDENCE BASE FOR UK DRUG CLASSIFICATION

MDA 1971. Conversely, organisations like Release who are linked with the ‘radical perspective’ have also been active campaigners for better use of scientific evidence in the operation of the current A, B, C framework. I was particularly concerned by Monaghan’s classification of DrugScope as an ‘official organisation’ (here grouped together with statutory agencies like the ACMD and ACPO) on the grounds that we receive some Government funding via the Voluntary Sector Investment Programme (VSIP). It is entirely proper to analyse the impact of Government money on the activities of the many charities and other independent organisations who are recipients, but Monaghan’s classification seems to me, frankly, eccentric and unhelpful. DrugScope is not, in any meaningful sense, an ‘official organisation’ (paradoxically, if we were, we could not receive funding through VSIP).

These misgivings aside, Monaghan’s discussion of drug classification provides a vehicle for some interesting and insightful reflections on the nature of the relationship – or rather relationships – between policy and evidence. Pointedly, there is no clear indication of where Monaghan stands on the substantive debate on drug classification or even of which of his three ‘perspectives’ he believes makes the ‘best’ use of evidence. Instead he argues that the relationship between policy and evidence is not a zero sum game (we cannot simply say that a policy position either is or is not evidence based), it is rather that different kinds of evidence inform policy development, implementation and analysis in a variety of ways with different impacts at different points in the policy process (for example, there is evidence that is relevant to the classification of drugs within the MDA 1971 and there is evidence relevant to the value of the whole classification enterprise) and within a context shaped by high principle and low politics.

In addition, some versions of the evidence-based policy mantra have appealed to an overly simplistic and outmoded epistemology and philosophy of science. In reality, even in the natural sciences, new findings have repeatedly challenged and overthrown old ones, and – particularly in social sciences – ‘inconsistent and often contrary findings are commonplace’. A nomination for the least likely thing you’ll hear from an academic researcher (at least in the social sciences) is the sentence ‘our research is conclusive and points unambiguously to a specific policy solution’ – there are usually equivocations, there is generally a call for ‘more research’ to be done.

Monaghan dismisses the ‘linear model’ of the evidence-policy relationship according to which there is or should be a direct and unmediated link between evidence production and policy making, exploring a number of alternative models of this relationship (‘political tactical’, ‘interactive’, ‘research as part of the intellectual enterprise of society’, ‘dialogical model’ and ‘evolutionary model’), before finally coming out in favour of what he describes as ‘a processual model’. Monaghan concludes by challenging ‘the widespread assumption that heavily politicised policies are evidence free, but also challenges supporters of the said politics from claiming them to be wholly evidence-based. The quest is to show the role of the nature of evidence in the decision-making process and to contribute towards a toning down, and more realistic appreciation, of what evidence-based policy is and can be’.

Monaghan’s book is a timely invitation to – and primer for – this important debate. My sense is that ‘evidence-based policy’ as we have understood it for the past decade or so, is in retreat, but then, as Monaghan argues, this understanding is not the only (or best) one. It is an interpretation that has been associated with centralist policy processes (topically, Monaghan links it, for example, with the EU, because its authority is based on claims for knowledge and expertise rather than democratic process). Apart from anything else, and despite the progress that has been driven by the New Labourist take on evidence-based policy, tactically, this is not a model of the evidence-policy relationship that will be an easy sell to the coalition government.

A good question, then, is what *evidence-informed* policy should look like for a Government committed, for example, to the reinvigoration of local democracy. Part of a good answer may be that if local decision making is not shaped and informed by evidence in the variety of ways that Monaghan discusses, this is not only a recipe for policy failure but also for sham democracy. Meaningful local participation depends on providing local decision-makers and populations with the tools that empower them to make informed and rational decisions on critical issues that affect their lives and communities. So understood, evidence and democracy are not in tension; on the contrary, the first is an indispensable condition for the meaningful exercise of the second.

■ **Marcus Roberts** is DrugScope’s Director of Policy and Membership.

'The Wire' comes to Hackney. Or does it?

Reviews

TOP BOY

Ronan Bennett
Series 1: DVD
October 2012
(first shown Ch4,
November 2011)
Series 2: Winter 2012



It was noticing a 12-year-old crack and heroin seller dutifully going about his business outside his local supermarket in the London borough of Hackney that spurred Ronan Bennett to write a screenplay about young, inner city drug dealers.

Determined to further investigate the largely hidden world he had just glimpsed, Bennett decided to speak to the boy. All he got was a few mumbled lines and a request for financial compensation for lost time. But then followed two years of interviews with a panorama of players in and around the drug trade, from police officers and cannabis farmers, to gang members and community figures.

Bennett's extensive groundwork formed the basis for the Channel 4 drama *Top Boy*, screened over four consecutive nights in November, and commissioned for a second series, to be shown later this year.

The series, which averaged 1.9 million viewers, represents the latest offering in a new wave of films and TV shows that have attempted to depict the drug trade with some sort of accuracy, and without resorting to urban myths and mindless stereotyping.

In a new era of crime and social issue dramas, largely influenced by the huge critical acclaim in Britain of the hit US series *The Wire*, credibility is king. Based on years of research by its writers, *The*

Wire offered a unique insight into how the drug trade actually worked, while placing it firmly in the bigger picture of policing, poverty and politics in city of Baltimore. As a result, post-*The Wire*, wheeling out the usual hoary old clichés about the drug trade is now a risky strategy for producers. They know audiences have wised-up.

Like *The Wire*, although nowhere like on its breadth or depth, *Top Boy* delivers a well-researched, contextual and objective approach to the world of drug dealing. Its plot has echoes of a classic Guy Ritchie style gangster caper, with snitches, brutal violence, rival firms and shady 'capos' holding court in dodgy nightclubs. But that's where this short but sweet series' links with more traditional TV and film depictions of this illegal economy ends.

Behind the fast-shifting storyline, *Top Boy* is a sincere and honest attempt at portraying the hidden drug and gang world and the characters that inhabit it. In Bennett's own words, it's "a visceral appreciation of a world that viewers have heard of but never seen."

The series opens, as Bennett first encountered it, amid Hackney's bustling streets. Alongside the wigs, goat heads and Caribbean food stalls, kids are carrying out street drug deals, overseen by two

'managers' in their mid-20s, Dushane and Sully, who slurp from drinks and fiddle with their mobile phones.

Drugs are served up in food boxes in take away restaurants, while deals are discussed in the local café. The runners offload their wares to buyers seemingly unhindered by the police or the public. Here, drugs are "part of the fabric of life", a line Bennett was given by a senior police officer he interviewed during his research. It's a line repeated by Dushane in the show, when he is explaining the way police largely leave the street trade untouched.

The show leads viewers into a parallel, but instantly recognisable universe of drugs, cut throat diplomacy, gangs and violence. It nevertheless exists only yards from some of the nicest streets in London. But while the action in *Top Boy* occurs on the fictional 'Summerhouse Estate', the mention of a rival London Fields gang in the opening five minutes places the show firmly in reality.

In 2010 Leon Dunkley, a member of a gang from London Fields area, shot dead 16-year-old Agnes Sina-Inakoju as she waited for pizza in a takeaway. A month later a sunbather relaxing on London Fields was seriously wounded after being shot in the lower back during a shootout between rival gangs. Both shootings received national media coverage and London Fields was being compared to Los Angeles.

Like *The Wire*, most of the characters in *Top Boy* are based on real people interviewed by Bennett: the respected middle aged community figure trying to stand between the gangs and the kids, the single mum growing cannabis plants to fund her escape from the sink estate, and the young boy dragged into a life of drug dealing. And like *the Wire*, some of the young actors are no strangers to the scenes they are playing out in front of the camera.

The lack of a police presence in the show – the Met only turn up at murder scenes – was criticised by a mini-focus group of local teenagers who watched the series for *The Guardian* newspaper. But the selective blindness of the police when it comes to the drug trade is actually one of a number of truisms in *Top Boy* that mark it out as a cut above the rest.

As Dushane later tells his drug boss, "the Feds know we are buying and selling in Hackney, but as long as we don't make a noise, they don't really care."

Indeed, the senior officer interviewed by Bennett backed this up. "As long as there's no rise in ancillary crime, breaking into cars, muggings, burglaries, we leave it alone."

Top Boy accurately depicts the modus operandi of drug dealing outfits around the UK. In one episode, Dushane and Sully temporarily move a team of runners into the grim-looking council flat of a heroin user called Robert, who is treated like a dog. Drug dealers will use the homes of vulnerable people – often those addicted to heroin and people with mental health problems – as a base from which to sell wraps to the local community or estate. In return the tenant will be drip-fed free drugs to keep them happy.

In another scene, two young boys, Gem and

THE VIEW FROM HACKNEY

Colin Stewart, drugs advisor at Release, who has lived on the same Hackney estate for 15 years

The Hackney of *Top Boy* does not exist. From my knowledge of drug dealers on estates in Hackney, the dealers in the film were stereotypes and there was not much of the real shades of grey. The gangsters seemed out of some American film – Dushane reminded me of a Spike Lee character. The white East End villain at the top of the chain was equally cardboard and I've never seen black dealers being run by a white powerbroker. The estates in Hackney have saturation police levels and in *Top Boy* they were just not there.

In my estate, drugs are generally dealt by one or two young residents working as sole traders, whose peer group will help out if there is a threat from another estate. But all activity is kept as low key as possible. If you score on the estate you will often see groups of two or three waiting for the boy to deliver the drugs. The dealers employ 'shooters' who can earn £100 a day.

In *Top Boy* all the dealers were young black men, which is not totally representative – you will have young white guys, second generation Turks and if you cross Hackney Road, the majority of those involved in street supply will be second or third generation Bengali boys.

The estate you grow up in can become almost a prison. Walking off your manor will potentially get you beaten up, stabbed and possibly shot, but the majority of estates are being gentrified in droves.

'Gangs' are largely a creation of the media, it is a much looser affiliation of people from the same place with common aspirations.

Ra'Nell, are asked if they want to earn some money selling drugs. The dealers know both boys have no fathers, they place wads of money in the boys' hands and offer them protection and favours. They point to two of their employees, a 10-year-old boy and a young schoolgirl. "You got to step up to the mark like these two. Your dads are not around, you gotta help your mums. We are here, we are your family now, think of us as cousins."

Many viewers will be familiar with the image of a shrine to a shot teenager. *Top Boy* provides the unseen aspect of this: the shrine, and the victim's family home are being watched around the clock by young lookouts working for Dushane and Sully, who are hunting a rival gang member.

One of Bennett's real life interviews, Gerry, a fitness trainer who is well respected in Hackney, hates the gangs. He told him: "They pretend they're your family, that they'll look after you, that they are there for you. But they're not, they're going to use you." While the lead characters are played by current or former rap stars, Ashley Walters, Kano and Scorcher, *Top Boy* is far too clever to end up glamourising or demonising them.

Most of the characters, like the people Bennett interviewed, are not evil, they are just looking for a route out. As Dushane explains to one of his superiors: "I want a good life. I was born and bred in Summerhouse, I'm 26 years old and I haven't anything to be – except this."

■ **Max Daly** is a freelance journalist and author of *Narcomania* (Random House, 2012).

39 factsheet



DrugWatch

Black Mamba



This factsheet is produced under the auspices of DrugWatch, an informal association of organisations including DrugScope, Lifeline, Crew 2000 and UKHRA, who share an interest in establishing a robust and flexible early warning system for drugs in the UK. This would include both illegal drugs and so-called 'legal highs'. A website for DrugWatch is under construction.

Black Mamba is the brand name for a light green herbal product that tests show contains the synthetic cannabinoid AM-2201 and Oleamide. Examples of packaging are shown below.

Structurally, AM-2201 bears a close resemblance to the more frequently reported JWH-018. However, AM-2201 is not currently controlled in the UK. Oleamide, a naturally occurring substance, is the amide of the fatty acid oleic acid. It induces sleep in animals and is being studied as a potential treatment for sleep and mood disorders. It is not controlled in the UK and may be added to enhance the effect of the synthetic cannabis.

Practitioners should be aware that there is a strain of real cannabis called Black Mamba and an energy-burning product called 'Black Mamba - hyper rush', aimed at bodybuilders (allegedly containing ephedra).

Where is it bought and how much does it cost?

As with other 'legal highs', this product retails from head shops and online. AM-2201, one of the active ingredients, is also being sold in its own right, both by the gram and in wholesale amounts. Typically, Black Mamba users are reporting that they have paid £10 for a packet containing a gram, or £25 for a 3g packet of herbal material

What does it look like?

The product itself looks like light green buds or herbal matter; no stalks or leaves are present although occasionally a very small red seed has been seen. When sniffed inside the packaging, a strong solvent / chemical smell can be detected, but there does not seem to be a strong smell on the buds themselves, nor does the product give off a strong odour when smoked.

On the green Kanna-branded packaging samples pictured here, the writing on the back is so small it is almost illegible, but it does state that it is legal in Russia and the EU (with no information about what the product actually is). User reports in this briefing all refer to the Kanna product.

The black packaging also pictured is for a product

which comes from a US based website supplying users with products in UK prices. This Black Mamba product seems to be more expensive than the Kanna Black Mamba and may not be the same substance. There are reports that Black Mamba is available as a white crystalline powder form, although there is no forensic data to back this claim at present.

Effects/risks

According to user reports, when smoked, the substance has 'skunk-like' qualities but is much more likely to cause uncomfortable distortions in reality and hallucinations.

It may cause breathing difficulties, vomiting, severe rashes, increased heart rate and cardiac arrhythmia (heart skipping beats) and 'loss of control' over some parts of the body. There are press reports of people being admitted to A&E after using the drug (see user reports below). It is reportedly as habit-forming as cannabis but long term risks associated with its use are unknown.

Users should be advised of the potency of the product and to use far less than a like for like measure of skunk. They should also be warned about the potential increased potency of the drug at the bottom of the bag where small amounts of whitish crystals have gathered which have probably fallen off the green buds. Even at tiny doses, these crystals are significantly stronger than the rest of the contents and likely to cause severe psychological reactions.

User reports

Two regular cannabis users from Manchester gave DrugWatch an account of their experiences of smoking Black Mamba. Both agreed that it was "much stronger than skunk" and that the high was both 'instant' and 'intense' - one said it was "like smoking weed but without the sunshine feeling." Hallucinations and visual distortions came on quickly and were disturbing. "It took me to a very uncomfortable place where I didn't want to be." Vomiting, loss of control of parts of the body and breathing difficulties were also reported.



A drug worker from North Tyneside took this report directly from a client, who had been hospitalised after smoking the drug for the first time with a group of friends. Almost immediately after inhaling the product, he described experiencing profuse sweating, a pounding headache and the feeling of having taken a stimulant. After an estimated two minutes, his reaction worsened:

“My throat started swelling up and I couldn’t breathe. You couldn’t touch my skin – it felt horrible and really hurt to touch. My skin came out in a rash and there were red blotches everywhere. It felt like my body was shutting down [...], like my body was going to explode. I fell on the floor and vomited everywhere and couldn’t stop being sick. I was twitching and couldn’t control my body. I can remember everything – I could hear everything but couldn’t control my body.”

He was taken to A&E and released the following morning, but later on had to be readmitted to hospital after finding it extremely difficult to breathe again. Staff from his support lodgings verified the account given by the client to the drug worker and reported that he had been given adrenaline, Amoxicillin and Piriton in hospital. The man reported that it was a week before he felt normal again. However to our knowledge in neither of these cases has the presence of AM-2201 or oleamide been confirmed in urine or blood samples.

Summary

- The name Black Mamba can refer to various different products; this briefing relates to a synthetic cannabis product. AM-2201 and oleamide are not currently controlled substances. The role of oleamide is unclear.
- When smoked, Black Mamba is fast acting and has ‘skunk-like’ qualities but is more likely to cause uncomfortable distortions in reality and hallucinations.
- Physical side effects include vomiting, breathing difficulties, painful rash and loss of control of body parts. One hospitalisation as a result of a severe reaction has been documented by DrugWatch.
- Users should be made aware of potency and potential risk to life if a severe reaction occurs.

Please note: DrugWatch is not suggesting that this particular compound is any more dangerous than any others in the large family of synthetic cannabis compounds, nor that others are safe. It is simply that this one has come to the attention of DrugWatch members.

drugworld DIARIES



EILEEN DOYLE

**Service Manager,
Cranstoun City Roads**

Cranstoun City Roads is a 17-bed residential detoxification unit for planned and crisis admissions. We were a pan-London service, but recently we have developed contracts with outer London and the Midlands. My post as Service Manager at Cranstoun's City Roads was always going to be challenging, despite over 20 years experience in substance misuse work and nursing prior to that. However, I am on a steep learning curve, especially given the wider social and political issues concerning health and social care delivery and funding.

City Roads is a very busy service with over 1,000 referrals annually, 500 of which become admissions. The crisis remit can throw up the unexpected too, so I am often involved in troubleshooting.

As service manager, I need to ensure that all teams operate effectively and communicate well. Our large staff team includes the admissions team for all of Cranstoun's tier 4 services and 19 volunteer/trainee workers, a vital part of our service.

Monday morning and I arrive for the handover early, so I can talk to night and day shift staff who provide 24-hour cover (nurses and social care). We discuss any dilemmas, such as behavioural issues that might jeopardise a client's successful completion. I catch up with the housekeeper, chef, and check in with admissions. Only then do I head off to tackle email, the ever-beckoning taskmaster.

I hold a practice management meeting with the social care and nurse team managers to agree the allocation of this week's business. These meetings cover anything from staff training,

Health and Safety reporting, menus, stats and clinical practice issues to whose turn it is to buy the coffee. It's always focussed on ensuring we are delivering the best possible service.

UNFORTUNATELY, IT'S NOT ALWAYS POSSIBLE TO PLAN ADMISSIONS: PEOPLE'S LIVES JUST DON'T WORK LIKE THAT. CRISIS INTERVENTION IS A VITAL PART OF THE TREATMENT SPECTRUM

This afternoon I have one of many partnership meetings with the London Pathways project at University College Hospital, working to reduce inappropriate hospital admissions from the homeless. Our common interest in working effectively with some of London's most vulnerable clients makes this a crucial discussion. My two managers support me and attend some of these frequent interagency meetings. Networking and liaising could almost be a full time job!

Throughout the day, I pop into the admissions department to discuss emerging issues around the contracts and liaison with commissioners. Today the team tells me that at 1.30pm they were asked if they could do a same day admission for a female who needs detoxification, but is also experiencing severe domestic violence and needs a place of safety. Our team excels at

responding quickly; by 4pm this client is safely admitted.

The care team are highly skilled but occasionally call on me for support. The new admission, Michelle, is aggressive; they were worried that she might hit someone. Meeting Michelle, I realise that she is simply terrified and defensive. As I talk to her about how we can support her, she stops shouting and starts sobbing..

I rush back to working on the report, due in tomorrow! There is always an urgent piece of written work, but we are here to support our clients – it's not always easy to decide what and how to prioritise! Our team are dedicated and most have worked at City Roads for a long time, but I try to maintain an open door policy. My two managers also support the teams well – especially when there is a deadline to meet.

I am concerned for the future of the crisis component of the service, because of the increasing emphasis on planned admissions and reduced budgets. Unfortunately, it's not always possible to plan admissions: people's lives just don't work like that. Crisis intervention is a vital part of the treatment spectrum. Some argue that outcomes for unplanned admission are poor; at City Roads, we are working on improving our monitoring to demonstrate the positive outcomes and lasting public health benefit of our work.

I feel that the funding for this client group should be grant-based. Demonstrating the need and the effectiveness of the crisis model to the powers that be will be a major focus for 2012. Looking back at how and why City Roads came into existence, I sometimes think we have come full circle.

**Tell us what
you think about**

Druglink

At the dawn of a New Year, we would like to give you a chance to express your thoughts and opinions about Druglink.

- In general what do you like or dislike about Druglink?
- What do you think of the quality of the articles?
- Does Druglink reflect your concerns and interests? If not, how can we improve?
- What would your view be about making Druglink available in formats other than print, for example: web, Kindle, ebook?
- Any other points you would like to make?

We may conduct a formal survey later in the year, but in the meantime we would genuinely welcome your feedback to harrys@drugscope.org.uk

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