NEWS AND BEST PRACTICE IN SUPPORTING FAMILIES AFFECTED BY DRUGS AND ALCOHOL

# families upfront

MARCH – MAY 2013 ISSUE 8

## > In Focus: club drugs and legal highs

## > The evidence base for family support

## > Staying silent: families and alcohol use

families **upfront**



{ Nobody has been accountable for driving up the quality of family support in the same way the NTA has for drug treatment at large }

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{ Parents may feel swamped by the sheer amount of different drugs available }

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{ With the benefit of hindsight all the signs were there, but I was unaware of them }

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**Acknowledgements**
Adfam would like to thank all those who have in any way assisted in the production of *Families UpFront*

Published quarterly by
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CHANGE has been a central theme of many articles in the *Families UpFront* archive and we might be tempted to ask ourselves – when will things settle down? Not yet, seems to be the answer. Even drugs themselves are changing, and we remain engulfed in a fog of shifting priorities, moving targets and evolving language in both policy and practice.

Changing language is a particularly interesting point, and one which runs through this whole magazine. In the news (pages 2-3), Iain Duncan Smith has been accused of 'moving the goalposts' as he seeks to change how we define child poverty: this is not simply an academic point, and could have huge implications for how we support disadvantaged children, and even how we see ourselves as a nation. The Government is also pressing full-steam ahead in encouraging local authorities to define their 'troubled families': again, this is not a matter of 'words are only words', as whether a family is classed as 'troubled' or not will go a long way in determining the support they can access.

If we describe family support in the language of 'structured interventions', does this make it more effective, or professional? We examine this question in a discussion of the family support evidence base on page 6. Our article about families affected by alcohol use (page 8) shows how the inability to answer the question 'how much is too much?' can hinder family members from seeking support. Can we class binge drinking as 'problem drinking', and how would it affect services if we did?

Our *In Focus* issue (page 10) is legal highs and club drugs – another area where language is confusing, with daunting new names like 'Black Mamba' and 'Benzo Fury' posing problems for families and services alike. We're surrounded by so many new words, phrases and definitions it can be hard to keep up – but I hope that *Families UpFront* helps you to do just that.

**Vivienne Evans** *OBE, Chief Executive, Adfam*

**Adfam's services include:**

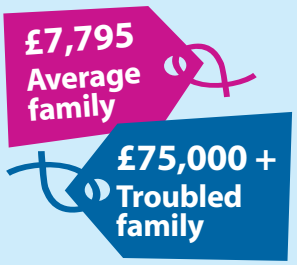
- **Policy briefings** to help keep the sector better informed
- **Training** for families and professionals
- **Publications** for family members and people working with them
- **Consultancy** around providing the best possible services for families
- **Regional forums** for family support professionals

## Troubled families 'cost £9 billion'

As the Department for Communities and Local Government (DCLG) continues its attempts to drive forward the troubled families agenda, *The Cost of Troubled Families* has been published to try and spur local authorities into action.

Using a variety of case studies from across the country, the report looks in detail at the burden placed by troubled families on the public purse: West Cheshire, for example, spends an £7,795 on an average family, but over £75,000 on a troubled one.

*West Cheshire local authority spending*




On a national scale, the DCLG believes that £8bn of local authority expenditure on troubled families is reactive and involves repeated interventions from the police, children's services, housing, health and other local agencies. Local authorities which contributed to the report were asked to cost out the savings they could make – Wandsworth, for instance, estimates it could save £30,000 per troubled family by making more effective interventions.

The DCLG is urging all local authorities to identify the unit costs of their different interventions with troubled families, with a view to identifying savings and inefficiencies. Though the arguments for reform are strong, the report identifies challenges ahead in convincing people to 'stop pursuing current ineffective and costly approaches and to invest in those that are evidenced to be more successful'.

***www.communities.gov.uk***

## Early Intervention Foundation to launch

The new Foundation will champion and support early intervention initiatives by assessing the effectiveness and value for money of different interventions and advising commissioners, service providers and funders. A consortium including 4Children and the Local Government Association will support the new foundation until the summer, when it will become established as a charity in its own right.

Graham Allen MP, who chairs the foundation and also called for its creation as part of his campaign on early intervention, said "it will have a vital role to play in ensuring that every baby, child and young person has the social and emotional capabilities to fulfil their potential".

On February 9, Allen also chaired a Parliamentary meeting to launch the NSPCC's new report *All babies count: spotlight on drugs and alcohol* and examine the success of the *Parents Under Pressure* programme for substance-using mothers, which aims to prevent abuse and improve parent-baby attachment.

Meanwhile, the Government has been accused of 'raiding' the Early Intervention Grant by diverting £150m into adoption reform. Helen Dent, Chief Executive of Family Action, said that increasing spending on adoption while cutting funds for early intervention is "like closing the stable door after the horse has bolted", and Dame Clare Tickell, Chief Executive of Action for Children, said "the uncertainty about the future of the Early Intervention Grant is potentially disastrous for local services".

## Khat stays legal

The Advisory Council on the Misuse of Drugs recently published its review on the harms of khat, a plant with stimulant properties chewed widely in East African communities. It concluded that 'the evidence of harms associated with the use of khat is insufficient to justify control under the Misuse of Drugs Act 1971', and so it will continue to be imported, distributed and used legally.

*Khat: a review of its potential harms to the individual and communities in the UK* found evidence on family breakdown to be contradictory. Somali women reported broken relationships as the most serious consequence of khat use, with men often absent from the household and spending hours at khat cafes; whereas Yemenis more commonly chew khat in domestic settings and did not report the same degree of familial strife.

***www.homeoffice.gov.uk/acmd***

## Data on parents in treatment released

The National Treatment Agency has released a breakdown of parental responsibilities in the treatment population, with national statistics showing that over half of adults in treatment are either parents or live with children and nearly 1,000 pregnant women started drug treatment in 2011-12.

Although parental substance use presents real risks, 'entering treatment has major benefits for parents and children' and serves as a protective factor, the report states. However, it also identifies possible gaps in joint working which could harm engagement with this group: the number of parents arriving in treatment via GPs and other health services is still very low compared with self-referrals or links with criminal justice channels.

Looking forward, the report also asserts that parental substance use will be a key priority for Public Health England when it absorbs the responsibilities of the NTA on 1 April.

*Parents with drug problems: how treatment helps families* is available on the NTA website.

***www.nta.nhs.uk***


## A decade of Talk to Frank

The Government's flagship drug information campaign, *Talk to Frank*, recently celebrated its 10 year anniversary with the launch of a new set of television adverts and a new live online chat function. According to Home Office research, 67% of young people would turn to Frank for advice on drugs, and the website received over 3.3 million hits in 2011-12.

## DWP mulls child poverty change

Work and Pensions Secretary Iain Duncan Smith once again turned his attention towards child poverty and parental addiction in a speech to launch *Public Views on Child Poverty,* the result of public polling undertaken as part of a Government consultation.

Revealing that 90% of the people polled rated 'a child having parents as addicted to drugs and alcohol' as either important or very important in deciding whether someone in growing up in poverty, Duncan Smith called for a more multidimensional definition of child poverty than existing measures based primarily on relative family income. He also suggested that in these families, lifting them above the poverty line may serve to increase dependency.

His comments, however, were met with stinging criticism from the children's sector. Matthew Reed, Chief Executive of The Children's Society said, "let's separate fact from fiction. The vast majority of families in poverty are struggling because they can't afford the basics - not because they are wasting cash on drink and drugs." Similarly, Alison Garnham from the Child Poverty Action Group reasoned that "now is not a time to airbrush the main causes of child poverty out of the picture and move the goalposts".

Research from the Joseph Rowntree Foundation shows that whilst one in five of the population is affected by poverty, less than one in twenty are 'problematic drug users' or dependent on alcohol. Poverty and Social Exclusion, a project funded by the Economic and Social Research Council, questioned the DWP's motives in commissioning the poll in the middle of a formal consultation process.

*The consultation is now closed.*

## NTA prepares to shut down

The National Treatment Agency will shortly fold into the new body Public Health England, leaving behind it some doubts about the future of funding and leadership in drug treatment. Defending its achievements to *Druglink* magazine, outgoing Chief Executive Paul Hayes was on bullish form: "some people in the treatment sector resisted every improvement we tried to instigate because they were quite comfortable being left alone to provide a terrible service to people that no-one else gave a toss about".

## Minimum pricing a step closer?

The Home Office has concluded its consultation on proposals to introduce a minimum unit price for alcohol and ban multi-buy discounting.

The consultation process was beset by predictable disagreement between industry figures and alcohol campaigners. Debating in *Druglink* magazine, Alcohol Concern's Emily Robinson welcomed 'the best national alcohol strategy we have seen', whereas Mark Baird from drinks manufacturer Diageo argued that 'no-one blames Ford or Toyota for road accidents or suggests putting up the price of petrol to deter irresponsible drivers'.

Adfam's response is available at ***www.adfam.org.uk.***


## Social Value Act up and running

Under the Act, which was passed into law in 2012 but 'went live' in January 2013, public bodies are required to consider the economic, social and environmental wellbeing of the local area when making decisions to procure services. This is intended to stem the 'supermarketisation' of local services, by which commissioning and procurement decisions have come to be made on price alone. Although the Goverment encourages social value to be taken into account in all contracts as best practice, the Act itself is only legally binding over a certain threshold of contract value: £113,000 for central Government and £174,000 for other public bodies.

Useful guide available from ***www.socialenterprise.org.uk.***

## Diary

### ● The Recovery Festival 2013

The inaugural Recovery Festival is being organised by The Recovery Partnership, formed in 2011 as the collective voice and channel for advising the Government on its drug and alcohol strategy. The underlying purpose of the Recovery Festival is to build bridges between the business and recovery communities, with a focus on human resources, training and recruitment processes.

*12–13 March, London,*
*£25/£40*
*www.recoveryfestival.org.uk*

### ● Happy families? Equipping practitioners to tackle alcohol issues in families

This conference looks at how parental alcohol misuse affects families, what the lessons learned from supporting practitioners on the frontline are, and how professionals can be equipped to work effectively with children, parents and families.

*25 April, London*
*www.alcoholconcern.org.uk*

### ● Drugs and Alcohol Today

Drugs & Alcohol Today is an accessible event for everyone involved in drug and alcohol services at only £30 to attend, with free places available. Register your interest for the event at info@pavpub.com.

*20 June, Brighton,*
*£30 (bursaries available)*
*www.pavilion-live.co.uk/drugs-and-alcohol-today*

**We are very pleased to have launched our brand new, easy to navigate website where we've split all our information, tools and support into two areas created specifically for families and for professionals.**

Log onto ***www.adfam.org.uk*** to see some of our new features. Browse the free resource library to find all the research, reports and toolkits you need to inform your work; find out about our regional development and see how to join up with your local network; get the latest information on professional development, training and accreditation; and get involved with the professionals peer support section.

We've also launched a **forum** where you can share your experiences, opinions and questions with your peers and we'd love you to use it to help other practitioners. It's also a great space to hear what colleagues are up to and find out about the latest events in the sector, so please do get involved and share your news. Join in at ***www.adfam.org.uk/professionals.***

## SROI RESEARCH FINDINGS

We have recently released a report which details the findings of research into the Social Return on Investment (SROI) of family support services. We commissioned this work from independent experts, who used an established model to test SIAS in Solihull as a sample service. The results were very encouraging.

Through support from SIAS, family members experienced improvements in health and wellbeing, independence, relationships and finances, whilst substance users showed an increase of 26% in treatment engagement, retention and recovery when their family was supported. The service also created huge savings for the state through the reduced burden on criminal justice and health services.

The social value of these outcomes was estimated at £240,000, from an investment of just £52,000. This is a ratio of 4.7:1 or, put more simply, for every £1 invested in the


service, it creates £4.70 of social value.

The research also examined Adfam's contribution to these outcomes as an umbrella organisation. As well as the SIAS case study, information from our annual Supporters' Survey was used, showing that on average, services gave Adfam a 19% attribution rate for the outcomes they secure. Even if we halve this rate to account for services we don't work as closely with, it would still show that we have our own social return of £2 for every £1 of investment.

It is hoped that this data – the first of its kind – will help strengthen the argument that family support is worth funding not just from an ethical standpoint, but from a financial one too. Of course, the full report is available on our website.

## MEASURING OUTCOMES

There is currently no standard system for measuring outcomes with families affected by someone else's drug or alcohol use, and of course we recognise that different organisations will use different tools according to their own service models and the needs of the families they support. However, we also recognise the need to identify best practice within outcome measurement, and provide guidance for organisations and commissioners looking to evidence their work. To help in this, we ran a series of focus groups during February.

The events looked at what family members need, what outcomes they want to achieve and which measurement tools might be appropriate to track their journey with a support service. We also looked at the systems currently in place to measure outcomes in family support, and sought the views of commissioners on what they were looking for when making funding decisions. The goal was to identify good practice and find common ground between how different organisations measure their work.

If you were unable to attend the focus groups then we'd still love to hear from you as we take this work forward. Please get in touch with Kate to discuss further. ***Email k.peake@adfam.org.uk***

## SOUTH WEST DEVELOPMENT

We're pleased to announce that we have recently welcomed **Alexis Woodward** as a new Regional Development Coordinator. She will be working alongside Kate Peake but is based in Bath, and will focus specifically on the South West and the West Midlands. If you work in these regions then do give her a warm welcome.
***Email a.woodward@adfam.org.uk***

## Recovery for families is...?

**At the Adfam/DDN *Families First* conference in November, we asked what recovery means for families. We have been continuing to explore this, and have received some very interesting answers.**

**So what does recovery mean for you and the families you support? If you would like to contribute to this work, please email o.french@adfam.org.uk.**

# The In Touch Project

## is a small charity based in Somerset with recovery at its foundation. Its founder tells her story.

The charity began back in 2006 when I was asked to speak at a conference about what I needed as a family member, and perhaps what I did not get. As part of this, I created my own 'Recovery Wheel', beginning a process of thinking about what family members needed – if this was what *I* required, then perhaps it was what others did too. Several months passed but this idea would not leave me alone. Eventually in 2007, a group of family members sat around my kitchen table and we began work on what was to become the In Touch Project.

Why 'In Touch'? We knew that 'connection' would be at the foundation of the project. We had all experienced stigma, shame, and isolation and had not known where to go for help, how to help our loved ones, or how to reduce our own stress. What we did know was that connecting with others played a large part in beginning our own recovery, whether that was connecting with services or with others who were in similar positions. Last year we connected with the UKRF (UK Recovery Federation) and were very excited to learn that one of their five ways of wellbeing was 'Connect', which resides in the heart of the In Touch Project.

The project provides a range of support to people over 18 living in Somerset who are affected by, or concerned about, someone else's substance use. We call these people concerned others. The project has four main aims: increasing the number of concerned others accessing help and support; promoting support networks; improving the emotional health and wellbeing of concerned others; and raising awareness of the effects of substance misuse on the people around the user and their own need for support.

We try to support people in a holistic way. Reaching beyond the problem of our loved one's addiction was not going to be an easy task, especially if they were not ready for change themselves; but we have seen the evidence many times that when a family member changes, it can have a huge effect on the person misusing substances. We know this is a valuable reason for engaging with concerned others, although that in itself is often a difficult task.

> We had all experienced stigma, shame and isolation, and had not known where to go for help

Once connection is made via phone or email, and when family members feel ready to meet one-to-one, we will start building relationships by doing little things like being there to listen over a cup of coffee and simply building trust. When they're feeling confident enough to visit a group we will offer to 'buddy up' and go along to Families Anonymous, Al-Anon or our own monthly peer support group, which has been running for just over a year and can be a place of both tears and laughter. The group can provide connections for those who have spent years supporting a loved one in addiction, and then felt rejected when that person finds recovery.

Peer support group meetings always end with some kind of creative or fun activity, as we believe it's important for people to leave with feelings of hope and an ability to connect with others outside of the group. We also offer a range of workshops for when individuals feel ready and, since fun is essential, coffee mornings, social evenings, and days out are all available.

Recently we have produced our first newsletter and in the near future will be busy with first aid and overdose training, IT workshops, a three-day residential and our main event, the Recovery in Communities Information Day. This April will be our fourth event and we are learning each year. The day is about raising awareness, changing attitudes, reducing stigma, allowing conversations to take place and connecting both substance misusers and their concerned others to services – and to one another.

A second-year student nurse stated last year that it was "brilliant, inspiring and powerful hearing and being part of other people's experiences. No textbook could have given me this understanding of human experience. The event was thought-provoking and excellently delivered by a wonderfully brave number of people." Our working group of concerned others will be busy planning and connecting to deliver our next main event.

There are many mountains to climb in creating our own vision and remaining on our path. For In Touch, recovery in communities means connecting and building relationships between services, concerned others, and people in recovery from addiction. It's about empathy and understanding and we believe we can all learn from each other.

There are many challenges to overcome when supporting concerned others and we know we will never have the perfect support for everyone. Our dream is to see all the main services work in a more systemic way, reducing added trauma to families.

***To find out more and see our own recovery on film, visit www.intouchproject.org.uk***





# Family support: proving what works

*Families UpFront looks at the shifting sands of the 'evidence base' and what it means for family support.*

THE 'evidence base' has been a buzzphrase for some time in drug treatment. There is a proliferation of different interventions for substance users like motivational interviewing, opioid substitution therapy and cognitive behavioural therapy, and they are the subject of their own handbooks, manuals, training courses and quality controls (see graphic opposite).

Driven largely by the National Treatment Agency (NTA), over the last decade there have been concerted efforts to drive up both the consistency and quality of care for drug users through the delivery of interventions with a proven record of effectiveness. Replicating successful models of care ensures that good quality services are available on a large scale and avoids the dreaded 'postcode lottery' of disorderly practice.

The General Medical Council's *Good Medical Practice* states that clinicians 'must provide effective treatments based on the best available evidence'. Along the same lines, the *UK Guidelines on Clinical Management* (commonly known as the 'Orange book') is 'based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances'.

This all sounds like common sense in medical terms, but what constitutes 'effective treatment' for families suffering the effects of a loved one's substance use? How much 'professional consensus' is there in family support? What would diagnosis look like, and what's the 'best available evidence'? What's an 'evidence-based intervention' for families?

## One step behind

Family support has often found itself playing catchup in drug policy. It's taken so long to convince people that family support is meaningful, and worth investing in on a national level, that the next step – the minutiae of which approaches work best with families, according to which measures, and why – has barely got off the ground. As noted by the UK Drug Policy Commission in its *Forgotten Carers* research, 'there [is] low delivery of named evidence-based interventions both to family members on their own or as part of joint working with family members and drug users.'

> family support is often based on enhancing coping skills to manage a situation that is largely outside their control

Nobody has been responsible or accountable for driving up consistency and quality in family support in the same way that the NTA has for treatment at large. It therefore remains a patchwork, and the consistency of practice that adherence to the evidence base can create has been lacking. Building this evidence base is a long and laborious process, and since family support has historically been a fringe issue, it does not have the benefit of decades of research, undertaken by academic institutions or sponsored by Governments.

## Effective at what?

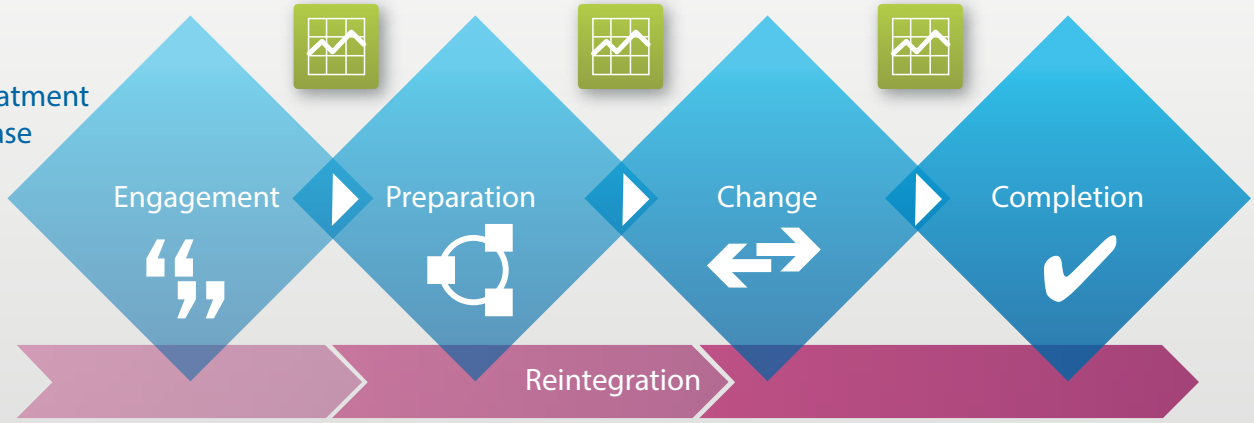
Another key problem in establishing the evidence base for particular interventions in family support is that in order to show that an intervention is effective, you need to show *what* it's effective *at*. That is – what do family support services aim to achieve? Is 'tough love' an intervention, for example, and what is it 'effective' at doing? Despite clear testimonies on the value of family support from those who receive it, there have often been grey areas in how the value of emotional support is played out in practice.

For instance – in drug treatment, the evidence base may be built around ideas like engagement in treatment, the transmission of blood-borne viruses, involvement in crime and, of course, abstinence from drugs. In contrast, consensus on positive outcomes has not been achieved to the same level with families: an 'effective' intervention could be one which improves the family member's mental health (which is difficult to measure in itself), it could help to engage the user in treatment, or it could support a number of outcomes in between. Even more difficulties arise when we see that family support is not predicated on changing the behaviour of its own service users in the same way that drug treatment is: notwithstanding the family member's role as an 'influential other', family support is often based on enhancing coping skills to manage a situation that is largely outside their control, ie the behaviour of their substance-using loved one.

## Beyond the intervention

Training workers up to deliver a particular intervention with a good track record could be much cheaper than commissioning independent research into an individual service. Put this way, an evidence base can provide a shortcut for services which aren't in a position to undertake bespoke, robust evaluation of their own practice – a Randomised Controlled Trial, the 'gold standard' of evidence, for example, is far beyond the means of most family support services. Delivering a particular intervention can allow services to 'piggyback' on existing knowledge rather than (or as well as)

**Skills framework**




*The Skills Hub is a comprehensive guide to interventions and competencies for work with substance users.* ***www.skillsconsortium.org.uk***

commissioning expensive individual evaluations.

However, not everyone thinks that the 'evidence base' for particular interventions is all it's cracked up to be. Writing in *Families UpFront* 6, Phil Harris stated that 'an 'evidence base' [for drug treatment] was created, but it didn't show that one type of intervention was better than another', and that 'type of therapy only accounts for 1% of overall outcomes'. The 'working alliance' between practitioner and service user is much more important, he argued.

Even *Routes to Recovery,* an NTA toolkit for implementing treatment interventions recommended by the National Institute for Health and Clinical Evidence (NICE), admits that 'it is important not to stress the technical aspects/competences of particular interventions at the expense of generic competences such as the importance of relationship building and the management of the therapeutic process', and that 'there is compelling evidence that variation in therapist competence and performance is... probably the single largest contributor to variance in outcomes'.

Another doubt about the evidence base is that many 'interventions' seem to describe fairly common-sense actions, or ways of working that services may have embedded a long time ago without a technical name. Again, as stated in *Routes to Recovery*, 'keyworkers will, in many cases, already be delivering the majority of the low-intensity interventions [in the toolkit]'.

As an example, 'contingency management' is listed as an approved intervention in NICE guidelines, and the terminology may not sound immediately familiar to a family support audience. However, on closer inspection, 'contingency management' amounts to little more than offering incentives to drug users (including money) as a reward for good behaviour (evidenced by negative drug tests).

Similarly, the 5-Step Intervention – one of the few designed and evaluated purely for work with family members – is built around the processes of listening, reassuring and exploring concerns; providing relevant information; counselling about coping; counselling about social support; and discussing needs for further help. None of these steps will be alien to family support services, but relatively few will be calling it '5-step' or implementing it in such a structured way, and may therefore struggle to use the evaluation success of 5-step in support of their own work.

## The future of evidence

This is not to say we should lose sight of the clearly laudable goal of consistent, effective practice on a national level, which the categorisation of different interventions has undoubtedly helped to improve.

But the nature of the evidence base is changing, and what was important to demonstrate even a few years ago may not win the same arguments today. In Government and commissioning circles, the direction of travel for the evidence base is very much towards models of evaluation which examine a service's *outcomes* over and above the interventions they deliver – the most obvious example being the growth of Payment by Results. This could provide more room for services to innovate, unencumbered by the need to abide by a particular process around which service delivery is designed, and gives a chance for family support services to take charge of their own destiny. It could also mean that support services which do not officially offer a particular structured intervention are not disadvantaged by never having putting a name on their work, as long as they can demonstrate that they achieve results.

There may be arguments to come as to what form these results take – hence Adfam's regional forums investigating outcome measurement for family support (see page 4). What may be seen as the most important outcomes by commissioners – the engagement of substance users in treatment, for example – may conflict with the deeply held belief that families affected by substance use should be supported on their own terms, and not just judged on the circumstances of the user. There may also be a conflict between what is easy to measure, and what is truly important to families' lives.

Whichever route is chosen by a family support service, there is still a need for structure and for a properly competent, trained and supervised workforce – as Harris notes, directionless treatment produces the worst outcomes of all. Services have to explain what they aim to change and how this will be delivered across whole groups of service users, which necessitates consistent models of practice. Demonstrating that you are providing an intervention with a proven history of success – albeit outside your own organisation – can still be a useful tool in demonstrating that a service has clear aims, knows how to go about achieving them, and is worth investing in. But the supply side of support work – an effective intervention and a qualified worker – is where things *start,* not where they end.

# Staying silent: families and alcohol use

*Adfam's new report* **Out of Focus: How families are affected by problem drinking, and how they seek support** *examines what the key challenges may be for families suffering the effects of a loved one's alcohol use.*

Drugs and alcohol are often grouped together in discussions of substance misuse. Although there are many crossovers, there are also some crucial differences, including in the impacts on the family and how relatives go about accessing support.

## Delayed access to support

Family members interviewed for Adfam's research often struggled for a long time before accessing help – many over five years, some over twenty, and some never at all. The reasons behind this were numerous and complex, but at the heart of it was a difficulty in identifying what constituted an 'alcohol problem'.

This could be linked to the seeking of help by the problem drinker themselves, many of whom wait twelve years longer to access treatment than drug users[1], which could in turn limit their family members from accessing support too.

## How much is too much?

Although they may face their own delays in seeking support – not least because of stigma and shame – families who find out a loved one is using drugs may be quick to identify this as a problem, as an illegal activity associated with a number of health and social harms.

By contrast, the legality of alcohol, its widespread use and the societal ambivalence towards (or even celebration of) heavy drinking all mean that concerned others can struggle to classify a family members' alcohol use as a drinking problem. This was tied up with assumptions and stereotypes of what an 'alcoholic' is, and an inability to match this up with their own family member.

Drinking problems can also develop gradually over time, without an obvious tipping point into dependency or alcoholism. This could be exacerbated if the drinker was able to conceal their consumption (one family member recalled finding a stash of empty cans in the attic as a moment of realisation), or if they were able more generally to maintain the pillars of a 'normal life' like holding down a job. Tipping points were hard to identify, but families said that only when the drinker was unwilling or unable to cut down that the problem really came into focus.

> one family member recalled finding a stash of empty cans in the attic as a moment of realisation

## Getting the point across

Binge drinking was a topic of interest for families, as it represented a pattern of alcohol use that was not classed as 'dependent' but which could still have significant negative impacts on family life and relationships. However, according to the research, GPs and specialist services usually didn't deem this 'serious enough' to warrant official intervention, and families could feel even worse for having broached the topic as it could provide support to the drinker's claims that there was no problem with their consumption.

Even when trying to open up to friends, families could find themselves in a catch-22: if they focused on the level of consumption alone, then they struggled to get their point across as to how serious things had become; but if they focused on the behaviours associated with their loved one's drinking – arguments, fights, car crashes, incontinence – then they risked horror, incomprehension and stigma from those around them.

## Looking inwards

Some family members also showed a lack of awareness of their own needs, and many assumed that getting help for the drinker was the only issue at hand. Even for those who did feel they needed support, they often didn't know it was available or were doubtful that it would do any good; families were again quite critical of GPs and specialist services, and examples of being signposted towards support were few and far between. These were crucial missed opportunities not just to engage families, but to engage drinkers too.

## Insufficient support for families

For the families interviewed who did access support, feedback was generally very positive – they viewed it as a 'lifeline' and a 'Godsend', and valued the opportunity to explore their problems in a non-judgmental environment. However, the range of support tended to be limited to self-help groups, where not all families felt comfortable, or were more focused on drug use than alcohol.

Overall, this research shows that families affected by a loved one's drinking seem beset on all sides by barriers which prevent them from accessing support. They may not have the knowledge to identify a drinking problem in the first place; they don't always recognise the impact it has on them, and their own consequent needs; they're often unaware of the existence of family support, or sceptical of the benefits it could bring; and their first step in reaching out may not be a positive one and knock them back even further.

As well as improving the reactions of professionals to families' queries, there is also a need for families themselves to increase their comprehension of problematic alcohol use so they feel confident and motivated to seek support when they feel that they need it. Perhaps the Government's current focus on the widespread, cheap availability of alcohol may make people confront how much they drink in ways we haven't seen before, although this remains to be seen; but either way, there is a clear need for expansion and improvement in the number and quality of services which support people struggling with the day-to-day impact of alcohol use in their family.

***Report available from www.adfam.org.uk.***

1 Naughton et al (2008) *Accessing treatment for problem alcohol users: Why the delay?*, Gloucester Research Unit

# Your organisation

*Recently published resources on third sector issues and charity governance .*

## 1 Collaborating for Impact

**NPC/Impetus Trust**

Collaboration between charities to deliver public sector contracts is becoming more common. As well as the key benefits of this cooperation – reduced duplication, for example – this report also sets out a number of inherent risks in collaboration, such as a reduced focus on service users in the drive to satisfy commissioners. Barriers to successful collaboration might include insufficient understanding of how scaling up will affect a charity's finances, or a culture in which organisations seek to protect their own independence or superiority.

***www.thinknpc.org***

## 2 Local Authorities and the Voluntary and Community Sector: Investigating funding and engagement

**Compact Voice**

This report is based on Freedom of Information (FoI) requests to 352 Local Authorities regarding their funding for Voluntary and Community Sector (VCS) organisations. For 2010-11, 71% of Local Authorities reported holding contracts with the VCS worth some £786 million overall; but in 2011-12, this dropped to 69% and £509 million respectively. 56% reported reducing their grant funding to the VCS between 2011-12 and 2012-13, whereas 35.5% said they made more money available. The information collected shows that around half of Local Authorities are using VCS organisations as a 'soft target' and cutting their funding disproportionately.

***www.compactvoice.org.uk***

## 3 Independence under threat: the voluntary sector in 2013

**Panel on the Independence of the Voluntary Sector**

This report identifies a number of key challenges which are putting the independence of the voluntary sector under threat. As well as a 20% fall in real-terms donations over the last year and shrinking state funding, charities are also losing their independent voice through fear of speaking out against the authorities; contracting arrangements increasingly favouring the private sector; and non-compliance with regulations to protect charities, like the Government's *Best Value Statutory Guidance*. It is suggested that conditions are deteriorating compared to a year ago, and there is stormy weather ahead.

***www.independencepanel.org.uk***

## 4 Making sense of the Big Society: perspectives from the third sector

**Third Sector Research Centre**

Despite a great deal of media and policy attention, there is little evidence of the extent to which normal members of third sector organisations understand or embrace the concept of the Big Society. On the one hand, there is widespread belief that the agenda presents nothing truly new; but on the other, there is some recognition that a renewed focus on the third sector could bring new opportunities. In particular, this briefing notes that many charities have reconsidered how they describe and package their work in the language of the Big Society in order to demonstrate a good fit with current Government thinking. Overall, the briefing illustrates the central contradiction that the civil society organisations which are essential to the delivery of the Big Society generally regard it with hostility and suspicion.

***www.tsrc.ac.uk***

## 5 Innovation (still) rules: an innovation and creativity guide for not-for-profit organisations

**nfpSynergy**

As well as setting out the essential conditions for innovation – that it's led from the top, given adequate staff time and resources, and is treated as an essential part of business development rather than a luxury extra, for example – this guide also sets out common myths and illustrates the opinions of frontline staff, such as that 40% of charity professionals think that the funding structures available to voluntary organisations inhibit innovation. Notable barriers include fear of failure, reluctance to invest valuable funds and misunderstandings about what innovation really means. Despite these challenges, the guide concludes that 'being good at innovation is within all of our reach' and that whilst innovation may be risky at times, so is continuing to provide the same services in a rapidly changing world.

***www.nfpsynergy.net***

# In Focus **Club drugs and legal highs**

NOW some of the dust has settled from the original explosion of 'legal highs' onto the drug scene, we can look back and say we've learnt quite a lot. Mephedrone isn't to be confused with methadone (yes, it has been); 'Benzo Fury' isn't a benzodiazepine; none of them are really plant food; and legality is no guarantee of safety. But in terms of how families are affected, and how to support them, there is still a great deal to learn.

It would be wrong to dismiss these new drugs as short-lived youthful folly or a flash in the pan: although mephedrone use has dropped from its highest level, it still holds firm as the third most popular drug amongst 16-24 year-olds. Mephedrone may still be popular with the users who were originally attracted by its legality, even now it's been outlawed, and these users may also have been exposed to other drugs, both legal and illicit. Just like many other substances, what began as experimentation or recreation has developed into something more harmful for some users – and for their families too.

The boundaries between legal highs, ex-legal highs and other popular club drugs have become increasingly blurred, and in this magazine we've found it useful to consider them together because they present a similar, new challenge for family support. Patterns of drug use are changing, and so is the concept of what constitutes 'problematic' substance misuse: sooner or later, family support services will have to adapt to meet the evolving needs of parents and concerned others.

The 'trainspotting generation' may be ageing, but drug use – and the problems it causes for families – will remain a fixture of our society for many years to come. Legal highs and club drugs, therefore, could be a window into the future for family support services.

**Joss Smith** *Head of Policy and Regional Development, Adfam*

boundaries between legal highs, ex-legal highs and other popular club drugs have become increasingly blurred

# Setting the scene

*A summary of the key facts on club drugs and legal highs.*

### What are club drugs?

It can be quite hard to accurately describe this group of substances. Adfam generally takes club drugs to describe those which are typically used in pubs, bars and clubs and at parties and after-parties. Many legal highs are included in this definition. 'Club drugs' is a category of usage rather than a chemical or scientific definition (like opiates, for example).

Stimulants like ecstasy/MDMA and cocaine are typical club drugs, but depressants like GBL and GHB also fall under this banner alongside ketamine (an anaesthetic) and less recognisable illegal drugs like 2C-B and 2C-I. Psychedelics like magic mushrooms and LSD (acid) occasionally pop up too, and although its use in the UK is currently fairly limited, methamphetamine (crystal meth) has been growing in popularity, particularly in the LGBT community (see page 14). Club drugs can be used in combination, often with alcohol also in the mix.

### Legal highs

'Legal highs' refers to a nebulous group of psychoactive compounds designed be used recreationally, and which often mimic the effects of existing illegal drugs. By changing a few molecules of a chemical formula, producers can circumvent existing drug laws but retain some or many of the desired effects. Confusingly, some of the best-known 'legal highs', like mephedrone, are in fact now banned under the Misuse of Drugs Act, but are sometimes still referred to as 'legal highs' because the name under which they became famous has stuck. Terminology is further complicated when legal highs are branded as 'plant food', 'bath salts' or 'research chemicals'. This is because, although legal to sell, they cannot be marketed for human consumption. Online stores and 'head shops' on the high street cannot make reference to them being used as drugs, so a spurious and misleading label is used to avoid legal sanction.

### Who takes these drugs?

Club drugs are some of the most commonly taken illegal drugs in UK. Although cannabis is the most frequently used drug, cocaine and ecstasy/MDMA are the second and third respectively. The British Crime Survey reports that 2.2% of 16-59 year olds used cocaine in the last year and 1.4% used ecstasy, and these percentages are significantly higher for 16-24 year olds. The National Treatment Agency (NTA) this year released *Club Drugs: Emerging Trends and Risks* which presents some interesting statistics and trends on club drug usage.

It is important to note that whilst widespread media coverage may project the idea that overall drug use is spiralling (especially among young people), this is not necessarily the case. Although some drugs have become more popular, others have been in decline: cannabis and amphetamine use have been falling for a number of years.

Evidence suggests that the typical profile of those running into problems with club drugs is fairly different from that of the 'traditional' problematic drug user. Dr Adam Winstock is quoted in the NTA report: 'they tend to be a group whose level of functioning is quite high next to heroin and crack users. They're not broke, they don't have criminal records, and they have sought treatment voluntarily before getting arrested or something else bad has happened.' If club drug users do have problems, they tend to have the resources in their lives to support effective treatment and deliver good outcomes – a job, a relationship, a home and a network of friends.

There is also a clear age bias: whilst evidence indicates that the heroin using population is ageing, the age of those using club drugs is generally much younger. Whilst club drug users make up only 2% of adults in treatment they constitute 10% of those under 18 receiving treatment.

### Knowledge and evidence

Because many of these drugs are new, there is a lack of information about them – particularly their long-term effects. Data on mephedrone usage, for instance, is only just starting to filter through. This is in stark contrast to evidence on more established drugs, where decades of academic research and longitudinal data has given us a relatively robust evidence base.

### The legal framework

Partly in response to the fast-moving nature of the legal highs market, the Government introduced a temporary class of drugs in 2011. This is essentially a holding pen for new substances, where importation, production and supply is banned while the Government's advisory council undertakes research into the possible harms of the drug. Simple possession is not illegal under this order, which can last up to 12 months. For instance methoxetamine, a previously legal substance similar to the Class C drug ketamine, was put in this temporary class and based on evidence subsequently gathered, it was decided by the Home Secretary to outlaw it permanently as a Class B drug.

## Find out more

1. **The Club Drug Clinic**
   *is the UK's only dedicated club drug treatment service.*
   **www.clubdrugclinic.com**
2. **Antidote @ Friend**
   *is a dedicated LGBT drug and alcohol support service.*
   **www.londonfriend.org/antidote**
3. **The NTA's Club Drugs: Emerging Trends and Risks**
   *report covers data and trends on the main club drugs*
   **www.nta.nhs.uk**

# New drug, new threat?

***Tony D'Agostino** discusses how services can adapt to the new challenges posed by legal highs.*

IMAGINE your teenage daughter has just received an online invitation to a party, which is happening this weekend. You catch a glimpse of the invite on her laptop and notice that near the bottom of the page there are some links to a website selling legal highs.

An online market in legal highs – also termed novel psychoactive substances (NPS) or research chemicals – has been taking advantage of new web technologies in the UK since 2003. E-commerce websites distributing legal drugs began popping up at a time when people were still unsure about parting with their cash online; but by 2007, for some individuals, buying drugs on the internet with their credit card had become second nature.

The internet is now a common utility in the family home and more and more people have access to it from multiple devices. As long as you have a connection, whether from your desktop computer, tablet or mobile phone, you are open to this modern drug market.

Some reports suggest that new, rediscovered or slightly altered chemical substances are entering the European club scene at a rate of one per week, so it can be difficult for parents and drug services to respond quickly and appropriately. Add to this the long list of illegal club drugs such as ecstasy, mephedrone, cocaine, amphetamines and ketamine, and things can start to become confusing.

"The drug scene is moving really fast at the moment and some people don't even know what they're taking," says Joanna Jones, a Project Worker from the OASIS Partnership in High Wycombe. "Most of the calls we receive are from concerned parents who know something is wrong. Sometimes a few pills or a bag of powder is found in a pocket, or maybe their child is taking risks or finding themselves in trouble with the criminal justice system."

Nobody knows for certain the impact these 'new' drugs might be having on carers and family members. Dr Owen Bowden-Jones, an addiction psychiatrist from the Club Drug Clinic in Chelsea and Westminster hospital (see page 15), said those who take club drugs tend to be younger, employed and sometimes affluent. They do not identify themselves as 'addicts' and are often in relationships.

> ***Parents and family agencies need to be aware of the myths that surround legal and illegal drugs***

Of course, it's worth remembering that whilst there may be hundreds of new drugs around, not all young adults who go out clubbing or partying consume these chemicals. Alcohol still dominates UK nightlife and is the substance that is used consistently by most people, and the most commonly used illicit drug is still cannabis.

Still, evidence now suggests that problematic use of these drugs is starting to come to light. *Druglink* magazine's Street Drug Trends Survey last year identified a number of young people's services in the UK seeing teenagers coming forward with behavioural problems associated with using mephedrone. A particularly worrying aspect of the study was that compulsive injecting was happening with a cohort of users who had never previously injected drugs.

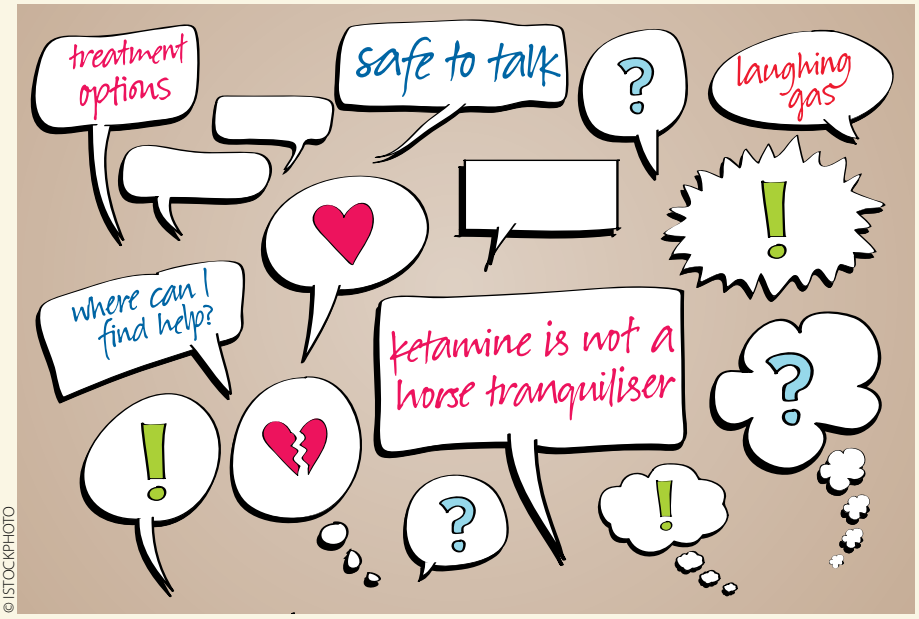
Parents and family agencies need to be aware of the myths that surround legal and illegal drugs. For example, ketamine is not a horse tranquiliser – it is an anaesthetic used on humans and small animals such as cats and dogs. Mephedrone is not bath salts or plant food – it will possibly damage the skin and kill your plants. Methoxetamine is not similar to mephedrone, and is reported to have similar psychoactive effects to ketamine – hallucinations and a sense of leaving the body.

"The whole thing about NPS (novel psychoactive substances) is they're so unknown," says Nick Casey, Health Promotion Specialist at East Sussex Healthcare NHS Trust, "and even more unknown when used in conjunction with alcohol and other illegal substances. That's why it's important for families to get the right information on where to get help and advice."

Casey goes on to explain, "when you search for a local drug service on FRANK's website – this certainly goes for services in East Sussex, at least – nearly all of the helping agencies don't exist anymore or have been commissioned to another agency. Many websites use the information that FRANK gives out to put on their own web page, so somebody looking for local help goes round and round in circles."

Parents and carers who come across unknown drugs, or are concerned about their child using them, can go online and see what services are available on their local Drug Action Team's website. Before contacting a relevant agency it might be a good idea to prepare some questions in advance. Calls can be made anonymously and you should feel safe to talk.

Drug resource websites such as DrugScope (www.drugscope.org.uk) provide accurate information on a range of drugs that parents may find useful.

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Additionally, search for the name of new chemicals on Wikipedia and Youtube and crawl internet discussion forums on research chemicals: this can provide some information on subjective experiences, possible side-effects and any health or psychiatric problems faced by users.

The knowledge base among drug workers, GPs and other professionals on new drugs may vary across agencies but then not all agencies are witnessing the same growth in research chemicals. Norfolk, for example, has only seen an increase in nitrous oxide - laughing gas. Ecstasy, cocaine, cannabis and amphetamine are still very prevalent in this area too.

Many drug services throughout the UK have also been set up primarily to deal with more established drugs such as heroin, and it may be possible they are not attracting this club drug client group. Or perhaps the problem just does not exist in some areas; it is difficult to tell without further research. Some agencies and charities are starting to see the use of legal highs or research chemicals and are responding accordingly to support users and families.

"We aim to raise awareness of legal highs and other substances through our parent and carers service, which will include treatment options and other support mechanisms that families may need", says Colin McGregor-Paterson, Chief Executive Officer of the OASIS Partnership in Buckinghamshire.

"Our website will direct people to other websites that have up-to-date information on these drugs. We will be setting up a legal high clinic one Saturday a month which will provide drop-in opportunities for people wanting more information or to talk to a project worker about their loved one's use."

The multitude of nicknames and brand names that online vendors and teenagers use can make the issue daunting and parents may feel swamped by the sheer amount of different drugs available. As Dr John Ramsey, a toxicologist at St George's University of London, said: "users could have no idea what's in the substances they're taking."

*Most of the commonly used legal highs are in fact closely related to traditional illegal drugs*

This is why it is important to go beyond the brand name and identify the actual chemicals that make up the drug. Most of the commonly used legal highs are in fact closely related to traditional illegal drugs. They sit within the same main seven chemical families that exist at the moment, of which phenythylamines and tryptamines are the main two.

We now know that mephedrone has its own unique pharmacology effecting serotonin and dopamine levels in the brain, and that its long-term observable side effects are very similar to other stimulants like amphetamines and cocaine. Could it be possible, then, to treat problematic mephedrone users with existing psychosocial interventions and harm reduction strategies that have been developed for stimulant drugs?

This might be the same for people who are experiencing problems using synthetic cannabinoids such as Spice and Black Mamba. Though these types of drugs may pose a challenge because there are so many of them, could existing cannabis programmes and interventions be effective? Some differences may come to light or need defining, but it is an area worthy of further exploration and research.

When supporting families affected by drugs, practitioners generally find that the issues are wider than the drugs themselves, with many different emotional and environmental factors at play. The needs are complex and there are often employment, housing and relationship issues: 'the harms of new psychoactive substances are multi-faceted and may be physical (intrinsic to the drug) or social in nature. Health services are starting to see problems caused by regular use of NPS affecting users' employment and education.'[1]

"We have a policy that actually is working," Prime Minister David Cameron has claimed; last year's British Crime Survey of England and Wales appears to back up his statement. The use of conventional drugs such as cannabis, cocaine and ecstasy does seem to be declining in Britain, particularly among the young. On the other hand, Tim Hollis, the drugs spokesman for the Association of Chief Police Officers, said the police were "flat-footed" trying to keep up with the pace of change.

It is difficult to predict how this issue will develop in the future or how Government agencies will respond if the problematic use of NPS increases and more families become affected. It is therefore important that families are educated about both new and traditional drugs, and that accurate information and adequate support is provided at a local level where needed.

1 Advisory Council of the Misuse of Drugs (2011) *Consideration of the Novel Psychoactive Substances ('Legal Highs')*

*Tony D'Agostino is a freelance trainer and has been working in the drug and alcohol field since 1997. For further information see www.tonydagostino.co.uk or www.drug-training.com.*

# Friendly faces

***Monty Montcrieff**, Chief Executive of London Friend, explores the impact of club drugs on LGBT communities.*

LESBIAN, gay, bisexual and transgender (LGBT) populations routinely report higher levels of drug use, yet are often all but invisible within drug services. Additionally they may also experience very specific challenges when it comes to seeking the support of their families.

Antidote, a project run through the charity London Friend, has been working with LGBT drug and alcohol users for over 10 years, and we've seen a picture which is often at odds with mainstream drug treatment. With LGBT people anywhere from three[1] to seven[2] times more likely to use drugs and alcohol than the population as a whole, you'd expect them to be packing out our drug services. But generally they're conspicuous by their absence.

One of the reasons for this is the drugs our community is using: overwhelmingly club drugs with little to no use of opiates and crack, the mainstay of mainstream services. We've always seen people present with cocaine and ecstasy use, but over the past few years patterns have been changing and we're seeing more mephedrone, G (GHB/GBL), and methamphetamine (crystal meth).

All of these have brought different, more challenging and more severe problems than the traditional party drugs. Whilst it has, so far, failed to significantly infiltrate the mainstream as feared, crystal meth is appealing to gay and bisexual men in particular, fuelling marathon sex parties as users are awake and aroused for days, and the risk of HIV and other sexually transmitted infections is heightened[3]. Our G users are the first wave to realise that the drug is dependence-forming, dosing every couple of hours and requiring medically supervised detox for complicated and potentially dangerous withdrawal. Mephedrone is by no means limited to LGBT users, but alongside the psychological problems emerging from its use we're seeing a sharp rise in people injecting, as many are with crystal meth too.

It's not an overstatement to say these drugs are changing the game for our communities, and for us as a support service. As we have had to adapt to a new set of challenges, so too must others providing support.

It's essential to understand some of the reasons behind why LGBT people use drugs and alcohol. As the term 'club drugs' suggests, many are using them to party long into the night. Nothing unusual there – although the gay scene has a tendency to elevate the status of the high life, with all-nighters presented as the norm and photos of body-perfect clubbers dominating the free magazines that fill gay venues. Throw into the mix the fact that LGBT people are less likely to have childcare responsibilities and more likely to party well into their 30s, 40s and beyond, and the opportunity for the lifestyle to 'catch up with you' is increased. When those newer drugs bring risks of dependence and psychosis, it's a very potent mix.

When people come to our service for help we often find the issues aren't just that they've 'overdone it'. Although being LGB or trans is much easier for many nowadays, this can make it harder for those still struggling with their identity to admit it. LGB people report higher levels of depression, anxiety and low self-esteem[4] whilst trans people face a separate set of prejudices with remarkably high levels of attempted suicide[5]. Strip back the drugs and we have a population scarred by name-calling, bullying, physical attacks, persisting stigma and the constant pressure of being told they don't live up to family, social or religious expectations. Many struggle with intimacy and relationships, sometimes because family and friends have distanced themselves after the person has come out or begun to explore their true gender role.

As LGBT people we've long had to struggle for even basic recognition of our identities. Same-sex partners only became legal next of kin with the introduction of civil partnerships in 2005; trans people only won the right to legally change their gender a year before that; and even with the upcoming introduction of same-sex marriage, we still face regular and ugly opposition from 'traditionalists' who deny the 'sanctity' of our relationships. And all of this is before we even begin to consider the opposition to us raising our own families.

The good news is that we see success. Many users come rich with 'recovery capital' and the personal resilience to turn their circumstances around, although services, family members and friends need to understand their lives in order to support them appropriately. Feeling that your identity is acknowledged and understood is key to building trust and confidence. We've been providing training to drug services to raise their LGBT awareness, and urging commissioners to include LGB and trans people strategically in their needs assessments, planning and performance management to ensure that effective support can be provided.

*Antidote @ London Friend is the UK's only LGBT-specific drug and alcohol support service.*
*www.londonfriend.org.uk/antidote*

1 UK Drug Policy Commission (2010) *The impact of drugs on different minority groups: LGBT groups*
2 Buffin et al (2012) Gay and Lesbian Foundation *Part of the Picture: Lesbian, gay and bisexual people's alcohol and drug use in England*
3 Kirby and Dunwell (2013) *High-risk drug practices tighten grip on London's gay scene*, The Lancet 381:9861
4 King et al (2008) *A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people*, BMC Psychiatry 8:70
5 Whittle et al (2007) *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*, The Equalities Review

# Clubbed out

***Dr Owen Bowden-Jones** explains the work of the country's first clinic aimed specifically at club drug users.*

KETAMINE is an anaesthetic and has been used for many years in hospitals in the UK, where it is particularly valued for its short-acting effects. But it is also known to be a drug of misuse. Usually sold as a white powder and snorted, it produces a range of effects including intense visual, tactile and auditory distortions and hallucinations. People using ketamine often attempt to reach a state of intoxication know as the 'K-hole' in which users describe vivid out-of-body experiences while at the same time being partially or completely paralysed. When intoxicated, users are particularly vulnerable to accidents and injury because they are less able to feel pain and are often significantly disorientated. A number of deaths have been reported due to accidents such as drownings or falling from heights.

The misuse of ketamine has been recognised for many years, although was thought to be a relatively small problem until recently: research shows a steady increase in both the number of people using the drug and the number subsequently experiencing problems. For some, the drug leads to dependence, with the user consuming large amounts on a daily basis. For others, ketamine causes a number of physical harms, including 'K cramps' and 'ketamine bladder'.

Ketamine bladder is particularly concerning and is still poorly understood by clinicians. Ketamine can cause an ulceration of the inside lining of the bladder, causing it to thicken and bleed. In the early stages, this results in users needing to urinate more frequently as the bladder shrinks, and as the symptoms progress, users often experience intense pain.

In an attempt to cope with the pain, users turn to the one thing they know will provide short-term relief – more ketamine. The result is increasing use and increasing pain, a difficult cycle to break. As the ulceration worsens, the user often sees blood in their urine and an urgent referral to a urologist is needed.

At the clinic where I work, three-quarters of people asking for help with ketamine are experiencing urological symptoms and we now have a urologist working with the team to help manage these problems. For a number of our ketamine users it has been too late and

*At the clinic three-quarters of people asking for help with ketamine are experiencing urological symptoms*

they have needed reconstructive bladder surgery; however for most, stopping using ketamine allows the bladder to gradually repair itself.

Harmful ketamine use, like all drug use, does not involve just the user but can also have a profound impact on family and friends. Most people have some knowledge of the problems caused by drugs such as alcohol and heroin, but for club drugs like ketamine, people may not know what to look for and how to help. Many relatives are the first to notice developing problems – often even before the user themselves – but for club drugs these problems may develop in unexpected ways. For instance, the bladder problems that can be caused by ketamine use can mimic urinary tract infections, leading to repeated treatment with antibiotics.

Surprisingly, many of the ketamine users asking for help at the clinic are holding down jobs despite escalating use and harm. This can sometimes falsely reassure friends and relatives that the problem is not too bad, when in fact, as the use of ketamine turns into dependence, things are only likely to get worse.

A frequent comment from ketamine users is that they would have asked for help sooner, but did not know where to go. GPs are often unfamiliar with ketamine use and 'traditional' drug services tend to focus on heroin, crack and alcohol. This can leave ketamine users, their relatives and friends aware of the problem but frustrated when looking for help. Fortunately, this situation is changing with a small number of club drug clinics beginning to appear around the country.

The Club Drug Clinic has received many calls from parents worried about ketamine and other club drug problems. This month we have recruited a family support worker following a generous fundraising event by the Friends of the Chelsea and Westminster Hospital: this worker is there to assist relatives who are struggling with a loved one harmfully using club drugs. We will shortly be establishing a support meeting one evening a month at the clinic for any relative who would find it helpful to tell their story and hear how others have coped.

*If you would like more information, then please contact us on 0203 315 6111, clubdrugclinic.cnwl@nhs.net or visit our website www.clubdrugclinic.com.*

# Welcome to K-town

*Families UpFront examines the challenges for family support presented by the growth in young people's use of ketamine, mephedrone and legal highs.*

WHILST trends in overall drug use, including among young people, are currently in modest decline, some drugs have bucked the trend. DrugScope's annual Street Drug Trends survey found ketamine to be the biggest riser in the UK drug market in 2011, and the same survey identified increasing numbers of people coming forward for mephedrone-related problems in 2012. The National Treatment Agency, meanwhile, states that 'whilst overall drug use has declined, there has been an increase in those needing treatment for ketamine and mephedrone'.

## What's behind the rise?

Theories abound to explain the rise and fall of many different drugs: cannabis and hippie culture in the 1960s or industrial urban decline and heroin in the 1980s, for example. In turn, the growth of legal highs has been associated with the internet – young people have been able to order psychoactive substances from the comfort of their own bedrooms. As well as drugs which are designed to circumvent existing drug laws, even those which are indeed illegal are still being traded online: ketamine has been a Class C drug since 2006, but partly due to its legitimate use in operations, it is still traded via pharmaceutical agents based in India and China. This ease of access has been a key feature of the debate, and has arguably opened up the drug market to consumers who may not have previously braved involvement in illegal activity or backstreet dealing.

But drugs like these aren't just relatively new to users – they also present a fresh challenge to parents, families and the services that support them. Jane Brown coordinates one such service – the Brighton-based Family and Friends Network, which provides support across West Sussex. Its catchment area includes Midhurst – or 'K-town', as it's known amongst local youngsters, in reference to the local popularity of ketamine.

To help explain this moniker, Brown hints at a possible vacuum in activity for young people. "It's a very rural area", she says: even pubs are out of bounds to many, as the 'gastropub' scene has eroded the drinking focus of licensed establishments, and the 'locals only' atmosphere in those that remain means many young people feel unwelcome, even if they have reached legal drinking age. "18-25 year-olds getting drunk isn't really tolerated" by the local community, where "everyone knows everyone". This has led young people towards more underground thrills – indeed, "it can be easier to get hold of K [than alcohol]".

*These drugs aren't just new to users – they also present a fresh challenge to parents*

The proliferation of new drugs with new names – and old drugs rebranded – can mean it's hard for parents and support services to keep up and drugs can seemingly appear and disappear within a matter of weeks. But it would be dangerous to dismiss these drugs as a fad: with ketamine and mephedrone, Brown says, "things seem to have stuck: people get into the lifestyle and find it hard to get out." Other legal highs and drug substitutes, which are used "a bit more fleetingly", have not shown the same staying power. And ketamine has now been on the radar for long enough – it was added to the British Crime Survey in 2006/07 – that acute health harms associated with heavy use are increasingly well documented (in particular bladder damage). It's also not just an opportunistic addition to a night out: surprisingly enough, Brown says, the users her service sees do not tend to be drinkers as well ("many prefer cannabis and ketamine over alcohol") and despite its common classification, she also says that ketamine's use as a 'club drug' is limited locally.

## Younger users

In instructing the Advisory Council on the Misuse of Drugs to review the latest evidence on ketamine in 2012, Home Secretary Theresa May noted that use is particularly prevalent amongst 16-24 year-olds – 2.1% compared to 0.6% in the general population. In terms of family support, this age profile means that concerns such as school performance, 'hanging with the wrong crowd' and living under the same roof are prominent, and Brown's experience is that it tends to be parents needing support rather than partners or other family members. There are also often no dependant children in the picture, so safeguarding or kinship care concerns are minimal.

This age profile also presents challenges for service delivery, as many 18-21 year-olds in particular can be stuck in a no-man's-land between child and adult services. "There's a gap for them, and it's harder", Brown thinks: "whereas in the young people's service all the workers are outreach and there's also a legal highs specialist, [over-18s] are expected to travel 20 miles to a drug service, get an assessment and sit in a room with 35-year olds with heroin addictions". Similarly, families affected by legal highs and club drugs will have different needs from those living with the impact of long-term opiate or crack use.

For family support services, reaching out to these younger users and their families will require more than just advertising in local treatment services

and doctors' surgeries – more mass-market appeals may be necessary (see box right).

## Knowledge is power

Although family support for parents affected by young people's ketamine use is integrated with the other services of the Family and Friends Network, the emphasis is on information provision – "knowledge is power", Brown says. "The knowledge base around ketamine is low – parents don't know what it is, it has all these fancy nicknames and there's this mythical fantasy around the 'k-hole'". The same goes for mephedrone – even just some help with mythbusting and understanding slang can do an important job, so whilst some parents will remain engaged with the service, others may get the information they need and go.

Perversely enough, it is precisely this lack of knowledge – relatively uncoloured by long-held assumptions and prejudices as they might apply to other drugs – which can make parents more likely to seek help quickly, rather than struggle on for years. The low level of knowledge around ketamine could actually work in favour of family support, since parents are more naturally curious and aware of their own need for information.

As well as the relative novelty of the drug, the quick escalation in use could also be a factor in families seeking help earlier. "Parents come forward when things have 'got bad'", Brown explains, but this can happen very quickly with ketamine: "in our experience, people don't really use it 'recreationally' – they quickly get into a pattern of destructive behaviour". In order to provide effective support, she says, "we need parents to be well informed and motivated to ask", which can also pay dividends with users: "often the young people will start to engage with services once the family has accessed support – there's a big success rate".

For families who do become more engaged with the service, there is an emphasis on dealing with anger, mistrust and effective boundary setting skills, especially around finances. Brown reports that high-interest payday loans have been used by young people to pay off dealers, and parents have found themselves bailing out these debts: "*children* getting into the cycle of addiction and debt is clearly concerning". Young people can use their own bank cards to order from the internet, and some have taken their parents' cards without consent.

Supporting parents together and trying to help them cooperate is also a key aim of family support in these cases, Brown explains: "often one [parent] can see things in black and white, and the other wants to help – but both should have a voice and be heard by the other. We try to help them find a happy medium". Again, addressing the problem quickly shows its benefits: years of disagreement over how to address the impact of substance use have perhaps not had the time to build up, and there can be hope unencumbered by the bitterness that the parents have 'seen it all before', 'nothing's ever worked', or 'it won't do any good'.

## Implications for the workforce

Even after several years of growing concern, club drug and legal high experts are still few and far between; so family support workers with a deep knowledge and understanding of the area are likely even more scarce. Brown is clear that the family support workforce has a lot to learn about these drugs, just as parents do: "I need help too!"

In this respect she praises the role of a local professionals' forum, which includes Youth Offending Teams, family support workers, young people's drug workers, schools (though only "sometimes", she notes) and other youth projects like the YMCA. "We all learn from each other, it's great professional networking – we find out what's going on, and we can then pass that information to parents". In the fast-moving world of the modern drug market, keeping an ear to the ground is doubly important for support workers.

Family support practitioners who have themselves dealt with addiction in the family, and who have been able to use this experience to empathise with their service users, may find themselves dealing with a different beast when it comes to drugs like ketamine. Having 'been through it' can give professionals invaluable insight into the needs of other families, but this experience alone does not necessarily make for effective support work: with such a rapidly evolving drug market, up-to-date knowledge and a bedrock of effective support work skills seem more important than ever.

## Looking ahead

So far, the Family and Friends Network has not seen the same ketamine clients re-presenting months later having developed issues with alcohol, heroin or crack. However, this does not mean that the problems they and their families face are not serious.

Unlike with a drug such as heroin, the use of which exploded in the 1980s, these new drugs are yet to create a generation of long-suffering parents – and of course, we can all hope that this doesn't develop. But as patterns of substance use change, new drugs emerge and the definition of 'problem drug use' becomes broader to reflect them, there will still be parents and families who suffer from their impact years into the future, and who require support for their own needs.

## Running a local campaign

**Support service Swanswell teamed up with Leicestershire and Rutland Substance Misuse Strategic Team (SMST) on the campaign 'legal highs, lethal lows'.**

**Chris Robinson, Swanswell's Director of Services, said: "The use of 'legal highs' is the latest concern for families across the country. Although they're not illegal, this doesn't mean they are safe or approved. So it's important for people who use substances, and their families, to have access to the most up-to-date and accurate information as possible to ensure they understand the risks and make informed decisions."**

**Debbie Langham from SMST explained: "the campaign used a new website, phone app, radio advertising, a poster and taxi campaign, Facebook and Twitter to offer advice, information, support and referral to treatment if required."**

**In recognition of the appeal of legal highs to younger users, the next stages of the campaign will launch in the run-up to the summer festival season and in preparation for university freshers' parties.**

**www.legalhighslethallows.co.uk**

# Volatile substances: the original legal high

*Victoria Leigh from Re-Solv and Richard Ives from educari look into the risks presented by the misuse of everyday products like aerosols, glues and gases.*

**The media storm surrounding the use of legal highs was partly fuelled by the release of official statistics which found that more than 40 deaths in 2011 were linked to a group of now-banned legal highs – over six times the previous year's figure.**[1]

What's more shocking is that this figure doesn't even include the number of deaths still caused every year by the most accessible of all legal highs: volatile substances, which you can buy on every high street and find in every home. Include volatile substance abuse (VSA) in the report, and you are looking at well over 80 deaths per year from legal products.

**VSA kills almost one person a week in the UK – that's currently more deaths than all the other 'legal highs' put together.**

## A drug often provided by parents

Volatile substance abuse (often known glue sniffing) is the inhalation of everyday consumer products such as lighter fuel gas, aerosols (like deodorants and hairsprays), petrol and other household solvents to obtain a high.

Young people try sniffing for the same reasons they experiment with alcohol and other drugs: curiosity, the desire to experiment, boredom, peer influence and in response to unhappiness or stress in their lives.

1 St George's, University of London (2012) *Drug-related deaths in the UK*

**80% of pupils who first tried drugs at the age of 11 or younger reported that they sniffed volatile substances.**

*Smoking, drinking and drug use among young people in England*, NHS, 2012

But VSA often starts at a younger age than other substance misuse, which means that the family may be more directly involved than with drugs encountered when a child is older. New research shows that 81% of deaths from VSA occur in the home or home of a friend and the reality, too, is that parents are often buying the very products being misused.

## Legal and lethal

Since VSA is the misuse of ordinary, household products, people often make the assumption that it's not that dangerous. But VSA can kill instantly. It doesn't matter whether it is a person's first attempt or whether they have been misusing for many years; the risk of death is always present.

**In the decade 1999-2009, VSA killed more under-15-year-olds in the UK than all illegal drugs put together.**

International Centre for Drug Policy report, 2010

The most common form of VSA death is 'Sudden Sniffing Death Syndrome'. VSA causes the heart to beat irregularly, and any further rush of adrenaline (for example, if a person is then surprised, upset, excited or physically active) can trigger heart failure resulting in instant death, giving no time for help to arrive. Deaths are also caused by accidents, suffocation or other trauma.

So while the good news is that most people who try volatile substances only sample them once or twice, the bad news is that even this short-term use could have devastating consequences.


## Recognising VSA

Identifying VSA isn't as easy as with alcohol and tobacco, which may be smelt on the breath or observed in physical behaviour. Though some effects of VSA are similar to those of alcohol, they tend to be short-lived: so a teenager can sniff a substance with friends and be 'off their face' but, twenty minutes later, present as normal to their parents, with only a headache as a possible giveaway.

**'With the benefit of hindsight all the signs were there, but I was unaware of them'**

Lorraine Morris, Aberdeenshire, whose 15 year-old son David died from VSA

© ISTOCKPHOTO

As with the use of other drugs, there may always be other explanations for certain signs and symptoms.
But as a general guide:

### Signs and symptoms

- 'drunken', withdrawn, irritable or inattentive behaviour
- increased time spent alone, or with a new set of friends
- a 'chemical' smell
- physical symptoms such as a runny nose, watery eyes, rashes or spots around the nose and mouth.

### Around the house

- empty gas containers, perhaps with teeth marks in the nozzle
- aerosols disappearing from around the house
- replacing products more frequently
- white marks on towels, socks etc (where the product has been inhaled through a material 'filter').

'I'd 'told all three sons about the dangers of smoking, alcohol and illegal drugs. I'd even spoken to them about safe sex, but I never spoke to them about [volatile] substance abuse because my knowledge of it was nonexistent.'

**Barbara Skinner**,
founder of VSA charity **Solve It**,
following the death of her
16 year-old son Darren from VSA

### What can parents do?

National VSA charities Re-Solv and Solve It encourage all parents to talk to their children about VSA, just as parents might already be talking about the dangers of unsafe sex, alcohol and other drugs.

If your child is using solvents, the best advice is to stay calm.

Crisis points are not the right time to have conversations involving questions like 'why did you do it?', but it might be good to plan to have such heart-to-hearts when the crisis has passed. VSA may have been a response to more deep-seated problems which you can now address together as a family.

**If your child is conscious but intoxicated:**

- Stay calm
- Talk quietly to the child – some sudden sniffing deaths are associated with fright or exertion
- Remove the sniffable product if you can do so gently.

**If it is an emergency and the child is unconscious:**

- Remove the sniffable products
- Put the child in the recovery position
- Call an ambulance.


*Re-Solv is the National Charity working to prevent Volatile Substance Abuse*
*• www.re-solv.org*
*• Helpline 01785 810762*
*You can also find out more at www.solveitonline.co.uk.*

*Richard Ives is the CEO of educari Ltd, and is working with Re-Solv on a 3-year research project funded by the Big Lottery.*

# Starting from scratch

***Jeremy Sare** illustrates the history of the Angelus Foundation, which campaigns on the dangers of legal highs and club drugs.*

THE Angelus Foundation was born out of sudden and tragic circumstances, so naturally there was no plan for campaigning at its origins.

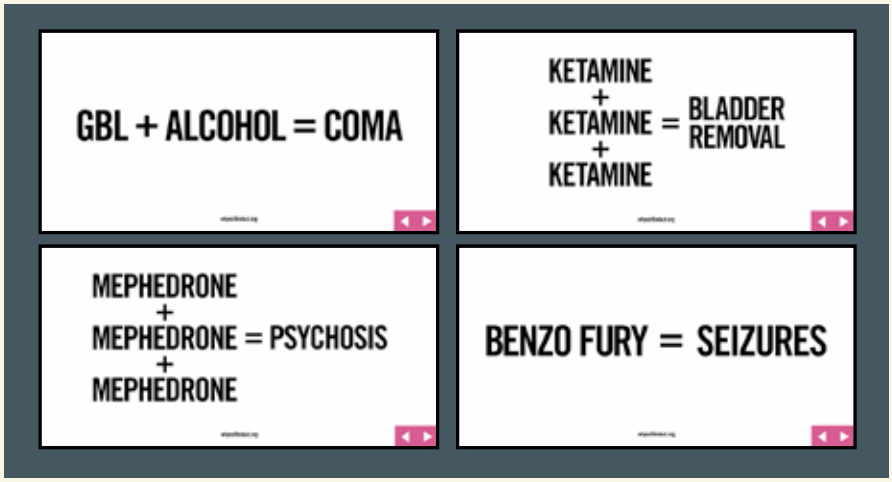
But the death of brilliant medical student, Hester Stewart, in April 2009 from the drug GBL – which was legal at the time – prompted her mother, author and broadcaster Maryon, to identify any means to stop other preventable deaths. The fact that Hester was not a drug taker underlined the fact that similar accidents could happen to a great many families.

Maryon created the Angelus Foundation in the summer of 2009 and its main activities were initially focused on lobbying Home Office Ministers to change the law and ban GBL. Maryon was entirely new to the world of drugs and knew only as much as the next parent about the subject.

Nevertheless GBL, along with many other new drugs like Spice, did become controlled (as a Class C drug) in December 2009. For the first time, the Talk to Frank website included information on legal substances like salvia and mephedrone. Google was also reminded of its civic responsibilities and agreed to remove the listing of many websites advertising potentially lethal products.

The ability of legislative change alone to impact on young people's safety is limited, so Maryon has maintained a strong media presence on TV, radio and in newspapers to reach as many people as possible. The consistent Angelus message has been to stimulate dialogue between parents and children about all dangerous substances, for all family members to learn more about the risks and to encourage young people to make wiser choices to stay safe.

Maryon also gathered together an advisory board of experts in chemistry, addiction psychiatry, policy and education, who shared the same deep concerns about the threat that legal highs pose to young people's welfare, and who could channel their expertise to a common purpose.




It was clear from the outset that raising awareness of the dangers of these drugs was to be the core campaign work of the Foundation. It had, in essence, already begun with making the politicians in power wake up to the immediate threat of this wave of new drugs.

The next step was to inform a wider circle of 'influencers' which included Parliamentarians, journalists, business leaders, celebrities and other charities, including the Amy Winehouse Foundation. Angelus held events at Parliament and Deutsche Bank, which included showing its first film *Russian Roulette*: this powerful film told the stories of Hester Stewart, Louise Cattell, Freddie McConnell and Amy Winehouse, who by different routes had all succumbed to various substances. The film moved many more people to get involved, particularly as their families had been touched by similar tragedies or 'near misses'.

The lack of a strong central source of funding was a hindrance to campaigning at first, but Maryon secured the pro bono support of advertising agency Leagus Delaney. The plan was to launch a national poster campaign highlighting the particular dangers of certain drugs: GBL, ketamine, mephedrone and Benzo Fury. It was important to find the balance on the messaging between what was scientifically accurate and what would make an impact on people.

The focus of the poster campaign, which began in October, was to direct people to the newly created website www.whynotfindout.org. It is the first dedicated site to the new psychoactive drugs, both legal and illegal. It also includes films, drug profiles, news, FAQs and a feedback service for individual enquiries.

Angelus also began drawing up a longer-term strategy with schools and parents. The in-school campaign involves presenting awareness-raising films and materials, and asking students before and after viewing about their knowledge and attitudes around new drugs: at the outset an average of only 22% of respondents believed that they were 'not safe at all,' but after viewing the film, that figure rose to 69%; and encouragingly 86% responded that the film would highly influence their decision if offered a new psychoactive drug. Angelus is also building enhanced links with health professionals, especially those working in mental health.

It is unfortunate that, like many drug charities, it has not been possible for the urgency of the situation to be matched with financial backing from Government. Angelus's momentum has therefore had to rely upon the considerable energy and drive of its founder, which remains as strong as ever.

*www.angelusfoundation.com*

# Re-Solv
responding to VSA

## Gases, Solvents, Aerosols, Petrol: a **hidden,** but very **real** problem

***It's not just about glue-sniffing anymore.*** The problem hasn't gone away...it is the products abused that have changed.

Volatile Substance Abuse (VSA) is the deliberate inhalation or sniffing of gases, aerosols, glues, petrol and other household products to achieve a high.

Re-Solv works to prevent the misuse of these readily available, everyday consumer products, particularly by young people.

Many people assume that because these products are legal they are 'safe'. **In fact VSA can kill suddenly and unpredictably.**

To be kept up to date on research, new services and resources, please sign up to receive our bi-monthly eNewsletter.

**www.re-solv.org**


- VSA is the **most common form of substance misuse** among 11-13 year-olds and second only to cannabis by the age of 15.
- The cheapness and accessibility of products make younger and more vulnerable children particularly susceptible.
- In the past decade **VSA has killed more under 15's** than all illegal drugs combined.

**Please see www.re-solv.org/resources for a comprehensive list of VSA resources to support parents, health professionals, youth workers, schools and young people.**


Re-Solv Services:

- **Training**
  We offer a FREE online training programme for professionals working with VSA. **training.re-solv.org**

  We are currently funded by the Department of Health to deliver free training workshops in England to professionals working with volatile substance users. Please email **nicola.morgan@re-solv.org.**
- **Support for users**
  We are currently in the process of setting up Community for Recovery, an online support service for volatile substance users and their families. If you would like more information, please contact **v.leigh@re-solv.org**.
- **Advice & Information**
  If you have any questions or concerns, please give us a ring on **01785 817885** or email **information@re-solv.org**

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