

LEARNING FROM EUROPE

practices and policies

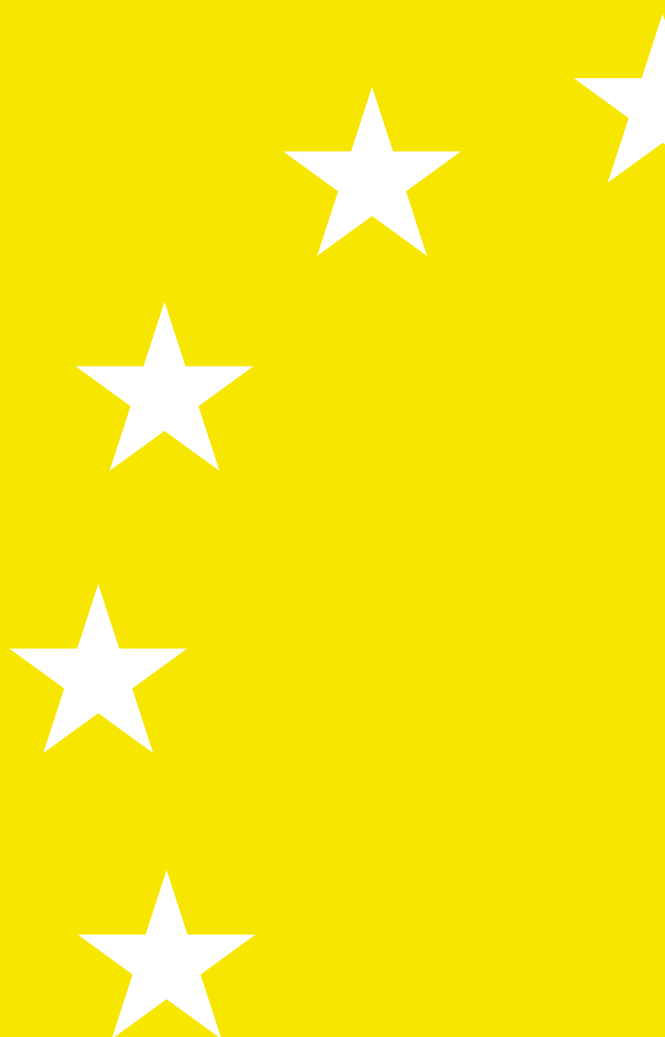
report of the conference 18 October 2004

LONDON
DRUG
POLICY
FORUM



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FOREWORD

This was my first conference as Chairman of the London Drug Policy Forum, taking over during the year from Roger Daily-Hunt. The idea and concept of “Learning from Europe – Practices and Policies” was very much Roger’s. He saw the need and benefit of examining best practice from across Europe and the United Kingdom and using this as an opportunity to consider how we improve and develop services and interventions to the benefit of all our communities. Though unable to join us on the day of the conference I am sure he will agree it met his goals.



This conference had a more reflective and contemplative edge than many previous events but still proved to be popular, as shown both in terms of the numbers who attended, and in their appreciation of the day. This is of course very much due to the quality of the speakers and we are especially grateful to those who travelled from across Europe to join us. Much credit to the smooth running of the day must also go to the Conference Chairman, Alex Stevens from the University of Kent.

Over the course of the day speakers covered a wide range of subjects; cutting edge developments and new policy initiatives around substitute prescribing; radical political and policy change; user involvement; experiences of local delivery; effective work with those in the criminal justice system and genuine community engagement. The manner in which experiences and new learning can be incorporated in practical policy development was also explored.

Practical and pragmatic approaches to drug problems have been at the heart of the LDPF’s approach since its inception in 1991. Being independent of party politics and Government funding has allowed the LDPF to ensure neglected and less politically attractive issues get the attention they deserve and to focus on those interventions which really do make a difference. We shall work with our partners in the Greater London Alcohol and Drug Alliance and others to continue this work and support those who deliver the services that improve the lives of all those damaged or effected by drug use.

If you would like more information about the work of the LDPF please contact the Policy Adviser (details on the cover of this report).

Finally, I must record my thanks to all those who contributed to the success of the conference and this report. I hope you find it of real interest and benefit.

Maureen Kellett

Chairman of the London Drug Policy Forum



INTRODUCTION

Maureen Kellett, newly appointed Chairman of the London Drug Policy Forum (LDPF) opened the conference by extending a warm welcome on behalf of both the Forum and the Corporation of London. She announced the theme of the conference: 'Learning from Europe – Practices and Policies'. Mrs Kellett highlighted the independence of the London Drug Policy Forum whose conferences had a tradition of raising thorny issues and being catalysts for change. She asked the conference to remember the previous chairman of the forum, Roger Dailly-Hunt, who conceived the idea for this thirteenth annual conference of the Forum, and asked all present to join her in sending him their best wishes. Maureen Kellett went on to invite the Lord Mayor to formally open the conference.

Alderman Robert G. Finch, Lord Mayor of the City of London, duly performed the formal opening of the conference. He welcomed the large number of delegates and stated that the London Drug Policy Forum has a tradition of holding key conferences which have succeeded in developing the agenda around substance misuse in the Capital. He made a special welcome to the speakers who had travelled from all across Europe. The Lord Mayor made the point that the City of London has benefited from the richness of the international experience of the many companies in the square mile and was confident that the conference would gain similar benefits from the different experiences of all those tackling drug problems across the continent.

The Mayor concluded his address by hoping that the discussions which took place at the conference would promote healthy debate and give rise to improvements in policies and practice. He then invited Alex Stevens to chair the conference proceedings.

Alex Stevens announced that the conference would hear presentations from all over Europe including one from London itself. The conference would be addressed by academics, politicians, policy makers and those delivering responses on the ground. Throughout the conference the focus would be kept on making a practical difference to drug problems.

Switzerland: from chocolate and cheese to a comprehensive drug policy

Dr Christoph Buerki, the Medical Director of the Heroin Assisted Treatment Centre, KODA, in Berne, gave a presentation on how the traditionally conservative country of Switzerland has developed a comprehensive treatment programme for heroin use.



The challenge

In the early 1990s, Switzerland encountered the growth of open heroin markets in its major cities. These were located in very public places such as outside the parliament building in Berne and caused general concern. These markets proved very difficult to control and there were major worries about the risky behaviour of many drug users – there was a threefold rise in deaths from drug overdose between 1985 and 1992.

The response

The Government decided to adopt a harm reduction approach to this problem in order to manage the drug markets and to protect the health of drug users and the wider community. Four key elements were critical to this change in policy:

Firstly, this was a very visible problem causing considerable public concern and the desire for action. Secondly, politicians adopted a pragmatic attitude to tackle the problem. In turn, this resulted in a shift away from a moral model of addiction towards the prioritising of public health concerns. Thirdly, there was recognition that no solution would be perfect and there would be a need to live with contradictions. Finally, was an understanding that developing and establishing a harm reduction approach is a complex cultural, political and social process, which can only be achieved over time.

Switzerland already had extensive methadone prescribing services and a good supply of detoxification and residential rehabilitation services. It was therefore decided to add another treatment option – the prescribing of heroin. The reasons for this were:

- many of those using the open drug markets had proved unreachable with conventional approaches

- they were greatly compromising their health, suffering poverty, infections, disease and sometimes dying as a result of their drug using lifestyle

- a new approach created an opportunity to target drug users engaged in the riskiest behaviours and reduce the harm they were inflicting on themselves

Eighteen heroin prescribing clinics were established in the German speaking areas across Switzerland with three more added in later years. The clinics targeted only those drug users who were local residents and who had been using heroin continuously for at least two years and who had tried and failed other treatment options. Drug users who did not want treatment were dealt with by the criminal justice system. Drug users attended the clinic two to three times daily to inject themselves with pharmaceutical heroin on the premises. The clinics were open 10 to 12 hours per day, seven days per week. In addition to heroin, all drug users were offered social work and psychiatric treatments where appropriate. The service provided help with other physical and mental health needs, including the prescription of other drugs for conditions such as HIV or depression.

The results

The heroin prescribing approach has been rigorously evaluated and has proved very successful in a number of areas. The physical and mental health of drug users improved markedly, the HIV infection rate decreased from 20% to 14% and deaths from drug overdoses fell from the peak of 419 per year to 177 in 2003. One percent of drug users attending the heroin clinics died per year compared to 2.6% of those receiving methadone and 8.9% drug users out of treatment. There were also considerable reductions in the amount of crime committed by this

heroin assisted treatment is the single most effective intervention ever tried to prevent crime

group, leading to the conclusion that: 'heroin assisted treatment is the single most effective intervention ever tried to prevent crime'.

The open drug markets were also able to be brought back under control and became much smaller owing to the combination of acceptable treatment and police enforcement.

The evaluation of this ongoing approach of prescribing heroin concluded that it:

- is feasible and economical
- succeeded in reaching its target group
- succeeded in retaining a high proportion of drug users in treatment
- led to significant psychosocial and health improvements
- reduced the amount of drugs consumed
- greatly reduced the mortality rate of those in treatment
- was a valuable extension of the currently available selection of therapeutic instruments.

Heroin treatment, lessons from Europe and the future in England

Dr Emily Finch, Clinical Team Leader at the National Treatment Agency (NTA), followed up Dr Buerki's speech with a presentation which gave a historical perspective of heroin prescribing in England, examined practice in Europe and described the NTA's plans for piloting an expansion of heroin prescribing in the UK¹



Heroin prescribing in England

Dr Finch started by tracing the history of heroin prescribing in England. Following the Rolleston report in 1926, doctors prescribed injectable heroin on a maintenance basis to a small number of addicts until the 1960s. The changing nature of drug use in this decade, coupled with the diversion of prescribed heroin on to the illegal market led to the establishment of drug treatment clinics and the regulation of doctors who prescribed diamorphine (the legal, pure form of heroin) by a licensing system. Both of these changes took place in 1968 following the report of the second Brain Committee in 1965.

The licensing system, combined with the increase of the use of methadone, resulted in a decline of heroin prescribing. In 2004, approximately 100 doctors were licensed to prescribe injectable heroin to about 300 patients.

Lessons from Europe

Dr Finch cautioned against simply importing a European model of heroin prescribing. Currently heroin prescribing in England caters for a very different group of drug users from those prescribed to in European countries, such as Holland and Switzerland. In England heroin is prescribed to a small number of socially stable patients on a long term basis at their request. In Europe heroin is prescribed to large numbers of chaotic heroin users who have failed to respond to other treatment regimes.

In Switzerland heroin is prescribed in tightly controlled circumstances with patients injecting two to three times per day under supervision on clinic premises, within the context of a psycho-social support programme. Patients are encouraged to move on to less intensive treatment. Prompt, good quality methadone prescription is universally available.

Currently in England, there is little consistency in methadone prescribing, waiting lists vary and methadone is usually dispensed and consumed away from treatment premises.

The Swiss model of prescribing heroin involves a high level of social control. If it was introduced in England, it would probably clash with the cultural expectations of both drug users and drug workers and could prove very hard to implement. If heroin prescribing were to be administered in the same way as the current English method of prescribing methadone, it would be very expensive and there would be considerable risks of large quantities of diamorphine being diverted into illegal markets.

Considering the future of heroin prescribing in England

Dr Finch reported on the work of the heroin working party which had been convened in response to political interest in the expansion of heroin prescribing. The working party had examined the evidence base and produced recommendations.²

The working party found that the evidence base was relatively weak but concluded that:

- injectable maintenance drug treatment is most appropriate for long term heroin misusers who have not responded to oral treatment
- where injectable heroin and methadone prescriptions are provided as part of a comprehensive treatment programme, both have benefits on health, social functioning, and crime reduction.

The working party agreed on a number of key messages:

- priority should be given to improving the effectiveness of oral maintenance prescribing for the majority of patients in all areas in England

- injectable substitute opioid drug treatment may be beneficial for a minority of heroin misusers

- future maintenance prescribing should be done in line with eight key principles

- services for patients in receipt of injectable drug treatment should be improved (if required) but patient stability is paramount.

Principles guiding injectable maintenance prescribing

- 1 Drug treatment comprises a range of treatment modalities which should be woven together to form integrated packages of care for individual patients.
- 2 Substitute prescribing alone does not constitute drug treatment. Substitute prescribing requires assessment and planned care, usually with other interventions such as psycho-social interventions.
- 3 Within the substitute prescribing modality, a range of prescribing options are required for heroin misusers requiring opioid maintenance.
- 4 Injectable maintenance options should be offered in a local area that can offer optimised oral methadone maintenance treatment including adequate doses, supervised consumption and psycho-social interventions.
- 5 Injectable and oral substitute prescribing must be supported by locally commissioned and provided mechanisms for supervised consumption.
- 6 Injectable maintenance treatment is likely to be long-term treatment with long-term resource implications.
- 7 Specialist levels of clinical competence are required to prescribe injectable substitute drugs. Heroin prescribing also requires a Home Office licence.
- 8 The skills of the clinician should be matched with good local systems of clinical governance, supervised consumption and access to a range of other drug treatment modalities.

¹ Three pilot sites are in the process of being established; two in Manchester and one in London.

² National Treatment Agency (2003) Injectable heroin (and injectable methadone): potential roles in drug treatment. The report and a separate executive summary are available on the NTA website at www.nta.nhs.uk.



Portuguese drug strategy 1999-2004: a pragmatic approach towards problematic drug use

Ms Maria Moreira, Director of the National Monitoring Centre on Drugs and Drug Addiction, gave a presentation on the Portuguese drug strategy which is coming to the end of its first cycle at the end of 2004

Identifying the problem

In the late 1990s, Portugal reviewed its drug problem and found a mixed picture. Overall, there were low rates of drug taking compared with other countries in Europe. However, levels of problem drug use were the second highest in the European Union. The main area of concern was the relatively high number of people injecting heroin and the related health problems of HIV/AIDS, hepatitis, tuberculosis and drug related deaths. Drug-related crime was also increasing.

Finding the solution

The Government recognised that a new approach was needed. The National Drug Co-coordinator sponsored the creation of a multi-disciplinary group, chaired by an independent expert, to develop a strategy. The group's report was widely disseminated and discussed with policy makers, professional groups and the general public. The final document was published as a legal resolution from the Council of Ministers, giving weight to its findings, and ensuring action.

Four key components of the new strategy are outlined below. Firstly, there was a significant culture shift in looking at the drug user primarily as an individual in need of treatment, not as a socially excluded criminal (unless he/she commits crimes). The purpose of this change was to try to intervene earlier in individuals' drug using, diverting them away from the criminal justice system into treatment. Secondly, the strategy spelt out key objectives and values, provided guidelines for areas to attain these, but made provision for some local flexibility of approach. Thirdly, the strategy tackled a wide range of issues, but priority was given to drug prevention with the main innovations being decriminalising personal drug use and adopting a harm reduction approach. Finally, an emphasis was placed on rigorous evaluation of the strategy from the start.

Measuring the impact

The strategy has had a positive impact in many ways:

- There has been an increase in the numbers of drug users attending prescribing services.
- The number of drug users with AIDS decreased absolutely and relatively to the total number of people with AIDS.
- Drug related deaths more than halved from 369 in 1999 to 152 in 2003.
- The number of drug users prosecuted by the criminal justice system fell steeply from over 2500 in 1998 to 13 in 2003 mainly due to the implementation of the decriminalisation law.
- The number of drug users in prison decreased both absolutely and relatively.
- The evaluation of the strategy, which remains ongoing, has proved coherent and useful; in the past evaluative work was more dependent on the scientific interests of local university departments rather than on trying to construct a robust and global evidence base.

Challenges for the future

Despite this positive perception of the strategy, there remain many areas to improve and new areas to tackle. Five key areas for the future were identified:

- 1 Ensuring that quality treatment is also available for those with different drug use profiles than the traditional problematic heroin user.
- 2 Re-affirming the importance of drug prevention work, which has been somewhat overlooked in some areas since the increased focus on treatment and harm reduction.
- 3 Addressing recent increases in young people's experimentation with drugs.
- 4 Developing a training strategy to ensure that drug workers and other professionals have the skills to deliver the new interventions.
- 5 Ensuring that young people in particular understand that drug use remains illicit, even though possession does not automatically result in criminal sanctions.

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User involvement: progress to social integration

Mr Stephen McGill, Head of User Involvement for the Scottish Drug Forum gave a presentation on involving drug users in the planning, development and operation of drug treatment services



The model

The Scottish Drug Forum (SDF) established four user involvement projects in different urban and rural locations in Scotland in the early 1990s. The SDF also provides developmental work and consultancy advice on this issue to the rest of Scotland on request. The focus of their work is on making a difference to the way drug treatment services are delivered. Their philosophy can be summed up as an expectation that people who use services are central to all decisions made about themselves and the services planned.

The core aims of the SDF's user involvement work are set out below:

- 1** To improve existing and future addiction service provision by
 - identifying the views of service users
 - representing views of service users/groups
 - advocating on behalf of drug users
 - developing policy
 - monitoring change in service provision.
- 2** To improve the lives of those who directly involve themselves within the user involvement groups by
 - positively using the skills of drug users
 - encouraging more informed response and changing public attitudes towards drug users
 - supporting their social and personal development through participation.

Improving treatment services

The SDF uses a model of peer research where drug users gain fellow drug users' views on how drug treatment services should operate. Users are involved early on in the process, having input into the questions that are asked. Not only do drug users normally feel more able to express an opinion to another drug user, confident in a shared understanding of important issues, but getting and paying attention to the views of service users gives

drug users need to be given the chance to play positive roles within society

credibility to any new service development. Throughout the process, SDF place great emphasis on identifying and highlighting positive practice - user groups are not set up as a force for complaining.

Improving the lives of service users involved

Most service users require considerable training and mentoring support and time to become sufficiently confident to represent local drug users at a Drug Action Team or other official meeting. The SDF place a strong emphasis on the fact that user representatives are talking on behalf of a group of local drug users, not just expressing their personal opinions. It is fair to say that not every service user wants to continue in user representation; before they start most users do not realise that multi-agency meetings can be repetitive and slow to achieve change.

The experience of the Scottish Drug Forum was that most users did not sustain their involvement unless there were some personal benefits. Service users who make presentations to conferences often do gain considerable gratification but there is a need for drug users to progress. SDF works with all individual users to develop a personal action plan to support them to move on into further education, training or employment or attain other personal goals. SDF user involvement projects have to recruit new users on a regular basis as existing users move on to work or study.

Making a difference

Ongoing evaluation has shown that user involvement has achieved small but important improvements on both operational and policy levels. Typical improvements to services include a

generally more user-friendly service with more convenient opening hours and a crèche. On a policy level the Scottish Executive has issued guidance on user involvement and requires Drug Action Teams to involve local service users in planning treatment services and report on how well they are doing this.

Mr McGill described the Supported Training and Rehabilitation (STAR) project which had involved both local drug users and the local community in developing a new local treatment service. This created a situation where, for the first time, a local community were in favour of having a new treatment service. The treatment service was born out of user views, some of the users consulted are now working at the service, and others are on the management board.

In conclusion

Mr McGill ended his presentation with three key conclusions:

- 1** There is small scale, but clear, evidence that drug users have a powerful voice that is worth listening to, and can make contributions both for themselves and for the communities that they live in.
- 2** Addiction policy needs to avoid focusing solely on treatment provision; treatment is only a means to enabling people to play a positive role within society.
- 3** Drug users need to be given the chance to play positive roles within society – user involvement is one way to do this.



Drug Action Teams in Hungary- the KEF experience

Dr Katalin Felvinczi, Managing Director of the National Institute for Drug Prevention, made a presentation on the KEF experience. KEFs are the Hungarian equivalent of Drug Action Teams. Dr Felvinczi described the KEFS, assessed their impact and drew parallels with English Drug Action Teams

The need for action

Drug use amongst Hungary's adult population remains at low levels, although misuse of legal drugs is considered to be a substantial problem. However, the results from the European School Survey Project on Alcohol and Other Drugs (ESPAD) found that the proportion of Hungarian school children who had ever used drugs doubled between 1995 and 1999.

This swift increase led to drug use becoming an increasingly important political issue in Hungary. In 1998 the Government criminalised all use of illegal drugs. In 2002 a new Government modified this legislation, establishing diversion schemes to try to engage drug users in treatment.

A national drug strategy

The first Hungarian national drug strategy was approved by Parliament in 2000; it had four pillars similar to those of the English national strategy:

- 1 Community
- 2 Prevention
- 3 Treatment, rehabilitation and harm reduction
- 4 Supply reduction

The structure for implementing the strategy was also very similar to the English approach. An inter-ministerial committee was established, a National Institute for Drug Prevention was created and Co-ordination Fora on Drug Affairs (KEFs) were established to implement the strategy locally.

The National Institute was charged with providing technical and administrative advice to KEFs; running a web-based information system for professionals; establishing research and development projects and collaborating with other countries.

The role of the KEFs was very similar to that of Drug Action Teams; they were made up of representatives from all stakeholder agencies and tasked with implementing the national strategy. They were expected to undertake needs assessments and develop local strategies and action plans. They were also expected to become a reliable local resource centre on all drug issues. Seventy four KEFs were operational at the time of this conference.

Compare and contrast

Dr Felvinczi drew a number of parallels between KEFS and DATs. They have a similar role:

- They are both underpinned by a community focus.
- Co-operation between different agencies is crucial.
- Their main function is the implementation of the National Strategy.
- They have responsibility for all areas/pillars of the strategy.
- They are expected to be responsive to local needs and opportunities.

They had also experienced some of the same initial problems; in particular getting representatives from local agencies with sufficient seniority to make decisions and commit resources and in developing a shared local strategy which is not undermined by individual agency ambitions.

Dr Felvinczi went on to describe some of the key differences between the local fora in both countries. KEFs are not a legislative requirement and as such sometimes lack political influence. They are also not reliably funded which makes it hard for them to adopt a long term strategic view.

Conclusions

The Doctor concluded by identifying six key areas where Hungarian KEFs could learn from the experience of English Drug Action Teams:

- Performance management of local providers.
- Organisational culture.
- Flexibility in responding to local needs.
- Clear vision and mission.
- Management, planning skills and techniques.
- Fully acknowledging the relevance of cultural diversity.



The West End Drugs Partnership

This presentation was delivered by three speakers representing the different agencies which make up the West End Drugs Partnership – Jim Murray from the local community and a partnership board member; Des Rock from the Metropolitan Police; and Tom Preest from the London Borough of Camden

History and background

There has always been a very active open drug market in the West End of London, an area which covers parts of two local authorities and four police divisions. Project Lilac³ was set up in the late 1990s to tackle this drug market by improved enforcement and treatment provision and by designing out features of the built environment that provided opportunities for the supply and use of drugs.

Project Lilac was considered successful although its funding finished in early 2002. Some of its successes lived on, others did not and the drug market re-established itself very quickly. In 2002 a large public meeting took place at Covent Garden with local people and businesses demanding action. As a result the Government Office for London took responsibility for a new project to tackle the market. Members of the community reference group from Project Lilac became involved in the steering group for a new project known as the West End Drug Project (WEDP).

The objective of WEDP was 'to reduce the impact of drug use and dealing and thereby improve the quality of life for those living, working in, and visiting the West End of London'.

Identifying the problem

WEDP placed considerable emphasis on listening to the concerns of local people. A great number of concerns related to nuisance behaviour involving the sale, use and injecting of drugs. The police did not have the resources to respond to many individual incidents, and when they did attend, the individual causing the problem behaviour had normally moved on. This led to frustrations for both local residents and the police. WEDP has developed 'Community Alert', a new way of reporting incidents, which allows the police and council agencies to identify patterns of problem behaviour and respond strategically.

Any concerned individual can report an incident relating to local quality of life via the community alert website <http://www.communityalert.org.uk/>. The information is organised in a searchable relational database so that local individuals and groups can see patterns of problem behaviour. Each concern is then routed to the appropriate enforcement authority through an efficient, seamless, email utility. Residents can then track the authorities' response to individual concerns and problems as well as larger incident type trends affecting local quality of life, and comment on the response.

Responding

The cornerstone of the response to these problems is delivered through the Street Services Team run by the Crime Reduction Initiative. There are four geographically based teams covering the WEDP area who meet fortnightly. The meetings are attended by a range of organisations including the police, housing providers, street wardens and drug treatment providers. The team targets five groups of individuals:

- 1 Rough sleepers
- 2 Beggars
- 3 Street drug users
- 4 Street sex workers
- 5 Street drinkers

The purpose of the meetings is to agree an individual case plan for all clients identified by any agency as engaging in street based behaviour causing a problem to local people. The focus is on encouraging individuals to engage with services which can help them. Where an individual declines help and their street behaviour continues, they are dealt with by the criminal justice system including creative use of new anti-social behaviour legislation. The Street Services Team is accountable to the local community which keeps a clear focus on the effectiveness of their work.

Success

WEDP has had a number of successful outcomes. In addition to engaging members of the local community, the partnership has worked hard to gain the participation and support of local services. The partnership has helped homeless hostels and local residents work together to solve local problems. The police from Westminster and Camden have worked collaboratively to tackle drug markets, where previously the focus had been on pushing the market out of their own area. There has been a campaign to encourage visitors to the West End to give to homeless charities rather than individual beggars, many of whom use begging to raise money for drugs.

Perhaps the success of which WEDP is most proud is the transformation of Phoenix Gardens. By taking down hoardings and opening up access, a small area which had become derelict and was used solely for the sale and use of drugs, has been featured in the London press as a favourite spot for local workers and residents:

From Time Out 7-14 July 2004

'A haven for wildlife, less a public park and more a community garden, behind Covent Garden Odeon, between Shaftesbury Avenue and Charing Cross. Wild flowers grow; expect to share your crumbs with blue tits, wrens and greenfinches.'

³ Project Lilac was featured in the 2001 London Drug Policy Forum Conference, Availability: the local connection. Conference report is available from LDPF website: <http://www.cityoflondon.gov.uk/ldpf>



Policy and the drug situation in Swedish prisons and probation

Mr Carl Åke Farbring, Programme Inspector in the National Prison and Probation Administration, gave a presentation on how Sweden had tackled drug use among offenders

A change was needed

Mr Farbring started by characterising the 1990s as a lost decade in the attempts to tackle drug use. He stated that the organization of social welfare in Sweden was constantly re-structured and that, as a result, operational focus was lost. Drug misuse increased both in society and within prisons during the decade. A clear and worrying indicator of this was the rapid rise in drug related deaths from 148 in 1990 to 275 in 1999.

Although there was a formal requirement for pre-release planning for every prisoner, drug treatment in the different communes was very variable and often a low priority. The communes did not have dedicated money to fund drug treatment. This situation frequently resulted in treatment gains made in prison being swiftly lost on release.

Reducing supply and demand

Sweden introduced a new drug strategy in 2002 which sought, amongst other aims, to tackle drug use and crime. This strategy was heavily funded with 100 million kroner made available to the prison and probation service over three years. A six point strategy was adopted:

- 1 Identification of drug users
- 2 Differentiation of provision according to motivation
- 3 Motivation and treatment
- 4 Control and security
- 5 Co-operation/throughcare
- 6 Enhancing competence

A high priority was placed on reducing the availability of drugs in prison to support the enhanced treatment options. Supply reduction measures included:

- thorough daily searches for drugs
- regular drug testing – averaging 2 to 3 samples per inmate per month

the key components of effective interventions are eliciting the clients' own priorities and goals and working jointly to develop effective solutions

■ targeted searches when prisoners left or arrived at the prison

■ careful searching of visitors.

Treatment initiatives were built on the concept of motivational interviewing and, once drug using prisoners were identified, they were diverted into one of three options:

- 1 Treatment wings/prisons
- 2 Wings/prisons for drug using prisoners ambivalent about changing their drug use
- 3 Wings/prisons for drug using prisoners with little motivation to change

Great emphasis was placed on building an evidence base of effective interventions and assuring the quality of all work.

Results

This heavily funded strategy resulted in a great increase in treatment capacity as the following figures for 2003 demonstrate:

- A total of 1381 drug treatment slots were created.
- 3,000 prisoners were assessed for drug use in remand prison.
- 1200 treatment contracts were drawn up per day.
- 150 pre-release plans were drawn up per day.
- 2300 staff were trained in motivational interviewing.
- 1015 inmates completed drug treatment programmes.

Mr Farbring identified the obstacles to progress and found that the most important one was the difficulty in implementing new treatment approaches with many staff clinging to their existing styles of work.

The Swedish Government is currently establishing the next phase of the drug strategy from 2005-2007. It is increasing the funding available for tackling drugs within the criminal justice system and is considering setting a guarantee of prompt access to treatment. Consideration is also being given to reducing prison sentences for offenders who participate in drug treatment. A major change will be a significant expansion in the capacity of methadone prescribing. The prescribing of Subutex, conversely, is being restricted because of a growing illegal market in this drug.

This next phase will see the prison and probation administration concentrate on improving the quality of motivational work undertaken with drug using offenders. A recent study suggests that the key components of effective interventions are eliciting the clients' own priorities and goals and working jointly to develop effective solutions. There will be close evaluation and monitoring of workers' competence to deliver motivational interventions.

Taking it forward: making learning work

Ms Sara McGrail, a Fellow at the Office for Public Management, made the final presentation of the conference which sought to establish how we could learn from effective practice across Europe and make positive change in the drugs field in England



Where we are

Ms McGrail started her presentation by exploring the state of the UK drugs field in terms of applying what we have learned to improve drug treatment services, public and individual health, and community safety.

Drawing on debates at recent party political conferences, she identified four key points of consensus:

- Drug issues are accepted by the public as a political priority.
- There is a universal acceptance of the link between drugs and crime.
- Treatment is seen as effective and the cornerstone of any successful strategy.
- The concept of harm reduction is accepted as vital to a successful treatment approach.

How we learn

Ms McGrail stated that the drugs field has historically been effective at sharing knowledge and good practice. She stressed that the commissioning cycle depends on strong information flow about the local area and awareness of good practice regionally, nationally and internationally.

Ms McGrail then proposed that the key to an approach to service development which learns from effective practice is an acceptance of innovation. She stated that currently there is considerable Central Government influence on what is commissioned. The move to standardise treatment services through officially sanctioned frameworks of provision such as Models of Care and the Drug Interventions Programme, has made it harder for us to accept new ideas. Local commissioning groups commission against the pooled treatment budget using a template of services prescribed by the National Treatment Agency. This effectively means that good practice has to be

centrally approved before it can be deployed.

Ms McGrail challenged the conference to consider whether spending the majority of local budgets on meeting national priorities in rather a prescribed way is what the drugs field needs. She went on to ask how local need can be met in this environment.

Ms McGrail argued that treatment providers have been the least important partners in service development over the last four to five years. She contested that contracts have often been limited and limiting, and that there might be more room for innovative service development within compacts of understanding. She went on to argue that research studies which come out with politically apposite recommendations should not be the end product in determining models of intervention. Good research should stimulate dialogue on how best to implement solutions to a problem.

How to do better

Ms McGrail then explored how to develop more effective local infrastructures to support the better application of innovation. She suggested a six step plan of action:

1 Strengthen local Drug Action Teams and Joint Commissioning Groups.

It is important to ensure that the DAT is not just a sub-group of the local Crime and Disorder Reduction Partnership. The involvement of both senior figures from partner agencies and service users may be the key to this.

2 Identify local funds for innovation.

The Communities Against Drugs fund was a national pot of money used for innovation. Although it no longer exists, there are other potential sources of funding, including Safer Communities monies, Neighbourhood Renewal Funds, the Lottery and the Future Builders Initiative.

3 Robust local data.

Good quality local information makes it possible to make a reasoned argument for a particular innovation to meet local need.

4 Good understanding of local service impact and limitations.

Planning service development involves close knowledge of the strengths and weakness of local treatment provision.

5 Make a local case for applying best practice from elsewhere.

Where an approach has been demonstrated to be effective elsewhere, make a reasoned argument for trying it locally.

6 Challenge central direction.

Don't be afraid to argue the case that your area needs a different response.

But be careful

Ms McGrail concluded her presentation with five key messages for local commissioners:

- Standardisation of services is important but is not about developing services which simply meet national requirements.
- Current data are often not reliable; good local information is vital to service development.
- Innovation for the sake of it is pointless. New ideas have to be adapted to local conditions.
- Consolidation is sometimes better than change.
- It is often possible to learn useful lessons from unexpected results – be creative in looking for what works locally.

Dr. Christoph Buerki, Medical Director of the Heroin Assisted Treatment Centre KODA in Berne. Born 1962, Christoph grew up in Lucerne and Berne. He graduated in medicine in 1990 and started working with drug addicts in 1991 in various settings. He did his thesis on 'Monitoring HIV risk behaviours and drug use in a street agency with injection room in Switzerland' and completed his postgraduate training as a psychiatrist at the university psychiatry services, Directorate of Community Psychiatry in 2000. Besides heading KODA, he has his private practice and is a member of the Quality Assurance Commission of the Swiss Federal Office of Public Health for Heroin Assisted Treatment as well as the Co-chair of the Association of Heroin Prescribing Doctors in Switzerland.

Carl Åke Farbring, Programme Inspector in National Prison and Probation Administration, Sweden. For many years Carl has led a scientifically evaluated Therapeutic Community against drugs in Österåker prison. He is Head Secretary of the Central Group against Drugs, and a member of the Scientific Accreditation Panel and the Group for National Programmes, as well as the author of a motivational programme widely used in Swedish corrections. He is also a member of a research committee that is responsible for the implementation of motivational interviewing in prisons and probation throughout Sweden, which will be followed by randomised research of the effects over the next two years.

Dr Katalin Felvinczi, Managing Director of the National Institute for Drug Prevention. Hungary. Before she joined the National Institute in 2001, Dr Felvinczi worked as a team leader and programme manager at the National Institute for Health Promotion, working on various international projects such as the European Network of Health Promoting Schools. She regularly lectures on drug prevention issues, focusing particularly on programme management and evaluation, and is a module leader at the Debrecan University, School of New Public Health.

Dr Emily Finch, National Treatment Agency Clinical Team Leader, has lead responsibility within the NTA for clinical aspects of policy delivery. She is also a Consultant Psychiatrist and honorary Senior Lecturer at the South London and Maudsley NHS Trust and the Institute of Psychiatry and has clinical responsibility for the North Southwark community drug services. She is the Deputy Clinical Director. Research interests include the outcome of treatment for opiate users, dual diagnosis, and coercive treatment.

She lectures and tutors on the MSc in clinical and public health of addiction.

Mrs Maureen Kellett JP., London Drug Policy Forum Chairman, was recently appointed Chairman of the London Drug Policy Forum. She was elected on to the Common Council for the Ward of Tower in 1986 and in 1988 became a Magistrate on the City of London bench. She currently serves on the Committees for Planning and Transportation, the City of London Police Authority, the Board of Governors for the City of London School, and the Barbican Centre. Mrs Kellett was also Chairman of the City of London Drug Action Team, Drugs Reference Group, which looked into the problem of drugs in schools and in the workplace, and was responsible for establishing the City of London Arrest Referral Scheme. She now sits on the Steering Committee which oversees the Arrest Referral scheme and is involved with the Drug Awareness and Resistance Education Programme (DARE).

Mr Stephen McGill, Scottish Drugs Forum, has worked for the last ten years in the field of social care research. Since 2002, Stephen has been working for the Scottish Drugs Forum as Head of User/Carer Involvement & Research Studies. Previously, Stephen was employed as the Senior Research Officer for Glasgow City Council Social Work Services managing the local authority research team, and specifically spent four years working as the Research Officer for GCC Addiction Services. He studied Economics and Politics at Trinity College, Dublin.

Ms Sara McGrail, Fellow, Office for Public Management. Sara joined OPM from the National Treatment Agency for Substance Misuse, where she was the Assistant Director of Programme Implementation. Prior to that she worked for the London Borough of Newham as Co-manager of the Community Safety Unit, with particular responsibility for developing internal and external partnerships through joint commissioning, planning and evaluation. Sara has worked extensively in the voluntary and community sectors and as a freelance consultant. She has a strong interest in business planning and a passion for drug policy equalled only by her passion for old punk and good wine.

Ms Maria Moreira, Director of the National Monitoring Centre on Drugs and Drug Addiction, Lisbon, has been working in the field of drug policy coordination since 1992. She is currently the Head of the National Monitoring Centre on Drugs and Drug Addiction, a department of the

Institute for Drugs and Drug Abuse, the governmental agency responsible for coordinating the implementation of the Portuguese National Strategy for the Fight against Drugs. She has been head of the National Reitox Focal Point for the European Monitoring Centre for Drugs and Drug Addiction since 1997, and spokesperson and deputy spokesperson of the Reitox Focal Points from 1999 to 2002. Maria Moreira has a MSc degree in Management of Information Systems and a specific interest in the fields of strategy, decision making and public policies.

Mr Jim Murray, West End Drugs Partnership. Jim was born in the West End, and has lived and worked in the area all his life. He now lives with his partner and three teenage children, and is self-employed as an Internet Systems Developer. His interests include Community Empowerment and Communications Systems and he is Chair of the Bloomsbury Association and Community Member on the West End Drugs Partnership.

Mr Tom Preest, Head of Street Population, London Borough of Camden Housing Department, has worked for London Borough of Camden since September 2000. He has been involved with the development and implementation of the borough's Street Population Strategy. The strategy seeks to tackle the social exclusion of clients engaged in street activity through the provision of appropriate services, and to address the community safety concerns the presence of street activity can engender through partnership work with enforcement agencies. Tom worked for front line homelessness agencies in London from 1994 until taking up his post at Camden.

Inspector Des Rock, Metropolitan Police Service. Des has been a police officer for 20 years. He currently works as the Co-ordinator for the West End Drug Partnership, a cross border group covering Camden and Westminster, which is funded by the Government Office for London and supported by Camden and City of Westminster councils.

Mr Alex Stevens, Senior Researcher at the European Institute of Social Services, University of Kent, manages a six-country European study of 'quasi-compulsory treatment of drug dependent offenders' (QCT Europe). His research interests include European perspectives on drugs, crime, social inequality and exclusion. He previously worked for Cranstoun Drugs Services as Coordinator of the European Network of Drug and HIV/AIDS Services in Prison.





The London Drug Policy Forum was established in 1991 to co-ordinate London local authority policy and practice and to encourage joint working. It is funded by the Corporation of London.

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Acknowledgements

The London Drug Policy Forum would like to thank all the speakers who addressed the conference:

Dr Christoph Bürki; Carl Åke Farbring; Dr Katalin Felvinczi;
Dr Emily Finch; Stephen McGill; Sara McGrail; Maria Moreira;
Jim Murray; Tom Preest; and Inspector Des Rock.

The Forum would particularly like to express gratitude to Alex Stevens who chaired the day's proceedings.

The Forum would also like to acknowledge, with many thanks, all those who helped to organise the conference, notably David MacKintosh, Jacky Davy, and Susannah Behr.

The views expressed by the speakers at this conference are not necessarily those of the London Drug Policy Forum or the Corporation of London.

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