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I had been in and out of rehab and hospitals many times, nothing worked until coming to Serenita. I have been able to get better by on-going support, personal development and guidance. I feel very comfortable here and am looking forward to walking out one day, not running.

- Martin, ARBD Resident

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CONTENTS

ON THE COVER

Contemplating a landscape of change and fear, HIT Hot Topics speakers called for solidarity.

EDITOR'S LETTER

'The situation requires a real shake-up in the way we engage'

'We begin to categorise and stigmatise without even realising it,' said a speaker at Hit Hot Topics (page 6). Throughout the event we heard how 'language can become perception' and be very alienating. We also heard about people who inject drugs 'being called transmitters and tracked like salmon' and feeling 'dehumanised'.

But we were also reminded of our responsibilities in actively challenging stigma and overturning myth. Public perception – relating to supervised injection facilities for instance – was found to be based on a lack of knowledge.

Within the sector we have a wealth of expertise to address this. Natalie Davies examines the argument for consumption rooms in detail (page 17); Catherine Larkin and Danny Hames take stock of the value of a naloxone strategy (page 16); Tony Margetts evaluates the progress of prison reform (page 19); Lizzie McCulloch looks at a new approach to cannabis policy and treatment (page 8) and two of the major treatment charities explain how they are tuned to the challenges ahead (page 11 and 14).

In a climate of fear, information-sharing is our weapon to keep options open and steer policy towards life-saving gains. As Stephen Malloy says (page 13), 'For the person whose life depends on it, the situation could not be more crucial and requires a fundamental shake-up in the way we view and engage people who use drugs, those receiving OST medicines, service users and patients.'

We'll be challenging stigma and indifference at our tenth anniversary service user involvement conference, 'One Life' – hope to see you in Birmingham on 23 February!

Claire Brown, editor

Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

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SMMGP

DEATHS IN PRISON HIT RECORD LEVELS

LAST YEAR SAW A RECORD 354 DEATHS IN PRISON CUSTODY, according to figures from the Ministry of Justice – an increase of nearly 100 from the previous year. Almost 120 were self-inflicted deaths, including 12 women, while three were homicides.

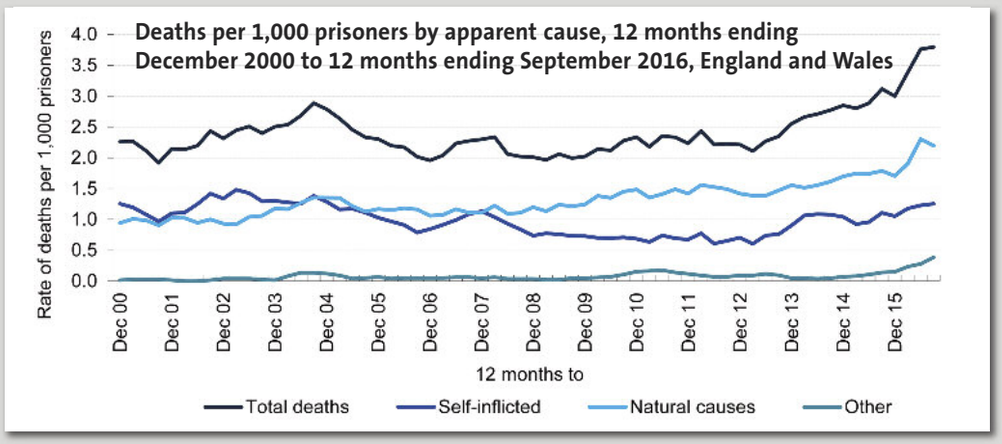
The rate of prison suicides has now doubled since 2012, says the document, while self-harm incidents also increased by nearly 7,000 to a record high of 37,784. Assault incidents were also up by more than 30 per cent, to another record high of 25,049 – almost 3,400 of which were classed as serious. Assaults on staff increased by 40 per cent, to almost 6,500, while prisoner-on-prisoner violence was up by 28 per cent to more than 18,500 incidents. Serious assaults on staff have trebled since 2012.

Responding to the statistics, justice secretary Liz Truss said that the government had taken action to 'stabilise the estate by tackling the drugs, drones and phones that undermine security. These are long-standing issues that will not be resolved in weeks or months, but our wholescale reforms will lay the groundwork to transform our prisons, reduce reoffending and make our communities safer.'

'It is official – more people died in prisons in 2016 than in any other year on record, and more prisoners died by suicide than ever before,' said chief executive of the Howard League for Penal Reform, Frances Crook. 'No one should be so desperate while in the care of the state that they take their own life, and yet every three days a family is told that a loved one has died behind bars. Cutting staff and prison budgets while allowing the number of people behind bars to grow unchecked has created a toxic mix of violence, death and human misery.'

Safety in custody statistics bulletin, England and Wales, deaths in prison custody to December 2016, assaults and self-harm to September 2016 at www.gov.uk

See feature, page 19



HARD TIME

A COMPREHENSIVE 26-COUNTRY STUDY of drug trafficking laws has been published by EMCDDA. *Drug trafficking penalties across the European Union* looks at the national laws regarding the trafficking of cannabis, amphetamine, cocaine and heroin, along with expected sentences and the time likely to be spent in prison. *Document at www.emcdda.europa.eu*

FINAL COMMUTE

BARACK OBAMA marked the end of his presidency by commuting the sentences of 330 prisoners, bringing the total number of commutations granted to more than 1,700. 'The vast majority of these men and women are serving unduly long sentences for drug crimes,' said a White House statement.

SCANDALOUS STATISTICS

THE NUMBER OF PEOPLE SLEEPING ROUGH in England has increased by 16 per cent in a year, according to government figures – the sixth annual increase in a row. The autumn 2016 figure was 4,134 rough sleepers, says DCLG, compared to 3,569 in autumn 2015, based on a 'single night snapshot' of street counts and 'intelligence-driven estimates' from local agencies. The statistics are seen by many as an underestimate, however, with the most recent figures from the Combined Homelessness and Information Network (CHAIN) putting the total number of people seen sleeping rough by outreach workers in London alone during 2015-16 at more than 8,000. St Mungo's chief executive Howard Sinclair said the figures were 'nothing short of a scandal', while Crisis chief executive Jon Sparkes said numbers were rising at an 'appalling' rate.

CRIMINAL SITUATION

THE MORTALITY RATE FOR PRISONERS is 50 per cent higher than for the general population, according to a report from the Revolving Doors charity in partnership with PHE, NHS England and the Home Office. The criminal justice system is 'uniquely placed' to tackle substance misuse and break the cycle of reoffending, it says, but adds that those in contact with the system may be the bearers of 'multiple stigmatising labels' that act as a barrier to accessing or engaging with healthcare. PHE has also published guidance on delivering programmes to reduce TB in 'under-served' populations such as people with substance misuse problems. *Rebalancing act at www.revolving-doors.org.uk; Tackling tuberculosis in under-served populations at www.gov.uk*

'Young people do not develop substance problems in isolation.'
ROSANNA O'CONNOR

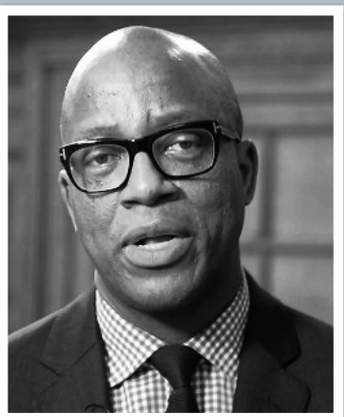
BEHIND THE HEADLINES

AROUND SIX PER CENT OF YOUNG PEOPLE SEEKING ALCOHOL OR DRUG TREATMENT REPORT HAVING BEEN THE VICTIMS OF SEXUAL EXPLOITATION, according to a PHE-commissioned review of young people's treatment services by the Children's Society. The figure is far higher among girls, at 14 per cent, than boys, at 1 per cent. A quarter of females starting treatment in 2015-16 reported having mental health problems, along with 15 per cent of males, while 33 per cent of females and 9 per cent of males reported having self-harmed.

Meanwhile, annual NDTMS figures show that the number of young people seeking help for substance issues has fallen to 17,000 from its peak of 24,000 just under a decade ago. While the drop in numbers was encouraging, it was important to 'look behind the headline' and remember that young people did not develop substance problems in isolation, said PHE's director of alcohol, drugs and tobacco, Rosanna O'Connor.

Specialist substance misuse services for young people and Young people's statistics from the National Drug Treatment Monitoring System (NDTMS) at www.gov.uk

NEARLY TWO THIRDS OF OPIOID USERS IN TREATMENT, SAYS PHE



'Services... need to be flexible, ensuring appropriate treatment to those seeking help for the first time.'
PROFESSOR KEVIN FENTON

SIXTY PER CENT OF ENGLAND'S OPIOID USERS ARE NOW IN TREATMENT – one of the highest reported international rates – according to an evidence review by Public Health England (PHE) which compares international research literature on treatment effectiveness to the English system. Rates of HIV infection among injecting drug users remain at just 1 per cent, it says, while 97 per cent of drug users are able to start their treatment within three weeks.

The areas where the English system were 'not doing so well', however, were the record rates of drug-related deaths (*DDN*, October, page 4) and the number of people who continue to use opiates after beginning treatment. Rates of abstinence from illicit opiates after three and six months of treatment in England stood at 46 and 48 per cent respectively, a 'relatively poorer performance' internationally, while the drug-related death rate was 'substantially lower than in the USA but considerably higher than elsewhere in Europe'.

The report reiterates the importance of factors such as housing, employment and good social networks in remaining drug-free, along with properly integrated services, and states that increases in drug-related harms are largely among a 'small but growing number of vulnerable, older entrenched heroin users' who experience poor physical and mental health. 'The number of drug misuse deaths has increased over the past 20 years, with a significant rise in the last three years, to the highest number on record,' it says. 'In the next four years, PHE estimates that there will be an increase in the proportion of people in treatment for opiate dependence who die from long-term health conditions and overdose.'

'Local areas increasingly have to meet the complex needs of older long-term heroin users, often in poor health, with other problems – particularly housing, poor social networks and unemployment – which are vital to successful recovery,' said PHE's national director of health and wellbeing, Professor Kevin Fenton. 'Services will also need to be flexible, ensuring appropriate treatment to those seeking help for the first time, particularly with emerging issues such as new psychoactive substances or the problematic use of medication.'

An evidence review of the outcomes that can be expected of drug misuse treatment in England at www.gov.uk

districts, with male incidence in Dublin 'statistically significantly higher than the national average'. The Irish Cancer Society said the figures were 'startling' and the 'result of decades of people in Ireland simply drinking too much.' *Document at www.ncri.ie*

'All membership services are being transferred to SMMGP...'
CAROL SHARMA

FDAP CLOSES

THE FEDERATION OF DRUG AND ALCOHOL PROFESSIONALS (FDAP) has made the 'difficult decision' to close, according to a statement from the organisation's board, with its members' interests to be looked after by SMMGP from this month onwards. 'To ensure there is no confusion I wish to state clearly that all membership services are being transferred to SMMGP,' said outgoing chief executive Carole Sharma. 'This includes all types of accreditation and re-accreditation for individuals, service providers and educational institutions. SMMGP will be writing to members soon and we are all working hard to ensure the handover is as smooth as possible.'

CONTROL CALL

MORE THAN 1,000 DOCTORS and other healthcare professionals have written an open letter to Theresa May and Jeremy Hunt calling for a new tobacco control plan to be published 'without further delay'. The signatories, which include five former royal college presidents, say the move is essential to tackle health inequalities. Although smoking prevalence in England has halved in the last 35 years – with less than a fifth of adults now smokers – the highest rates of smoking are found in disadvantaged communities. *Open letter at www.bmj.com*

ADDACTION APPOINTMENT

MIKE DIXON will take over the role of Addaction chief executive from 1 May, the organisation has announced, replacing interim chief executive Guy Pink. He is currently assistant chief executive of Citizens Advice, prior to which he worked as a director at Victim Support and as an advisor in a number of government departments. 'Mike has an excellent track record of working at the highest levels of government and the voluntary sector in a wide range of political, strategic and service delivery roles,' said Addaction's chair, Lord Alex Carlile. 'We are confident he will bring formidable strategic vision and operational energy to Addaction.' *See feature, page 14*

GRIM MEASURES

THE NUMBER OF PRIMARY LIVER CANCERS in Ireland increased by more than 300 per cent between 1994 and 2014, according to figures from the country's National Cancer Registry. 'The increase in alcohol consumption observed in Ireland in recent decades is likely to have had a strong influence,' says *Cancer trends: primary liver cancer*, with rates three times higher in men than in women. Men in urban areas were also 64 per cent more likely to develop liver cancer than those in rural

CORE CORRUPTION

PHILIPPINES PRESIDENT RODRIGO DUTERTE has announced a temporary suspension of his violent 'war on drugs' while he addresses the problem of police corruption. He told a press conference that he intends to abolish the Philippine National Police's (PNP) anti-drugs units and replace them with 'an anti-narcotics body that will work hand in hand with the Philippine Drug Enforcement Agency (PDEA)'. The announcement follows the alleged murder of a Korean businessman on police headquarters.

'Suspending police anti-drug operations could reduce the killings, but they won't stop without a meaningful investigation into the 7,000 deaths already reported,' said deputy Asia director of Human Rights Watch, Phelim Kine. 'Unless there is an independent international investigation into these killings, and soon, the already long list of grave rights violations linked to the "drug war" will only continue to grow.'

'Independent international investigation' vital to address rights violations.
PHELIM KINE

DEBATE

Contemplating a landscape of change and fear, HIT Hot Topics speakers called for solidarity.

DDN reports, pics by *Nigel Brunsdon*

ACROSS THE GREAT

'When we meet someone, we ask what music they listen to – it gives us a mirror we can understand. We start to apply labels 'us and them' as soon as we start to talk that language.' Talking at the recent Hit Hot Topics conference, epidemiologist Keith Sabin suggested that we being to categorise and stigmatise without even realising it.

Even the researchers were part of the problem. 'We put people in a box and say "these people are higher risk". It's a dichotomy that doesn't need to exist. We have to overcome this language, because language becomes a perception.'

With Donald Trump's election victory newly sinking in, the threat of division and alienation felt raw to many of the speakers and delegates.

'The war on drugs is an efficient and effective umbrella for genocide,' said US activist Deborah Peterson Small. 'The goal is to eliminate people, and what's happening in the Philippines is the logical extension. It's not just the actions of a mad man – it's happening all over the world... if you think Duterte is an aberration, think again. Read your history – all the conditions before World War Two are in place now.'

Furthermore, she said, the media talked about 'this stuff' as if it was normal. 'But Trump and his hostility to drugs and drug policy is no joke.'

So what do we do to stop this slide into the abyss? Neuroscientist Dr Carl Hart drew a positive from the shock election result.

'The progressives fell asleep under the Obama administration... maybe now they'll wake up!' he said. 'We claimed victories for things that weren't victories. You know the score with Trump. It's best to know the score than to hear pretty lies. Go to work!'

For many of the speakers, the challenges were very clear. Magdalena Harris, qualitative sociologist at the London School of Hygiene and Tropical Medicine, brought scrutiny to the complicated scenario of hepatitis C treatment.

For the 216,000 people living with chronic hepatitis C in the UK, the revolutionary new treatment was giving them the opportunity of a 90 to 100 per cent cure rate, without the former gruelling side effects. Being able to dispense the treatment in community drug treatment settings conjured up the vision of eliminating hepatitis C in a generation.

But restricted budgets, and a list price of around £35,000 per person per course (although the price to the NHS was confidential), meant that NHS England had limited treatment slots to 10,000 a year. The 22 local area networks had just 50 slots each a month, so were having to prioritise patients with the greatest clinical need, such as those with cirrhosis.

People who inject drugs came high up on the priority list – but only because they were seen as at risk of transmitting the virus, Harris explained. 'They are being called transmitters and tracked like salmon. This language can be very alienating.'

While reducing mortality and onward transmission were clear criteria, Harris was also concerned that other life transforming benefits of treatment were not being acknowledged, such as the change to identity and the social benefits. It was easy to lose the full picture when looking at statistics and ranking greatest clinical need.

Faye McCrory, a recently retired consultant midwife, said we should cast the net wide for the full picture.

'What has a midwife to do with drug services?' she said, before answering 'Drug misuse does not sit in isolation.' Her challenge while working at a specialist midwifery service was to get staff to treat patients 'as women, not as drug users and prostitutes'.

Many taboos had had an impact on these women – sexual abuse, child sexual exploitation, human trafficking, sharing information, safeguarding and child protection – and there were many ethical and moral dilemmas that meant health professionals should listen without prejudice.

Researcher Aaron Goodman also had an interesting

DR SUZI GAGE


DR CARL HART


AARON GOODMAN


FAYE MCCRORY


DEBORAH SMALL


MICHAEL S

DIVIDE

view on challenging stereotypes, presenting his digital storytelling initiative, Story Turns (www.storyturns.org). Working with people who used heroin, he involved them in workshops to make a short video telling their personal story. Instead of the 'dark, seedy, anonymous' portrayal of drug users, the project resulted in 'humanising' stories and images – the message that (in the words of one participant) 'there's more to me than addiction'.

Psychologist Dr Suzi Gage shared another imaginative initiative, the 'Say why to drugs?' project, which uses podcasts to look at the harms and the potential benefits of drugs, with 'no judgement, no spin and no hyperbole'. Her first series, in conversation with rapper Scroobius Pip, took the conversation to young people and aimed to take them into territory where they could ask questions and build up a full and fair picture of drugs and people who use them.

The theme of changing the narrative continued, from both a UK and international perspective. Michael Shiner from the London School of Economics focused on disproportionate policing, particularly stop and search, which had 'engulfed policing since 1980' and intensified since the Stephen Lawrence inquiry gave police 'more power with less accountability'.

He explained that he was part of an organisation called Stop Watch, which was trying to change the narrative around stop and search, including tackling the 'massive disproportionality in relation to drugs'.

Maria Phelan of Harm Reduction International (HRI) widened the view to the global state of harm reduction. While there had been progress on opioid substitution therapy (OST) in Monaco, Senegal and Kenya, funding cuts – and in some cases the lack of momentum to prioritise harm reduction – had scaled down progress in many countries.

Referring to HRI's latest biennial report, she highlighted that harm reduction in prisons 'lies far behind what's available in the community', with several programmes closing since the last report and Spain being 'the only country that has anything up to scale'.

While Europe was seen as the 'leader of a harm reduction approach', there had been a decrease in needle and syringe programmes in the last two years, including in Portugal – the result of its financial crisis. Hepatitis C among injecting drug users remained a serious concern.

'There has been growth, but not fast enough,' she said. 'The biggest question is how do we get countries to invest and sustain funding? It's about protecting the gains we've made.'

In a talk about supervised injecting facilities, the Scottish Drugs Forum's Kirsten Horsburgh suggested that doubts about their advantages tended to relate to lack of knowledge. When presented with clear benefits (from the results of 135 research projects) and 'myth busting' facts, most people were persuaded that providing a sterile environment was beneficial all round and did not perpetuate drug use.

Sharing this kind of research and information was of great benefit to drug users – the 'popular scapegoats', according to Mat Southwell (main pic) of the European Network of People who use Drugs (EuroNPUD).

'Drug user organising is no longer seen as separate, marginalised work,' he said. 'Europe has a strong network of drug user activists and we realised there was a need to get our act together and mobilise... We need to seize the opportunity to be active partners – we are high level advocates and technical providers.'

Looking at developing joint advocacy plans with other networks and running simultaneous campaigns would 'help to create more noise' and move towards meaningful representation with government and the EU.

But above all, the close working and information-sharing had the potential of much greater results – a key message from this year's Hot Topics. 'We are committed to solidarity,' he said. 'Changes can't happen in isolation.' **DDN**

SHINER


MARIA PHELAN

KEITH SABIN

MAGDALENA HARRIS


KIRSTEN HORSBURGH

By HOOK or by CROOK

We're not reaching people with problematic cannabis use says Lizzie McCulloch**, whose report** *Black sheep* **offers a new approach to policy and treatment**

Cannabis is now being cited as a problematic substance by 21 per cent of clients going through treatment and figures from Public Health England (PHE) show that new presentations for cannabis treatment increased by 55 per cent between 2005 and 2014. These figures do not paint the whole picture though, as there are also thousands of people outside of treatment who require support.

In response to indicators showing there is an increasing need for support and guidance, Volteface, a drug policy think tank, wanted to find out how effectively existing interventions were supporting people experiencing problematic cannabis use. Drawing on contributions from leading experts and practitioners, and people with lived experience of problematic cannabis use, our newly released report, *Black sheep*, shines a spotlight on the harms of heavy and sustained cannabis use.

Put bluntly, we found that cannabis has been neglected in public health discourses, which is at odds with the growing number of people in England who are seeking support for problematic cannabis use. It was apparent that there has been increasing attention given to problematic cannabis use, mostly at an operational level, but overall, cannabis has not been appropriately prioritised. What is concerning is that out of non-opiate clients accessing treatment, cannabis users were the most likely to have unchanged use at the six-month review, which equated to 42 per cent of those who entered treatment.

For people who do not enter treatment, it was revealed that the 'image' of treatment was off-putting, whether due to social stigma surrounding treatment or the perception that treatment was only for 'extreme' cases. However, alternative options were limited as one-to-one interventions were mostly confined to dedicated drug treatment services, with wider community services severely limited in what they could offer. For people who are seeking to manage their cannabis use relatively independently, there are limited public resources available, with added concerns over quality and accessibility.

A unified and multifaceted approach is needed to respond to the cannabis cohort. A wider structural barrier that stakeholders identified, however, was that practitioners do not have a clear strategy for linking people experiencing problematic cannabis use into services. With the current illegal and unregulated market reducing the visibility of cannabis users, one practitioner commented that 'we're just fumbling around in the dark trying to find them'. Among people showing signs of cannabis dependence, only '14.6 per cent had ever received treatment, help or support specifically because of their drug use, and 5.5 per cent had received this in the past six months'.

To respond to these challenges, Volteface have drawn up sensible, innovative policy options, which are grounded in contributions from stakeholders and experts. We identified that a two-stage approach is needed: reforming existing public health measures to tailor support to the needs of problematic cannabis users and the introduction of a regulatory framework that links these public health measures with their intended audience.

Research into the social costs of problematic cannabis use by PHE would provide justification for commissioners, and therefore providers, to appropriately prioritise cannabis within treatment. Moreover, a shift towards holistic service provision and promotion by drug and alcohol service providers and wider community services would aim to increase interaction and engagement with support, while reducing stigma attached to drug treatment.

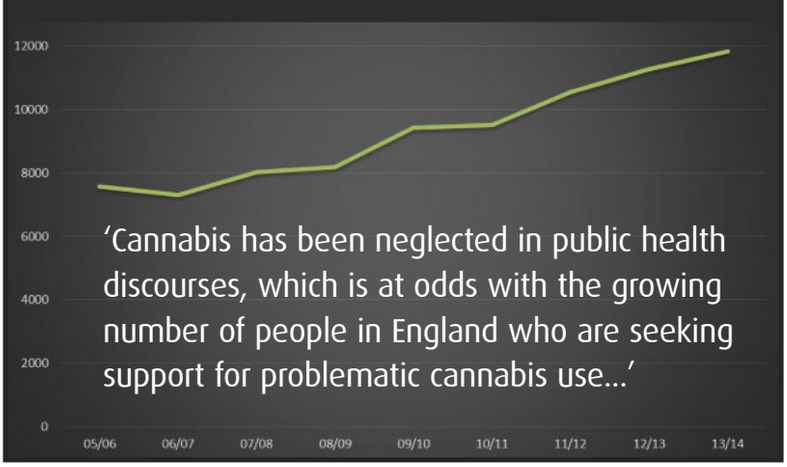
A move towards a regulated market would offer a targeted dialogue with people experiencing problematic cannabis use, offering opportunities for harm reduction advice to be delivered at point of purchase, and any person in need of support to be linked into reformed public health measures. There would also be the emergence of wider opportunities for more public guidance, packaging controls, products that vary in potency, and research into cannabis culture and consumption. During Volteface's consultation with people experiencing problematic cannabis use, it became apparent that respondents felt 'advice from a professional is far better than advice from a dealer'.

Despite numerous examples of good practice taking place across the sector, the collective effort is currently not meeting the needs of people experiencing problematic cannabis use. Change is within our grasp, but we need to be ambitious and innovative when it comes to reaching a growing and diverse group of people.

Volteface's recently released report, Black sheep *is at http://volteface.me/publications/black-sheep/*

Lizzie McCulloch is policy advisor at Volteface

UK Cannabis treatment presentations, 2005-2014



'Cannabis has been neglected in public health discourses, which is at odds with the growing number of people in England who are seeking support for problematic cannabis use...'

Read the full stories and more:
www.drinkanddrugsnews.com

FROM OUR FOREIGN CORRESPONDENT

Trauma of war

In Germany, refugees from Syria, Iraq, Iran and Afghanistan already traumatised by war and upheaval are seeking treatment for substance dependence. What are the lessons for the UK, asks **Dr Chris Ford**

'In his early twenties he was arrested and faced the choice of avoiding the expulsion of his family by registering as a "volunteer" for deployment in Syria.'

I WAS LOOKING FORWARD to hearing my friend and colleague, Hans-Guenter, talking about the issues of caring for refugees who have already been traumatised by war, violence and upheaval when they presented seeking help with their substance dependence. When Hans had told Mr A's story there was complete silence in the room.

'Mr A was in his mid-20s and was born and raised in Iran. His family was originally from Afghanistan, from where they had fled to the neighbouring country. When Mr A was 17, the family was expelled by the Iranian authorities and returned to Afghanistan. There the father was killed and the mother once more battled her way with the children to Tehran. At this time Mr A began to consume theriac, as opium is called in this part of the world, and then after a while to smoke heroin. In his early twenties he was arrested and faced the choice of avoiding the expulsion of his family by registering as a "volunteer" for deployment in Syria. There he fought in the Iranian military units on the side of the Assad government. When the heroin supply he brought along was getting low, his commander supplied him with morphine. After a shrapnel injury he returned to Iran, continued taking heroin and, for the first time, methadone. He took some methadone with him when he fled to Europe, where some months after arriving in Hamburg he relapsed and came to our clinic and asked for treatment.'

Hans-Guenter explained that over the past 25 years the clinic in Germany had seen people from at least 50 countries, including migrants and asylum seekers from Afghanistan, Iran and Turkey, partisans from the mountains of Kurdistan, refugees from the Balkan wars and from the conflicts in the former republics of the USSR.

He explained that many were treated, and had been able to establish new roots and become members of the community in Hamburg. From January 2015 to August 2016, however, one million people applied for asylum in Germany – two out of three were from Syria, Iraq, Iran and Afghanistan, and many of the men had grown up in an opium/theriac/heroin culture.

How did Hamburg cope with this large influx of refugees? It responded quickly, setting up a model system, which included consultation hours in the refugee reception centres, uniform screening for all and special places reserved for children and women.

All departments are working together, with prevention available in key languages and the police supportive. Sadly the situation isn't like this in other areas of Germany.

Hans-Guenter then posed a number of questions, which I now pose to you: Can we manage to gain transcultural competence in treating refugees? Do we need special teams? When is it the right time to take a detailed medical history of traumatic experiences? How can we bring trauma therapy and addiction medicine together? How can we reach the female refugees with a substance problem from these countries? In the context of migration, should integration be defined as the fifth pillar of drug policy? Should we develop recommendations, guidelines and best practice models for treating refugees with substance use disorders?

And in the UK: what do you provide in your area for refugees? Which are the main groups you are seeing? How do you manage with translation? What additional skills would you like?

Dr Chris Ford, IDHDP with Dr Hans-Guenter Meyer Thompson, Hamburg

MEDIA SAVVY

The news, and the skews, in the national media

GAMBLING ADDICTS have 'WEAKER' brains – just like alcoholics and drug addicts, scientists discover.
***Sun* news story, 3 January**

WHY IS EASTERN EUROPE the only region in the world that still has a growing HIV epidemic? In one of the region's countries, Russia, more than two thirds of all HIV infections, and 55 per cent of the near 100,000 new infections reported last year, resulted from drug injection... Russia adopted a new strategy against HIV/AIDS in October 2016, but it is not an evidence-based and pragmatic approach focused on public health and does not include harm reduction. Resistance and outright opposition to strategies to minimise the health risks associated with injecting drug use, despite evidence of effectiveness and increasing international acceptance, rely on narratives that prioritise prohibition. Harm reduction has become a highly polarising issue and an example of how health is increasingly being politicised and how policy decisions can be disconnected from scientific evidence.
Michel Kazatchkine, *BMJ*, 17 January

THE 'NEWS' is apparently that some people got drunk on New Year's Eve. The horror is that some of these people were female... Bingeing on booze is not good, but it happens. Binge moralising however is a problem. One tends to lose all contact with reality in a constant quest for the high of smug superiority.
Suzanne Moore, *Guardian*, 2 January

IF YOU HAVE ENGAGED in social media in 2016, you've probably heard of Dry January, Dryuary, or Drynuary, the latter of which sounds like cold medicine. The concept is simple, albeit puritanical: participants simply do not drink alcohol for the first month of the new year. The execution, however, is downright infuriating. Dryuary is not for people wishing to better their lives. It's for people who wish to publicly better their lives, and inadvertently shame those who continue to indulge in the semi-frequent glass of wine.
Kate Taylor, *London Evening Standard*, 6 January

POLICE, having more or less given up enforcing the cannabis law because they didn't feel like bothering, have now begun a stealthy campaign to decriminalise class A drugs by default... Police chiefs know this government's pose of being tough on drugs is just that – a pose. A few noisy raids on dealers are expected to fool the public into believing something is being done.
Peter Hitchens, *Mail on Sunday*, 29 January

LETTERS AND REVIEW

DDN WELCOMES YOUR LETTERS

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

'I am not suggesting that aiming for recovery is wrong... [but] for all the talk of recovery, the evidence suggests that we are not very good at making it happen.

OFF THE MARK?

I am sure you know the story of The Emperor's New Clothes. Two weavers promise him a new suit that they say is invisible to those who are unfit for their positions, stupid, or incompetent. When he parades before his subjects in his new clothes, no one dares to say that they don't see any suit of clothes on him for fear that this is how they will be seen.

Arguably this is how the treatment field has been treating recovery. Because commissioners say they want it, guidance says we should do it and everybody else says how they great they are at it, we feel we must go along for fear of being described as 'unfit for our positions, stupid, or incompetent'.

We can talk about recovery but we can't hide from the facts, namely:

1. The NDTMS website shows the current recovery rate for opiate users is 6.6 per cent – a drop from 8.59 per cent in 2011/12. For all service users the rate is 38.24 per cent, a rise since 2011/12 of just 3.52 per cent.
2. Drug-related deaths have risen and continue to rise. They are at their highest point since data was first collected in 1993.

I am not suggesting that aiming for recovery is wrong. I am not trying to make an argument that harm reduction is somehow better than the focus on recovery. All I am saying is that for all the talk of recovery, the evidence suggests that we are not very good at making it happen.

This isn't just a provider issue. Commissioners have been commissioning 'recovery focused' services for a number of years and yet the recovery rate has dropped. As they have pushed for more recovery, and the providers have responded with plans, initiatives and service models that don't appear to work, drug-related deaths have risen.

If you were in central government and could see that all the investment into the field was achieving an annual recovery rate that was dropping, would you continue to invest? Perhaps it's time we all had a realistic discussion about what can be achieved before it's too late.

Howard King, head of Inclusion

HEAVY INDUSTRY

In your article 'Industrial strength' (*DDN*, November 2016, page 10), I was surprised to see so much space detailing the arguments made by mostly alcohol industry and associated bodies at the recent Westminster Social Policy Forum.

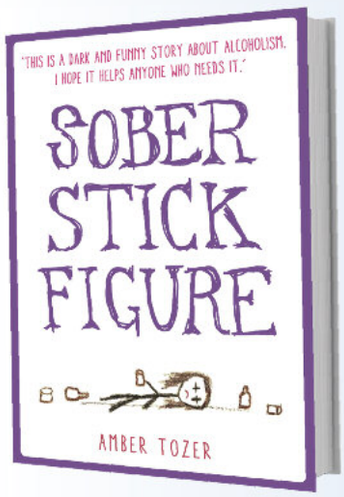
Henry Ashworth of the industry-funded Portman Group stated he was disappointed not to see more representation of public health at the event, but looking at the dominance of industry-related bodies on the agenda the reason for this seems rather self apparent. Whilst I was asked to speak at the conference and agreed, I was certainly ambivalent about doing so.

I was given five minutes to speak on a fairly narrow brief, but tried to highlight some of the limitations of a continued focus on 'partnerships' and 'voluntary action' without addressing key environmental influences such as price and availability. Whilst I do not wish to see complex policy debates over-simplified or polarised, there is a clear need for caution over how policy debates are framed and influenced by different agendas.

James Morris, Alcohol Academy

BOOKSHELF

Recommended reading – from the drug and alcohol sector



Sober Stick Figure

By Amber Tozer
Published by Blink Publishing
ISBN: 9781910536636 £9.98
Review by Mark Reid.

'In just a few strokes of her pencil, the childlike pictures are a great way to show addiction for what it is...'

AMBER TOZER'S STICK FIGURES brilliantly follow the recovery idea of 'keep it simple'. In just a few strokes of her pencil, the childlike pictures are a great way to show addiction for what it is – destructive: drink too much of this and you'll end up on the deck. It helps that Amber's commentary alongside her storyboards is by turns hilarious and caustic.

Many drunks do 'geographicals', jumping from one place to another trying to find themselves or, more often, to leave themselves behind and shake off the drink. Amber's geographical takes us on a tour of the USA. It starts in her 'hometown of Pueblo, a midsize lower-middle-class city in the foothills of Colorado'. Her mother runs the Do Drop Inn where 'men on stools with their elbows on the bar drink one after another'. Amber always loved the attention they gave her. She then takes her drinking to New York and Los Angeles – a coast-to-coast all-inclusive of high jinks and horror stories.

Amber is spot-on describing untreated alcoholics – low self-esteem but big ego: 'compliments made me nervous and when I did accept a compliment, I'd let it go to my head. I'd fluctuate between feeling worthless or like I was better than anyone else – nothing in between'.

Then, getting drunk, all that mental discomfort disappears and Amber enjoyed 'laughing at something I would normally be worried about'. Amber 'loved the manufactured feeling alcohol gave with bad ideas that I thought were 100 per cent great'.

It is a relief when Amber finally chooses recovery. Stopping is one thing. Staying stopped another. 'I was still stuck with the reason I drank in the first place. I drank because I had obsessive negative thinking, and without alcohol I still have negative thoughts'.

Like fearing the worst. Sober Amber was dog-sitting 'a tiny, white, fluffy Bichon poodle named Latte'. A coyote made off with him, 'dangling from its mouth'. In shock, Amber had two thoughts: 'a coyote turned Latte into lunch' and 'I get to drink over this'. Then suddenly the poodle bounds back into the garden 'tongue poking through his huge smile'. Amber's 'excuse' to drink is gone. The stick figure drawing for this is my favourite. 'I kicked that coyote's ass' says Latte. Somehow he escaped. So has Amber.

Mark Reid is peer worker at Path To Recovery (P2R), Bedfordshire

ADJUSTING THE FOCUS

Change, grow, live's executive director of health and social care, Mark Moody, tells *DDN* about the organisation's change of name and what it signifies

'I think it's much more representative of who we are,' says Mark Moody of the name 'change, grow, live' (CGL).

It's coming up to a year since the organisation, which had developed through working with people who accessed it via offender housing or arrest referral schemes, decided to stop calling itself Crime Reduction Initiatives (CRI). 'The scope of what we do had grown massively beyond that and the old name wasn't representative,' he says. 'With alcohol services and young people's services particularly, it's quite a low number of people who come to us via a criminal justice route.'

Perhaps surprisingly, the people who most felt a name change was in order were the staff. 'Service users would sometimes say they didn't much like it, but if their experience was good they got over it quickly. But we did identify that for some it was a barrier – just one more thing to make them wonder "do I really want to go to this place?"' Everyone refers to it as a rebranding, but for me the name should be what you do. It's just calling it something that makes it more attractive to people who might need us.'

As well as moving away from the original criminal justice focus, 'change, grow, live' reflects a belief that change is something anyone is capable of. Was this more positive slant in any way a response to the ongoing challenges facing the sector? 'It's more about the way we choose to deliver the services,' he says. 'All providers have gone through the journey of much more recovery-focused services, with an emphasis on doing things with people rather than to them. I strongly believe that the way we deliver services now is just better than it was ten years ago, even if there was more money in the system then. I think we would be doing things this way regardless of the challenges, financial or otherwise. So it's more about the opportunities.'

The new identity could be defined as a 'pragmatic and realistic positivity' for both service users and staff, he says, and it's been well received. 'There's been a bit of joshing on social media – I've heard us called 'Eat Pray Love' and someone told me we sounded like a charity for disenfranchised horticulturists, but I haven't spoken to anyone who thinks we should have hung on to the old name. We consulted staff, service users, external commissioners, and people really do think it articulates what we do and how we do it.'

So has it led to a renewed sense of focus or energy? 'It's already a very focused and energetic organisation, but I think there was a relief to get past something that had become an unwanted distraction – occasionally we'd find ourselves having the whole "this is why we're called that" conversation – and it does provide an opportunity to get the message out there to the people who need us. When you do something like this you're kind of forced to put your head over the parapet a bit, so it's probably encouraged us to be more outward looking. Despite the size of the organisation, historically we've probably been less visible on a national scale than some other organisations. All the emphasis has been on local services, and even now a lot of people accessing our local services won't have a clue who's running them, because they have branding that's relevant to their community.'

So how would he define the organisation's vision and strategy for the coming years? 'I think the most important thing is that we continue to focus on delivering services of the quality that people really require. It's no secret to anyone that there are cuts to funding, but I think if you continue to do things the way you always have, but with less funding, then simple arithmetic tells you that you're going to have a worse service. So it's the importance of really looking at what works and at innovation – investment in technology to allow us to work more out in communities and so on. Just getting a lot smarter about the way we use resources and stealing some business practices from the private sector but retaining the charitable ethos. It's about being prudent, innovative, looking at different ways to do things.'

'Even if someone's presenting problem is substance misuse, living the life they want is about a whole lot of things beyond that.'

Part of this comes from 'truly embracing the recovery ethos', he states. 'For me, running a recovery-oriented organisation is not about being an organisation that just deals with a narrow set of problems, but one that exists to help people get past their immediate challenges and move on to have the kind of life they wanted. We've never been solely a substance misuse organisation – we've always done other things, like domestic violence, family services, homelessness. Even if someone's presenting problem is substance misuse, living the life they want is about a whole lot of things beyond that – housing, social connections, jobs, the stuff that makes it possible to be a happy person. Mostly the substance misuse part is a symptom.

'So the way we do things would have changed whether there was a change in the funding scenario or not. You learn as you do this work that the way you've always done it might be OK, but there's always a way to be better.'

EMPOWERMENT

MAKING CH

How can we improve the range of options available to bring more people into services, asks *DDN*

The options that exist for drug treatment surely influence a person's choice on whether to enter treatment at all. Broadly speaking there's the pharmacotherapy option, using one of two main drugs as opioid substitution therapy (OST) – methadone or buprenorphine or both at different times – and there's psychosocial support. Both are vital components in the package of support that people may need at different times in their lives to help reduce or end illicit 'problem' drug use. But there's an unhelpful polarity that exists between interventions targeting immediate abstinence, and substitution treatments promoting stabilisation and harm reduction.

The use of OST has for a long time been challenged politically and through mainstream media. This cultural opposition, despite a strong evidence base for harm reduction, suggests that politicians and the public are still not fully aware of the benefits of this treatment approach.

In 2010 the (UK) drug strategy made clear the government's concern that 'for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there' and that it wanted to 'ensure that all those on a substitute prescription engage in recovery activities'. Two years earlier in 2008, the Scottish Government published *The Road to Recovery*, stating 'Recovery is a process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society'. Both strategies were essentially saying the same thing; drug treatment MUST be about becoming illicit or problem drug free, with the ideal being abstinent from drugs/alcohol.

The UK drug treatment sector refocus was sharp, and the proactive involvement of abstinence-based fellowships, groups and programmes proliferated. The sector was rebranded to reflect this aspiration and the lexicon was changed. 'Recovery outcomes' replaced treatment retention goals, and recovery coaches and mentors were set to support the change. It brought about the showcasing of visible abstinence-based recovery in the community and let communities see that 'people can and do recover'. Services became places for working towards ending illicit drug use and OST prescriptions, and exiting drug free in a timely fashion.

The government's drug strategies would also influence clinical management and pharmacotherapy protocols, as noted in *Medications in Recovery: re-orientating drug dependence treatment*: 'The task was to provide guidance to clinicians and agencies so they can help individuals on opioid substitution treatment (OST) achieve their fullest personal recovery, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing'.

But there's a significant problem with this, believes Stephen Malloy, who as a trainer, consultant and volunteer board member of the International Network of People who use Drugs (INPUD), has an insight into the disparate interests of stakeholders.

'The current paradigm dictates that the individual's choice is simple – to engage with treatment and progress towards becoming a drug-free and active member of society, or not to engage. There's no "half way" option... if you're not compliant then it's quite likely you'll be exited from the service.'

Considering that the person making the decision to enter treatment could be motivated by an acute crisis in their lives, it's a tough commitment to make.

'Suppose you're a 40-something heroin user and you've been in and out of treatment several times over the last 20 years,' he says, by way of example. 'Your health is failing and you're experiencing withdrawals from a break in supply of heroin on the street and there's lots of other difficult stuff going on in your life, so you present at a drug service looking for a script. Imagine saying, "well I'm only looking for a script to keep things stable. I might continue to smoke cannabis, I might still have a drink now and again, and I want a bit of flexibility in my prescribing, because I might use illicit heroin again".

'I'm quite sure that the prescriber would explain that this would be impossible because of the risks attached to using on top of a prescription, in addition to prescribing being tied to compliance with a recovery programme and drug testing. So instead of saying this – which may be a fairer representation of where you are at – you agree to engage with a programme that you may not be "ready" for.'

Malloy meets 'lots of people in this situation', who appear to engage effectively with treatment until the crisis has passed. 'Then it's a question of what happens next. Signs of returning to illicit drug use, or noncompliance with any recovery programme activity will likely bring about challenge by the service. Continued noncompliance will see you detoxed and exited from the services.'

Saying whatever needs to be said to get treatment can completely undermine 'one of the key factors that is pivotal to progress' – the relationship with workers or care providers, he says. 'That relationship has to begin with honesty.' And for it to be honest, the person must have choices that are viable.

Fundamentally, we still don't know enough about what motivates an individual to access treatment, he says, and so drug-related deaths (DRDs) continue to rise, with many of these people not in touch with treatment services.

Scotland's system of having a drugs death database offers insight through 'a kind of social autopsy', he explains. This shows whether the person was working, their economic circumstances and whether they had been in treatment and on OST. It also looks at whether they had been in hospital recently or in touch with a GP, 'and what you routinely see is that 70 per cent of the people who die were in touch with some form of service in the six months before their death' – maybe a GP, hospital, community psychiatric nurse, or mental health care worker. Figures from 2014 show that only around a third of people were prescribed ORT (predominantly

More on patient choice at
www.drinkanddrugsnews.com

HOICE REAL

methadone) at the time of death.

With more than 100,000 people accessing OST on a daily basis, this still represents 'a very significant community' who are working to 'stay compliant' (or not get caught if they're not) within prescribing and dispensing regimes. Concern about misuse has seen the pharmaceutical industry introduce medicines with 'abuse deterrents' added (naloxone's addition to buprenorphine, for example) ostensibly to prevent their injection or reduce the chances of diversion. Urine screening takes place routinely to corroborate what the client is saying. Malloy is disturbed that 'recovery workers who've been through treatment programmes themselves are now being coached to catch someone else'.

Even The language around OST is negative, he points out – 'nobody likes you going to the chemist for that', or 'you're not in recovery'. This, coupled with the broader stigma attached to OST, 'doesn't frame drug treatment as a particularly attractive prospect, when everything around it is about squeezing you out of it.'

With the pharmaceutical industry racing to develop forms of OST – such as fast-dissolving buprenorphine products, which offer additional benefits to clients and healthcare professionals, and which are easier to dispense, supervise and consume – he believes it's never been more important to understand what's driving each new development: 'Is it about patient acceptability, clinical effectiveness, cost effectiveness, or systems compliance?' Alongside current and new forms of oral (sublingual or on the tongue) buprenorphine we are familiar with, we may see longer acting formulations – implanted pellet-type formulations and depot injections.

'For the person whose life depends on it, the situation could not be more crucial and requires a fundamental shake-up in the way we view and engage people who use drugs, those receiving OST medicines, service users and patients,' says Malloy.

He throws a challenge to the treatment sector: 'charities and commissioned services must have on their governing board representatives from the population they're seeking to treat and support. At the moment we might hear, "we consulted with service users" – but they don't actually empower them to be involved in the decision-making. You're back to a rather paternalistic approach of "here's what we'll do for you".'

Further to this, 'the pharma and regulatory industry has to make greater efforts to engage the patient population,' he says. A way forward could be through community advisory boards for OST patients and drug users to learn about the regulatory machinery for newly developed drugs.

'We have to start having this conversation,' says Malloy. 'Because the market is changing – and if we don't respond to some of these changes, they will be imposed on us. We'll find ourselves with options that very few people will properly understand or have been consulted on.'

This article has been produced with support from Martindale Pharma, which has not influenced the content in any way.

'Charities and commissioned services must have on their governing board representatives from the population they're seeking to treat and support.' STEPHEN MALLOY

A MOMENT TO REFLECT

Addaction started 50 years ago with a desperate mother writing to the paper about her son's addiction. Much has changed but the charity's purpose grows ever stronger, says **Alistair Bohm**

FIFTY YEARS AGO, the *Guardian* newspaper published a letter from Mollie Craven (above). Mollie's son had been a registered heroin addict since the age of 18 and, feeling powerless to help, she wrote: 'we parents of addicts are a neglected and ignored group.' Her vision was for a parental support group that could research the little understood issue and support each other to find effective ways of helping children with drug problems.

That organisation was founded in 1967 as APA, standing both for the Association of Parents of Addicts, and the Association for Prevention of Addiction. Sadly, Mollie's son died at the age of 21, but she continued her pioneering work into the 1990s, helping to influence policy in the UK. APA also continued, moving increasingly into harm reduction and treatment services throughout the heroin epidemics of the 1980s and 90s, and rebranding as Addaction in 1998.

Addaction has grown significantly since then, from 19 services in 1998 to 120 today. Staff numbers have increased ten-fold in that time, taking in nurses, doctors and pharmacists as the charity expanded its remit into more clinical work. The staff profile has also changed. The number of former service users volunteering as recovery champions has grown and the people who use Addaction services now have influence across the entire organisation, including in senior leadership settings.

In recent years, there's been an increasing appreciation of complex needs, expressed through mental health issues, wider physical health concerns, and higher levels of medication. We've also seen the emergence of new psychoactive substances, an explosion in alcohol problems, and rising mortality associated with an ageing heroin-using population. Throughout, Addaction has adapted to the environment while lobbying for a system that works more effectively, and for more people.

Children's tshirt design competition 1993

APA football competition 1996

More on services and support at www.drinkanddrugsnews.com

‘OUR WORK IS SADLY MORE NECESSARY THAN EVER’

The charity’s chair, **Lord Alex Carlile**, looks to the challenges ahead

ADDACTION’S 50TH ANNIVERSARY is both a cause for celebration and an opportunity for reflection. Every charity should aspire to build a world in which it is no longer needed, but for Addaction that remains a distant ambition. Much has changed in 50 years, but our work is sadly more necessary than ever.

We can be proud of our successes in the UK treatment system, boasting comprehensive coverage, adherence to the evidence base, basic humanity and pragmatism. We can also take heart from the ever lower rates of heroin use over the past decade. However, in the record numbers of drug-related deaths, the estimated 1.6 million dependent drinkers and the emerging issues in young people’s mental health needs there lies a warning: the system doesn’t work for everyone, and our most vulnerable citizens deserve better.

In that sense, it was heartening to hear the prime minister’s plans to transform mental health support at the annual Charity Commission lecture. This is an issue that unites us across the political spectrum, indicating the widespread recognition that the status quo is no longer acceptable. However, rhetoric is one thing and resources quite another. Following years of underfunding and neglect, it’s essential that any plans to transform mental health provision are backed up by concrete commitment of resources. Without that, comprehensive change will be a very tall order indeed.

For Addaction’s part, we’re looking to the future with a broader offer, supporting people in all of their complexity, and taking action early to tackle harmful behaviours. We believe that our role as a charity can’t be limited to service delivery but requires us to influence policy to provide easier and more equitable access for all. Were Mollie Craven still with us today, I believe she would be immensely proud of where her letter has taken us. I believe too that she would recognise how much remains to be done.

DOE’S STORY

DOE’S LIFE CHANGED AT 15 YEARS OLD when she discovered her dad wasn’t her real father. ‘My mum told me I was actually the product of a rape. I’d never felt so alone and I started hating myself. If I’d had someone to talk to back then, I don’t think my life would have spiralled quite so far out of my control.’

Leaving school with few qualifications, Doe met her partner through drug taking and they got married. ‘We thought babies might make everything better. I did stop using when I was pregnant, but as soon as breast-feeding ended, it all began again. My kids didn’t have a good start. The house was disgusting, with no lightbulbs and no carpets. We would inject in front of them.’

Doe’s husband died suddenly at the age of 37. ‘I hated him for dying. I wanted that to happen to me. I was aware how awful life was, but didn’t know what to do about it.’

One morning, Doe woke at 4am with the shakes. ‘Every little bit of alcohol came back up. My body was rejecting it. I crawled downstairs to get help. I’ll never forget the look on my daughter’s face as she watched me being taken to hospital.’

Doe spent six months in rehab before attending Addaction. ‘I was terrified of the world outside. I ran the whole way from the front door of the rehab to the reception at Addaction. I’m now volunteering five days a week. Just being here for people to talk to, and inspiring them with how things can change. It’s like I’ve found my life again.

‘I’m so grateful to everyone who has supported me. I didn’t have the strength to do it for myself, because I didn’t think I was worth doing it for. I now know I am.’

CLARE’S STORY*

‘BEFORE IT ALL HAPPENED I WAS A VERY INDEPENDENT PERSON. I relied on nobody at all to help me through situations in life.’

Clare, 50, came to Thinkaction Merton after finding out about the service from a local group.

‘I know now I was having a breakdown. I had lost my job, and the job centre was making me even more anxious and stressed. Then I lost my home, which pushed me into a depression.’

‘I know now I was having a breakdown. I had lost my job, and the job centre was making me even more anxious and stressed. Then I lost my home, which pushed me into a depression.’

Clare self-referred to Thinkaction. ‘I had had depression before, when my daughter left home. And I went through a nightmare with that – we were close and it really hurt. When you’re in that state, nothing really makes sense.’

Clare spoke to Hannah at Thinkaction for a number of therapy sessions on the phone and found common ground talking about photography – something she had wanted to do, but had never had the opportunity to pursue. After the third or fourth session, Clare realised that she wanted to take it up again and joined a photography club.

‘We talked about techniques to manage my thoughts. The five minute rule became very handy with getting things done, because I had also developed anxiety as well as depression. By starting tasks in small time chunks it really helped me to be calm and productive. I still use it today.

‘I’m one of those people who, before this happened to me, wouldn't even ask my friends for help. Now I'm doing okay. I’m pushing ahead with the photography. Without Hannah digging in and finding out what I wanted to do, which I couldn't see myself, I don’t know where I would be.’

**Clare’s name has been changed*

Find more on naloxone at www.drinkanddrugsnews.com

WINNING ATTITUDE

Being recognised through a national award made **Catherine Larkin** and **Danny Hames** realise the value of Inclusion's eager adoption of a naloxone strategy

Last November Inclusion, which is part of South Staffordshire and Shropshire NHS Foundation Trust, won the *Health Service Journal* award for patient safety. This was for our project titled *Naloxone – Increasing Awareness, Saving Lives*. As much as this award was well received – and for the team involved, a chance to stop and take pride in what had been achieved – it was also a moment to reflect on what had started back in 2009 in Birmingham.

This was when Inclusion began issuing naloxone in its services. We were able to do this because of the expertise and knowledge our colleagues in medicines management were able to provide, a benefit from being part of an NHS organisation. It wasn't commissioned or paid for, it started because it was clearly the right thing to do. We could do it because of the infrastructure we had alongside us, and Inclusion were willing to fund it.

The change in legislation that occurred in 2015 provided the catalyst for the development of a national protocol, enabling us to increase the reach of the naloxone through training frontline staff, service users and family members across all our services. We were able to take advantage of the change in legislation straight away because of the knowledge and expertise we had in our trust, and as such were the first organisation in the sector to introduce a protocol of this kind.

The benefit of all this has been that since July 2015, nearly 2,500 people have been trained to administer the kits and, so far, at least 130 lives have been saved and at least £408,000 saved to the local health economy. This has been achieved through the hard work of those involved in the project – service users, managers and staff but also through the bold actions of those who led the organisation and had the foresight and courage to enable the provision of naloxone and then be ready for the change in legislation.

The benefit of making naloxone available is clear for all to see in terms of saving lives, and we know that for every £1 spent on naloxone it saves the health economy £14.30. However, we have also found that there are further benefits to service users' health and wellbeing through providing an effective naloxone distribution programme. One example of this has been that we have increased and strengthened our relationships in settings where the most vulnerable service users can be reached. Hostels are a great example of this; working closely with the hostel staff, training them and the service users has meant that stronger relationships have been formed.

By providing naloxone you have a tangible and powerful intervention available to people, and the benefits are obvious. Through forming these relationships, we have then been able to offer health and wellbeing clinics in these settings and provide some of the most vulnerable with flu vaccinations. Before the naloxone programme this wouldn't have happened, but it is just another of its benefits, raising awareness and improving a service's ability to engage.

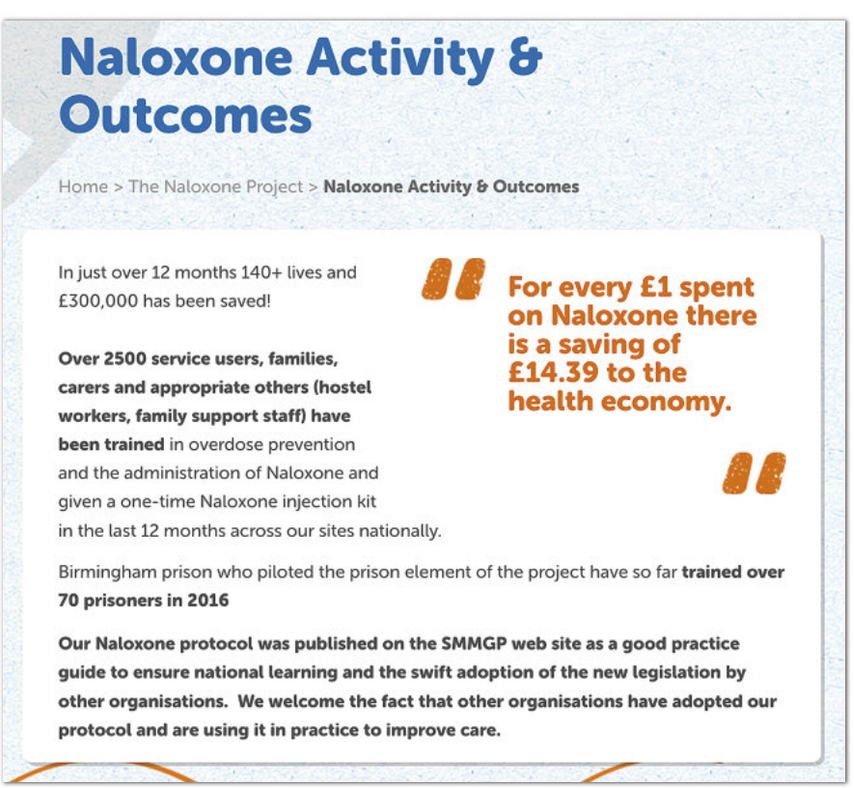
So the reflections from that awards night are that there is still more to do, and that an effective naloxone programme creates new opportunities to reach the most vulnerable members of our communities. It is heartening to see that the provision of naloxone in all community services is increasingly becoming an expectation and reality; however, as we enter into 2017 there are no excuses that this shouldn't be the case across the whole UK.

There is a responsibility for commissioners, but also providers, to make sure this happens. Who pays for it and how this is achieved are problems to be solved. But there is a moral imperative it should happen, because if it isn't solved quickly more people who use and don't use our services will die, with all of the impact on those who are close to them. Surely for all of us, whether we work in the NHS, local authorities, charities or are independent providers, this cannot be tolerated.

Inclusion is committed to this and will continue to champion the use of naloxone in our services and to offer any help we can to those who want to learn from our experience.

Catherine Larkin is clinical director and Danny Hames is head of development for Inclusion

'By providing naloxone you have a tangible and powerful intervention available to people, and the benefits are obvious.'



More tasters from Findings at www.drinkanddrugsnews.com

SAFE CORNER

What would persuade a city to accept a drug consumption room? **Natalie Davies** examines the argument

GLASGOW could become the site of the UK's first drug consumption room (*DDN*, November 2016, page 4) in response to visible public injecting and a spike in HIV infections in the city. Brighton floated the idea in 2014, but despite 50 cities in mainland Europe having opened rooms, concluded that the time was not right. So what lay behind their decision, and how could the story end differently in Glasgow?

Brighton was known for having one of the UK's highest rates of drug-related deaths, prompting its Independent Drugs Commission to recommend in April 2013 that 'where it is not possible to stop users from taking risks, it is better that they have access to safe, clean premises, rather than administer drugs on the streets or in residential settings'. A working group was set up to investigate the feasibility, but a year later delivered their verdict that it was not a priority.

As well as other options to meet the needs of drug users and the wider community, there were, they felt, inconsistencies between drug consumption rooms and the prevailing policies of enforcement and abstinence-based recovery.

One critical issue for the group was whether a drug consumption room could operate legally in the UK, and if so, what would be required. The UK Misuse of Drugs Act makes it illegal to allow drug dealing or production on your premises, but when it comes to using drugs, only the smoking of cannabis or opium must be prevented – premises owners do not contravene the act by allowing the possession or injecting of controlled drugs like heroin or cocaine.

Yet, based on statements from Sussex Police (a key stakeholder), the Home Office, and the Association of Chief Police Officers (ACPO), the working group determined that drug consumption rooms were 'unlawful'. The fact that the room's potential users would be breaking the law by possessing controlled drugs was somehow conflated with the legality of the rooms themselves.

Sussex Police said officers *could* use their discretion, but had 'fundamental concerns'. Deploying the pejorative term 'shooting galleries', ACPO feared such facilities could 'impact on local communities as a whole, attracting drug users to one area and also create a hotspot for associated criminality and anti-social behaviour'. Though understandable, 'hotspot' fears have invariably been contradicted by the evidence; most consumption-room users live locally.

Without a 'local accord' between police and other stakeholders, the proposal failed the test of feasibility. Resistance was attributed partly to a 'shift in focus for substance misuse services from harm reduction to recovery [which placed...] a greater emphasis on abstinence'. It was unclear whether stakeholders were themselves aligned with the values of abstinence-based recovery, or whether the policy and funding climate was forcing their hand.

Brighton's local paper The *Argus* reported that weeks after the feasibility study was launched, several stakeholders spoke out against drug consumption rooms, including Andy Winter, chief executive of Brighton Housing Trust, who wanted to see 'something far more positive [done] with addiction and recovery'. Frustrated at what he considered a 'distraction' from 'recovery, treatment and abstinence', he resolved to 'oppose any further waste of public funds, time and effort on exploring [their] feasibility'.

According to the final report of the Independent Drugs Commission in May 2014, the working group concluded that drug consumption rooms would have 'little impact on the types of factors contributing to deaths in the city'. While some injectors could benefit, 'the overall need for the local community' did not warrant this new type of service – particularly as 'the improvement in the number of drug related deaths [in Brighton] since 2009 suggested that the current strategies [were] having an impact'. Yet there was little appreciation that effective mainstream strategies may be inaccessible to people who would use drug consumption rooms, leaving a vulnerable cohort.

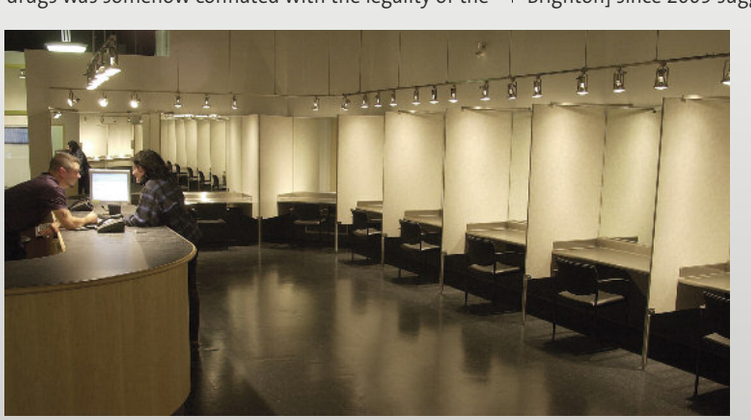
Drug consumption rooms are typically aimed at socially excluded drug users who would otherwise be injecting in public places or unsafe domestic settings. This includes sex workers, homeless people, and those who have never been in treatment. The bubble of acceptance within the four walls of a drug consumption room not only supports users to inject safely, but provides a link to vital health and social care services, including addiction treatment.

Admittedly, this acceptance of drug-taking is not an easy message to sell, and even areas with flourishing needle exchange and naloxone programmes would probably consider drug consumption rooms a 'big leap'. But what many struggle to understand is how consumption rooms can provoke more controversy than people dying from preventable fatal overdoses.

Drug consumption rooms may not be the answer to addiction, but they are a humane solution to public injecting. In the end, the decision about whether to introduce drug consumption rooms in Glasgow may come down to how the debate is framed – the extent to which local stakeholders are looking at the *opportunities* of extending harm reduction among vulnerable, marginalised, and socially excluded injectors. If, as in Brighton, they view them through the lenses of enforcement and recovery, the project could stop before it has started, and the human cost of public injecting will continue to stack up.

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

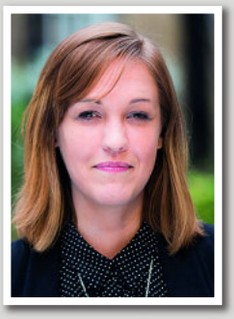
Natalie Davies is assistant editor at Drug and Alcohol Findings, http://findings.org.uk



'Drug consumption rooms are typically aimed at socially excluded drug users who would otherwise be injecting in public places or unsafe domestic settings. This includes sex workers, homeless people, and those who have never been in treatment.'

Left: Consumption rooms in Vancouver http://www.vch.ca/your-health/health-topics/supervised-injection/

LEGAL EYE



Nicole Ridgwell of Ridouts answers your legal questions

'We have received criticism for not providing clear patient pathways on exit from our residential treatment service. We are very focused on aftercare and have strong relationships with fellowships and community groups – however these are informal. How should we present our evidence to demonstrate that we provide this?'

NICOLE ANSWERS:

While the question does not confirm whether the criticism originates from CQC, the local authority or a third party commissioner, the answer remains broadly the same: to refer to the standards against which you are being measured and ensure that you produce the evidence in the recommended format. The easiest way to demonstrate compliance is to use the language of the body assessing you.

For example, within their specialist substance misuse services provider handbook, July 2015, CQC set out their commitment to focusing on 'transitions between services, care pathways and joint working as part of our inspections of specialist substance misuse services'. It highlights the importance of addressing both physical and mental health needs and enabling service users to achieve a good quality of life by assisting with aspects of wellbeing such as housing, employment and social participation. CQC always focuses upon the ability of services to provide a holistic person-centred approach, with integration of healthcare professionals, to meet individuals' needs and expected outcomes.

A service looking to demonstrate compliance, therefore, would ensure their policies identify stages during treatment when post-rehab support is discussed and advice given. Care plans and patient notes should record these conversations, include evidence of when and to where individuals were signposted, and aftercare organisations should be required to provide confirmation of arrangements made with individuals prior to discharge from the service.

However, that is easier said than done if relationships are informal, and you should begin to formalise those relationships so that you do not encounter the same criticisms again. Services are expected to provide documented proof of an integrated care pathway, from initial assessment through to post-treatment referrals and aftercare plans. Your protocols should list the organisations and groups with which you have relationships and on whom you rely for aftercare, and should identify which types of service users are suitable for referral to which group. Finally, your files should demonstrate that you put those policies, procedures and protocols into practice.

In circumstances where you have yet to draft formalised policies, I would suggest obtaining as much evidence of your actual practices as possible – such as statements from the groups themselves, questionnaires completed by service users and excerpts from care notes.

The question of what appropriate aftercare looks like is a timely one. The inspection system for substance misuse services is currently being re-evaluated by CQC, with the expectation that more services will become subject to regulation than ever before; among those will be certain categories of aftercare. This may assist services by structuring expectations and reducing the chance that services are caught out by not appreciating the need for formalised policies.

Nicole Ridgwell is a solicitor at Ridouts LLP, www.ridout-law.com

Send your legal queries to legal@drinkanddrugsnews.com

RESOURCES CORNER

Focus on family

The 5-Step Method offers services a valuable tool for working with relatives, says **George Allan**

FEW WOULD DISAGREE that adult family members of people with substance problems rarely receive consistent responses across frontline agencies. Dealing with substance users leaves little space for working with 'others' who continue to be viewed, primarily, as providing potential support systems for recovery or as allies in dealing with childcare concerns. Lacking training, practitioners may be wary of engaging more fully with relatives. It is easier to signpost them to self-help groups; these will not suit everyone or may not provide a forum for addressing all their difficulties. However, a model has been developed which concentrates entirely on helping relatives to cope.

The 5-Step Method is present-focused. It discards the notion that the causes of substance problems inevitably lie in past family problems and views relatives as 'ordinary people facing highly stressful circumstances'. As such, family members tend to adopt one of three coping styles – 'standing up to it'; 'putting up with it'; 'becoming independent'. Each of these has advantages and disadvantages and the practitioner's task is to help the person explore what is best for him/herself and then adopt effective coping strategies and build supportive networks. The practitioner style mirrors that used in motivational interviewing: non-judgemental; use of open questions; reflective listening etc.

The 'steps' are themes to be worked through with the family member:
Step 1 – listening; exploring stresses
Step 2 – providing targeted information
Step 3 – discussing coping responses
Step 4 – enhancing social supports
Step 5 – exploring what else might be needed.

The method is readily learned, and can be adapted to various settings and delivered flexibly over a shorter or longer number of sessions. It is important, however, that sufficient time is given to step 1 and that step 3 is not addressed too early.

'Commissioners should build it into every contract for services for substance users so that their family members receive due attention.'

The 5-Step Method chimes with guidance given by NICE. As the gold standard for working with relatives, commissioners should build it into every contract for services for substance users so that their family members receive due attention.

The application of the model is fully described in *The 5-Step Method: Principles and practice*. Coppello, A., Templeton, L., Orford, J. and Velleman, R. 2010. *Drugs: Education, Prevention and Policy*, 17 (s1). This supplement to the journal also contains papers exploring the development of the model and is well worth accessing in full.

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

For information and resources:
www.drinkanddrugsnews.com

A MATTER OF CONVICTION

Tony Margetts looks at whether prison reform is heading in the right direction

For all the wrong reasons prisons are in the news. Hardly a week goes by without a major incident, adding further pressure on governors, staff, prisoners and the still relatively new lord chancellor and secretary of state for justice, Liz Truss. While there is a great deal of consensus about the cumulative impact that budgets and staffing cuts have had since 2010, the increased presence of novel psychoactive substances – particularly synthetic cannabinoids such as 'spice' – have also undoubtedly exacerbated a difficult situation.

As part of a group set up by the Royal Society of Arts (RSA) I was involved in suggesting some key reforms. *A matter of conviction* set out to develop a blueprint for a future community-based rehabilitative prison (*DDN*, November 2016, page 4). It argued that the potential impact that prisons could have on reducing reoffending and community safety has been undermined by a lack of consistent political leadership and clear purpose and that this has led to reactive policy, which has disempowered the workforce and undermined public confidence. We argued for a national rehabilitation strategy with health and wellbeing as a key component.

So what lessons can recent history on drug policy and practice have to offer in rising to this challenge and how does the *Prison safety and reform white paper*, published in November, seek to learn from these?

Some of our ideas have found their way into the white paper, including introducing a new duty on the secretary of state to 'reform', along with additional freedoms for governors and an enhanced inspection regime. But it fails to address wider links to the community or aftercare in detail and has not embraced our proposals for a phased process of devolution and the introduction of local prison boards. This approach leaves the central grip – of the National Offender Management Service – intact, while introducing greater accountability on governors, risking, we believe, a mismatch between local decision-making and central directives.

The additional investment in prison officers and some focus on workforce development is welcome and, alongside a greater emphasis on education and employment, should help to reduce demand; if people are bored, miserable and locked up for most of the time, drugs have a greater pull. Also welcome were some of the longer-term proposals including attempts to control the supply side of drug taking in prisons. The increased emphasis on local commissioning and decision-making will be accompanied by a target to reduce reoffending, and more governor involvement in health services in custody.

Prisons are not healthy places and have always had a high proportion of drug and alcohol users among their population. The provision of treatment has had to balance three considerations – the health of prisoners, reducing reoffending and the good order and running of prisons – which can create conflicts in management.

Back in the real dark past, prisons had the Prison Health Service. This responsibility was then moved to the NHS, and health services were effectively commissioned between Primary Care Trusts with the prison service acting as co-commissioners, often through local partnership boards. The prison service also directly commissioned a drug service in prisons, known as Counselling, Assessment, Referral, Advice and Throughcare, or CARATs, from the turn of this century, provided by trained prison officers in some prisons and by voluntary organisations in others. From around 2006 additional funding was provided via the NHS to commission drug treatment in prison.

In 2013 drug and alcohol treatment became part of prison healthcare and was commissioned through NHS England, reducing the role both of local drug and alcohol commissioners and prison management. Since this happened, I have been concerned that the focus on the treatment of illicit opiates, particularly heroin, in healthcare contracts left prison drug treatment services slow to respond to new patterns of drug use in prisons and did not recognise the significance of alcohol use and dependency. Prison drug treatment has been slower in adapting to changes in drug use than community services, in particular the emergence of novel psychoactive substances in prisons since 2009, the use of image and performance enhancing drugs (IPEDs), particularly anabolic steroids – whose prevalence has greatly increased in both prisons and the community – and the misuse of prescription medicines.

So what can be done? The RSA report proposed prison and community boards as a way of breaking down barriers between prisons and communities, driving longer-term strategy and enabling a locally accountable approach. It argued for an increased role for local and regional government including city mayors and police and crime commissioners (PCCs), in commissioning probation and prison services. This approach would bring services closer to communities, encourage co-commissioning and the pooling of resources and address some of the concerns regarding disinvestment.

Despite Theresa May being a champion of PCCs while at the Home Office, the white paper does not go this far and it remains to be seen what the Ministry of Justice review of probation will suggest. The focus on rehabilitation by prisons, and by implication the rest of the criminal justice system, is very welcome. It is to be hoped that we can edge towards good quality, evidence-based drug and alcohol services in prisons, which are linked to the community and are part of a wider package of measures designed to reduce further reoffending.

Tony Margetts is the substance misuse manager responsible for commissioning drug and alcohol treatment for the East Riding of Yorkshire

'Prison drug treatment has been slower in adapting to changes in drug use than community services.'

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part of the Phoenix Futures Group

Experts in recovery for more than 45 years

At **FOUNDATION66** everything they are and everything they do is channelled into helping people affected by drug and alcohol problems to make positive changes in their lives. **Grace House** is **FOUNDATION66**'s female-only residential service providing drug and alcohol free support for women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders. Amy's story is typical of the opportunities offerered at **Grace House**

LIFE CHANCE

'It has been life-changing. I have been given the chance to build the future I deserve'

These are the words of Amy Munford, 27, after she spent nine months at Grace House, Foundation66's all-female rehab in Camden, North London.

Amy had been a heavy drinker and had suffered from an eating disorder since her teenage years, which became progressively worse through her time at university and into employment. Getting into an abusive relationship and surrounding herself with people who aided her addiction made matters worse and it wasn't long before Amy had deteriorated to the point where she was just surviving on drinking all day – her friends had deserted her and her family had no idea what more they could do.

With her health suffering to the point where she was unable to walk, Amy was referred by Westminster Drug and Alcohol Project to Grace House, where an all-female team provides friendly support to women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders.

Amy moved into the house, where she was assessed and given a personalised treatment and counselling programme that gradually helped her turn her life around. Looking back on her time there, Amy reflects: 'It was a wonderful community to recover in. I had enough freedom to grow and rebuild as a person and was able to input into my own recovery. Thanks to Grace House, I now have my health back, have been able to re-connect with my family and have built lasting friendships.'

'Amy's story shows how the philosophy behind Grace House really works.'

BEA WHEELER, LOCALITY MANAGER

Since leaving Grace House, Amy now has her own flat, at 'Amy's Place' (provided through the Amy Winehouse Foundation), is attending college and continues to have treatment for her eating disorder. She is now looking positively to the future, with plans to study further, move in to her own property and start a new career.

'Amy's story shows how the philosophy behind Grace House really works.' says Bea Wheeler, Foundation66's Locality Manager, 'A stable home is the basis for a successful and sustained recovery and Grace House provides women, like Amy, with the time, space and support to address their substance misuse and complex needs, to help them take the next step to a brighter future.'

If you would like further details on the **Grace House** service, either to refer, or self-refer, then please call on **020 7916 5013** or email **GraceHouse.Referrals@foundation66.org.uk**

EXPRESSIONS OF INTEREST

Southwark Council
southwark.gov.uk

EXPRESSIONS OF INTEREST FOR THE RECOVERY SUPPORT SERVICE FOR SUBSTANCE MISUSE IN SOUTHWARK

Southwark Council is seeking to invite competitive tenders for the provision of the Recovery Support Service for Substance Misuse located within the geographical boundaries of the London Borough of Southwark.

Our vision for the provision of the service is for the effective coordination and delivery of a range of peer support interventions as well as representing the voices of Southwark drug and alcohol treatment service users at strategic forums and as part of treatment service design, delivery and monitoring. The service will offer a dynamic recovery community that supports the borough's drug and alcohol treatment service users to access support and achieve and maintain recovery.

The service comprises one lot inclusive of peer support and service user involvement and it is anticipated that the contract will be awarded to a single provider.

A maximum annual contract value of up to, and including, £75,000 is offered and it is expected that the contract will commence on Saturday 1st July 2017 for an initial period of three years (with an option to extend for two further periods of one year at the discretion of the council). It is the authority's view that the provisions of the European Council Directive 2001/23/23/EC of 12 March 2001 TUPE will apply.

A Bidders' Event will take place at 1:30pm (for 2.00pm start) on Thursday 2nd March 2017 at Southwark Council, 160 Tooley Street, London, SE1 2QH.

Please register your intention to attend the Bidders Event via email: AdminDAAT@southwark.gov.uk by 4pm on Monday 27th February 2017. Places are limited to a maximum of 2 representatives per organisation.

The tender will be conducted using e-procurement via London Portals. Interested organisations can register at https://procontract.due-north.com

For any questions regarding this tender please email: AdminDAAT@southwark.gov.uk

It is anticipated that invitations to tender will be posted on London Portals on Friday 24th February 2017.

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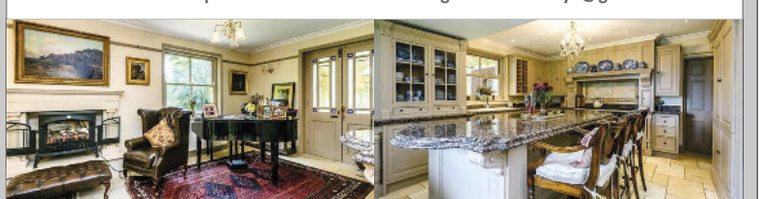

DDN national service user involvement
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