

DRINK AND DRUGS NEWS

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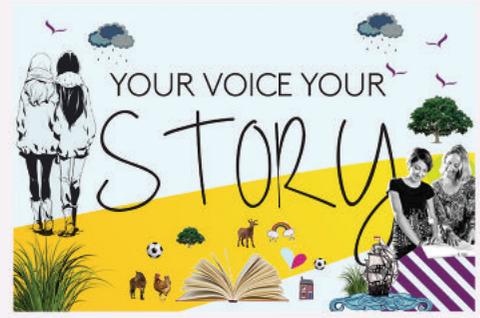
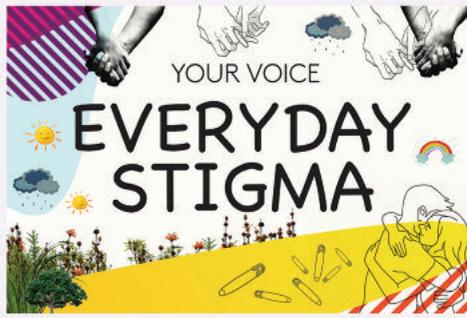
DDN



MAKING WAVES

JOINING FORCES TO HELP BRIGHTON'S STREET SLEEPERS

Inside: Fentanyl, drug-related deaths, reaching out to young people



We're planning a range of projects to help bring together the voices of people affected by addiction and those working towards a more recovery friendly society. Join us to look at what's working and what needs to change.

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EDITOR'S LETTER



'Most drug-related deaths are of people not in treatment'

By the time many of you are reading this, the next government will have been chosen – and who knows, the wheels may have started turning again after a static couple of months for policy. As I write though, the debates are still in full swing and the leaflets are still dropping through the door.

So much noise, and so many promises by the politicians to listen. So here are some suggestions served up by this month's issue. Turn to page 4 to learn that the sector is vulnerable and volatile, and that services closing could lead to thousands of people dropping further down the waiting lists.

Go to page 6 to be reminded that most drug-related deaths are of people not in treatment – and that the first place to look for these people is on the streets, where outreach workers do their best to engage with and protect a growing population of rough sleepers despite diminishing resources.

Turn to page 8 for a comprehensive briefing on fentanyl – a drug with many highly dangerous forms that requires a robust and proactive harm reduction and education strategy, rather than a knee-jerk 'ban everything' reaction.

Then carry on to page 12 to hear feedback from young people on how to engage around substance misuse in a way that is meaningful to them – and finally, read some difficult pages (14-17) about drug-related deaths, the topic you don't really want to acknowledge. If major treatment agencies are willing to put competition to one side to look for joint action to halt the climb in mortality figures, shouldn't politicians join in?

Claire Brown, editor

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



Published by CJ Wellings Ltd,
Romney House, School Road,
Ashford, Kent TN27 0LT

Editor: Claire Brown
t: 01233 638 528
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising manager:
Ian Ralph
t: 01233 636 188
e: ian@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
t: 01233 633 315
e: subs@cjwellings.com

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LIFELINE CLOSES AFTER ALMOST 50 YEARS

THE LIFELINE PROJECT, which provided services to around 80,000 people, has closed as a result of financial difficulties. Staff at the charity, which was established in 1971, were told last month that it was aiming to transfer its services to other providers.

The organisation's data on the Charity Commission website for the last financial year show that it had income of £61.8m and spending of £60.5m, as well as £3.2m of own-use assets and £9m of other assets. Its total liabilities were listed as £5.9m.

Ex-UKDPC chief executive Roger Howard resigned from Lifeline's board last November after raising concerns about management and governance issues. He also raised the concerns with the Charity Commission.

'I was reminded of the lessons arising from Kids Company – the failure of governance and leadership,' Howard told *DDN*. 'Yes, austerity is there, there have been substantial reductions in the ring-fenced grant for treatment, the constant re-tendering process is incredibly challenging – and staff did brilliantly in sustaining through that. But you have to ask the question of why is it that CGL, Turning Point, Addaction, Phoenix or any of the other organisations are coping with the sort of managerial and governance demands being placed upon them. I think that's where there was a pretty clear failing on the part of Lifeline. It's easy for the field to think that this is all the result of big bad commissioners and funding constraints, but in this circumstance I think that narrative probably needs to be challenged.'

The pressure to deliver more services against a background of financial uncertainty made it 'vitaly important that all organisations in this sector are impeccably well-run and well governed', said WDP chair Yasmin Batliwala. 'That is why it I look forward to the results of a full investigation into this regrettable development, which was surely preventable.'

From this month onwards, a large number of Lifeline services will be taken over by change, grow, live (CGL), with the transfer of more than 1,000 staff and 40 delivery contracts. This will allow the services 'to continue to exist without withdrawing vital treatment and support, ensuring that minimum possible risk is caused to service users' lives' says CGL. Service users will be able to expect 'the same level of treatment and care', with referrals continuing as normal and service contact details staying the same for the time being. 'CGL are looking to help and, quite rightly, to preserve as many services and staff as possible,' said Howard.

'Our engagement with Lifeline over the last few weeks has been explicitly to make sure that service users are safeguarded, there's continuity of service provision and that employment is protected,' CGL's executive director Mike Pattinson told *DDN*. 'They approached us around what support we could offer, and then asked us about transition of services. Our engagement was at their request.'

CGL has written to Lifeline staff and aims to provide as much stability as possible in the short term, added Pattinson. 'Clearly our explicit

involvement with Lifeline staff could only start once Lifeline had communicated to their employees themselves. We're working to protect as much employment as we can, but we've also said we do need to make sure that the services that are transferring are on a stable, sustainable financial footing – that's the commitment we've got to make. There are a number of issues we're going to have to look at, but our intention is to protect employment, protect service users and protect continuity of service.'

Lifeline was contacted for comment for this story.

Any Lifeline staff transferring to CGL and who have questions or concerns should contact servicetransfer@cgl.org.uk



'...clear failing on the part of Lifeline.'

ROGER HOWARD

DUAL DIAGNOSIS

AROUND 2.9M UK ADULTS now use electronic cigarettes, according to a report from ASH. The number has increased fourfold since 2012, when there were just 700,000 users, and for the first time the 1.5m ex-smokers using the devices outnumber current smokers using them. However, although most people use e-cigarettes to stop smoking there is still a great deal of 'dual use', the document says. 'The message for the 1.3m vapers who still smoke is that they need to go further and switch completely,' said ASH chief executive Deborah Arnott. 'It's excellent news that the number of vapers who have quit smoking is continuing to grow, but there are still 9m smokers compared to only 1.5m vapers who don't smoke at all.' *Use of e-cigarettes among adults in Great Britain 2017 at ash.org.uk*

WILTSHIRE WARNING

POLICE IN WILTSHIRE have issued a warning to parents following incidents in which around 20 young people received medical treatment after taking the prescription drug Xanax. All of the incidents took place within a single week in

the Salisbury area, and there is increasing concern that the drug – the brand name for the potent benzodiazepine alprazolam – is gaining popularity among young people, partly as a result of its perceived celebrity associations (*DDN*, April, page 6). All of the young people receiving medical treatment in Wiltshire were 15-16 years old, say the police. 'Taking any drugs which haven't been specifically prescribed for you can have serious or even fatal consequences, and we urge parents/guardians to talk to their children about the dangers,' said Inspector Pete Sparrow.

EARLIER INTERVENTIONS

MORE NEEDS TO BE DONE TO HELP VETERANS with the underlying issues that cause problem drinking, says the charity Combat Stress, as most put off seeking help until their 60s. 'As many as 43 per cent of veterans registered with Combat Stress have a current problem with alcohol misuse,' said chief executive Sue Freeth. 'We're all too aware that many of the veterans use alcohol or drugs to help them to manage their trauma and emotional health. More support is needed to increase awareness

among veterans of the dangers of drinking harmful levels of alcohol, to help them recognise they need help, and to assist them in engaging with specialist services sooner.'

FAMILY AFFAIR

A MAJOR NEW NATIONAL SURVEY on the impact of addiction and recovery on family members has been launched by Adfam and Sheffield Hallam University, with funding from Alcohol Research UK. The Family Life in Recovery project aims to provide insight into the experiences of family members to support and encourage others, as well as create the first evidence-based resource to recommend which support services are 'urgently needed for family members of people at each different stage' of recovery. 'Much is known about the economic and social costs of addiction and problematic drug use, but we know very little about what happens to family members of those using or in recovery, and how they manage their own wellbeing through this incredibly stressful and challenging process,' said project lead Professor David Best. *Survey at www.surveymonkey.co.uk/r/LTKX65N*



PROF DAVID BEST



LIB DEMS PROMISE LEGAL CANNABIS MARKET

THE LIBERAL DEMOCRATS have made a manifesto commitment to decriminalise the possession of illegal drugs for personal use and introduce a 'legal, regulated' market for cannabis. The latter would 'break the grip' of criminal gangs and raise £1bn in annual tax revenues, says their manifesto document, which also pledges to repeal the controversial Psychoactive Substances Act.

Anyone arrested for possession of drugs for personal use would either be diverted into treatment and education as part of a 'health-based approach' or be subject to 'civil penalties', says *Change Britain's future*, with the authorities concentrating instead on those who import, deal or manufacture illegal drugs. The Psychoactive Substances Act would be repealed as it has 'driven the sale of formerly legal highs underground', while the departmental lead on drug policy would be moved from the Home Office to the Department of Health. The party would also introduce minimum pricing for alcohol, it says, 'subject to the final outcome of the legal challenge in Scotland'.

The proposed regulated cannabis market would 'introduce limits on potency' and allow cannabis to be sold via licensed outlets to people over 18, the document states. The party previously commissioned an expert panel chaired by Transform's Steve Rolles to produce a report looking at how such a market could work in practice (*DDN*, April 2016, page 4), and last month Liberal Democrat health spokesperson Norman Lamb wrote in *DDN* that the war on drugs was 'a completely stupid approach' (*DDN*, May, page 10).

'The war on drugs has been a catastrophic failure,' says the party's manifesto. 'Every year, billions flow to organised crime while we needlessly prosecute and imprison thousands of people, blighting their employment and life chances, and doing nothing to address the impact of drugs on their health.'

While the Lib Dems also state they would replace police and crime commissioners (PCCs) – 'elected at great expense in elections with very low turnout' – with accountable police boards made up of local councillors, the Conservatives' manifesto says that they would widen the role of PCCs to include having them sit on local health

The proposed regulated cannabis market would 'introduce limits on potency' and allow cannabis to be sold via licensed outlets to people over 18.

and wellbeing boards to enable 'better co-ordination of crime prevention with local drug and alcohol and mental health services'.

Perhaps predictably the Conservative document, *Forward together*, largely approaches the issue of substance misuse from a law and order perspective, stating that the party would create a national community sentencing framework to include measures such as 'curfews and orders that tackle drug and alcohol abuse', as current community punishments 'do not do enough to prevent crime and break the cycle of persistent offending'. However, it also pledges to address the issue of racial disparity in police stop and searches, saying that the Conservatives would 'legislate to mandate changes in police practices if "stop and search" does not become more targeted and "stop to arrest" ratios do not improve'.

Labour's manifesto, *For the many not the few*, promises to 'implement a strategy for the children of alcoholics based on recommendations drawn up by independent experts' and states that prison 'should never be a substitute for failing mental health services, or the withdrawal of funding from drug treatment centres', but otherwise contains little on drug policy issues. 'Labour should be the party that shouts the loudest about the need for drug reform,' said treatment adviser at the Volteface think tank, Paul North. 'Their political ideology should see drug reform as an opportunity to stand out from the rest of the field.'

Manifestos at www.libdems.org.uk, www.conservatives.com, www.labour.org.uk

POOR DEAL

POORER PEOPLE ARE MORE LIKELY TO SUFFER alcohol-related ill-health than the better off even when drinking similar amounts, according to a study published in *The Lancet*. 'Low socioeconomic status was associated consistently with strikingly raised alcohol-attributable harms, including after adjustment for weekly consumption, binge drinking, BMI, and smoking,' says the research, which is based on a sample of more than 50,000 people. *Socioeconomic status as an effect modifier of alcohol consumption and harm* at www.thelancet.com

PURITY PROBLEMS

INCREASES IN DRUG PURITY have led to a 50 per cent rise in A&E admissions for UK cocaine users since 2015, according to this year's *Global drug survey*. The survey also reveals increased use levels for ketamine, nitrous oxide and LSD, as well as more people reporting buying drugs from the 'dark web'. 'This year's study shows that increased drug purity is leading to a surge in admissions to A&E departments across the UK,' said report author Dr Adam Winstock. 'We need to educate users about purity levels and the impact that they have on their bodies,' www.globaldrugsurvey.com

'Opium production could be up by more than 40 per cent.'

WEIGHTY ISSUES

THE AREA UNDER POPPY CULTIVATION in Afghanistan is expanding, according to UNODC's latest survey. The total cultivation area in 2016 increased by 10 per cent on the previous year, meaning that potential opium production could be up by more than 40 per cent – to as much as 4,800 tons. *Afghanistan opium survey report* at www.unodc.org



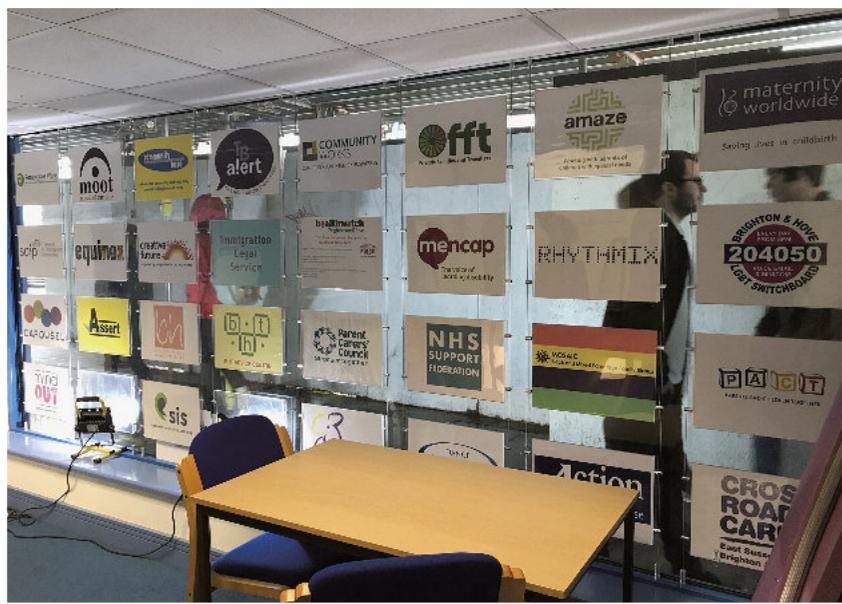
'There can be real consequences to overstating evidence or implying certainty when there isn't any.'

CLARE MURPHY

PREGNANT PAUSE

TELLING WOMEN that small quantities of alcohol during pregnancy can cause irreparable damage to a developing foetus causes needless anxiety and has 'no basis in evidence', according to the British Pregnancy Advisory Service (BPAS). Although the chief medical officer's advice to pregnant women was revised last year to avoiding alcohol altogether (*DDN*, February 2016, page 4), there is 'no robust evidence' that isolated episodes of binge drinking – including before a pregnancy

is confirmed – causes long-term damage, says BPAS. 'There can be real consequences to overstating evidence or implying certainty when there isn't any,' said director of external affairs Clare Murphy. 'Doing so can cause women needless anxiety and alarm – sometimes to the point that they consider ending an unplanned but not unwanted pregnancy because of fears they have caused irreparable harm. But just as importantly, it assumes women cannot be trusted to understand risk, and when it comes to alcohol, the difference between low and heavy consumption.'



Vital connections

Most drug-related deaths are of people not in treatment.

DDN visits Equinox outreach team in Brighton to hear how they engage with a growing population of rough sleepers

Rough sleeping figures continue to rise. In the government's latest report, local authority counts showed 4,134 people out on the streets in England on a snapshot night in autumn last year – up 16 per cent on the previous year's count. Brighton is near the top of the league table with one in 69 people homeless, and the challenge is clear for the city's outreach team.

Among the members of Pavilions, Brighton's partnership of treatment services led by Cranstoun, Equinox are hard at work at the community base in Queens Road, a few roads up from Brighton's seafront. There's plenty going on as usual, and people buzzing in and out of offices shared with many other agencies, from housing support to mental health.

While explaining what they do, they break off to deal with an urgent suicide threat nearby. One of the regular clients is threatening to kill himself, having been caught shoplifting again. Anti-social behaviour caseworker Kristina has rushed up there to help out, knowing that he will have been shoplifting to feed a drinking habit of 40-50 units a day. It's a situation he's been trying to escape, but he has a girlfriend who drinks and he's finding it hard to change.

For this man, as with many other Equinox clients, there are no quick fixes. The team members know they are in it for the long haul, explains manager Jesse Wilde. The working model is 'assertive outreach with recovery at its heart'. In practice this means going back again and again, taking the knockbacks and offering a friendly chat until one day it's welcomed.

'These are people who will never make that call for help,' he says. 'Their life is often a web of chaos, often involving begging and jail. One day something will change – maybe they'll have had a bereavement – and they'll want to talk.' The assertive outreach is the only way, as 'signposting isn't going to work'.

The key workers are obviously vital to what happens next, and Wilde explains that their training equips them to build rapport. 'Some people are avoidant, wary of intimacy or any interaction, even being told "well done"', he explains. 'So we'd

keep it very business-like in this case, and chat on the way to appointments.' In the textbook it's called 'attachment theory'; he calls it 'keyworking by stealth'.

Outreach worker Scott Crossley is well versed in these techniques. He acknowledges that many clients can be 'chaotic, disruptive and challenging', but he rises to the challenge of gaining their trust, trying to look at the root of their behaviour, and working out how to offer support.

'It takes time to establish trust and a rapport,' he says, and the first stage is demonstrating reliability. They might have complex trauma and personality disorders, and a history of people saying they're going to do something but not turning up. We're always going to turn up.' After a while you see people soften and reciprocate.

It can be a long road, and at the start 'the worker can be running around a lot, almost like a PA'. But then you need to find a way of 'handing responsibility back, giving that power back', so they are not dependent on the worker and can take charge of their own life. The results can be life-changing: 'We've had people who screamed and shouted, and they're now in their own accommodation, completely different people... but that takes time.'

The scope to work in this way comes from being part of Pavilions, Brighton's network of support. The important parts of Crossley's work takes place away from mainstream hubs, 'taking recovery to people who can't do mainstream'.

'You've got one person but lots of strands, almost like a spider web, for housing, mental health, whatever they need,' he says. Through multi-agency working, they can get a support package together, including OST at the right titration.

'We can get them so we're holding them,' says Crossley. 'We've got a platform and can then do the good work of preparing them for a stint in rehab. If you put someone with so much trauma without preparation work into detox, all the years that drugs have suppressed – this filing cabinet of feelings – opens up and these feelings go everywhere.'

The involvement of mental health teams makes a vital difference, he believes. 'Before, we would do all the work to prepare them and leave them at the rehab



L-R: Multi-agency offices in Brighton; visiting nurse Mike confers with ASB caseworker Kristina; outreach worker Scott, with Dolores from head office and manager Jesse.

'One of the things we try to instil in the team is that you need to be assertive and have confidence... when you lose posts and money, you have to work more closely together.'

door. We can now go on working with them and liaise. The drop out rates are down – it's been amazing.' Another success is that the team all carry naloxone in their bags, and consider that this should be mandatory everywhere.

The success of partnership working has energised the team's proactive approach to trying different initiatives, and Wilde describes how 'Sensible on Strength', seen to be working well in Norwich, has been adopted by Brighton and is highly successful in tackling anti-social behaviour and improving public health. Around 200 alcohol retailers have agreed to take high-strength alcohol off their shelves, through working with the local authority and local residents.

'It's now rare to see a can of Tennents Super,' adds Crossley. 'I never in my wildest dreams thought it would be this successful.' He recalls how an incident black spot near to an off-licence – a place where an inebriated girl once got run over by a bus – has been transformed. Following pressure from residents the licence was revoked until opening hours were changed and the shop agreed not to sell super-strength alcohol. A local doctor has called the project 'the single most important health initiative in recent years'.

Such initiatives contribute significantly to the health of homeless clients and are also helpful in improving relations with the local community. Each month progress is discussed at a 'high impact case forum', involving police, the substance misuse teams and other community partners, covering the most offensive forms of anti-social behaviour, from urinating on the street to aggressive begging. Ideas and action points from the group feed back out to the day to day work with many community partners, including the church, city college and local residents.

'There's an entrepreneurial element to being a frontline worker,' suggests Wilde. Increasing complexity among clients, mental health services that are stretched to the limit, and the fact that substance misuse and mental health funding still exist separately – not to mention a massive 25 per cent cut of PHE funding to the outreach team – mean that staff are faced with more challenges than ever.

'One of the things we try to instil in the team is that you need to be assertive and have confidence,' he says. 'When you lose posts and money, you have to work more closely together.'

The outreach team also benefits hugely from having members who are themselves in recovery. 'It's made them a lot more "no nonsense" about the work,' he says. 'They know what a blag is.'

The team also has little time for strategies that sit on the page and make little sense in the hand-to-mouth environment of the street. Crossley dismisses 'off the shelf' recovery and talks about harm reduction side by side – part of the 'whole person' vision.

'I hate that word "motivation",' says Crossley, referring to target-speak for a moment. 'Our guys have a different motivation – not to get sick; to get money to get drugs. These guys aren't going to sit in groups. They have a £200 a day habit and they need to beg. For these people you have to throw "motivation" out the window. If you ask them "do you want to be injecting in the neck?" they'd say no. They have no choice.' **DDN**



With a vast range of forms and potencies, the fentanyl family bring too many unknowns. Kevin Flemen gives an essential guide

MEET THE FENTANYLS

Another day, another drug warning – lately we've had drug scare after drug scare. There was flesh-eating Krokodil, Bath Salt cannibals, Hippy Crack, Zombie Spice and, in the May issue of *DDN*, concerns about an increase in Xanax use.

Most recently came warnings about fentanyl-type drugs. Such bulletins can risk losing impact, but if the evidence from North America and elsewhere is anything to go by, fentanyl and its derivatives have the potential to become a huge problem and cause significant loss of life.

Although fentanyl-type drugs have featured sporadically in the UK drug scene for a while, concern about them has increased markedly in the past few months, leading to official warnings from the National Crime Agency (NCA) and Public Health England (PHE). So, it's time (and some would argue, long overdue) to get up to speed with the fentanyls.

Fentanyls are opioids, with fentanyl (Duragesic) used for severe pain. It has numerous analogues and derivatives, with new ones emerging – Wikipedia lists 42 and this may be an underestimate. Several of the fentanyls have legitimate medical use and so are better understood in terms of potency, doses, and metabolites, but others have been developed to sidestep legislation or restriction on precursors. Less is known about these newer compounds.

The potency and half-life of different fentanyls varies massively. To illustrate relative potency, fentanyls are compared to morphine – but this is a crude indicator, especially when the composition and purity of street-sourced fentanyls is unclear.

To further complicate the issue, some analogues have more than one isomer, which in turn vary in potency. So 3-methylfentanyl ranges in potency, from 300 times the potency of morphine to 6,000 times stronger, depending on which isomer is present.

Given such a wide range of products and potencies, the risk of overdose cannot be understated. There is every chance of misidentification and mis-selling throughout the supply chain, from producers inadvertently supplying the wrong analogue or isomer through to suppliers mis-identifying their product.

To reduce the potency to usable levels, fentanyls need to be bulked out with a non-psychoactive filler agent, such as mannitol. This demands correct identification of the drug, careful calculation of the amount of filler to be added, and thorough mixing of drug and filler.

Such mixing is at best prone to errors. When fentanyl is mixed with more granular substances, such as brown heroin, it is impossible to achieve a thorough mix, and so the risk of separation and 'hot-spots' is greater still.

SOURCES AND SUPPLY

Synthesised in China and elsewhere, fentanyls have become increasingly available on the dark web. Products reputedly on sale included fentanyl, furanyl-fentanyl, carfentanil and other analogues.

Given their very high potency, they are an appealing option for international smuggling. They offer a low bulk/high potency alternative to heroin and are available via labs online, rather than engaging with heroin suppliers.

Fentanyls have become a very significant factor in drug deaths in North America and the major cause of opiate deaths in British Columbia, with the number almost doubling between 2015 and 2016. Closer to home they have been an issue in the EU, but it has primarily been Baltic countries, especially Estonia, which have seen the biggest problems.

There may also be some European production. In April, West Yorkshire Police raided a 'drugs lab' where fentanyl was involved, although it is not clear from the reporting if the 'lab' was synthesising fentanyl, or compounding imported fentanyls with heroin for onward sale.

THE UK MARKET

Medically diverted fentanyl is abusable, but the combination of limited prescribing and transdermal preparations has meant it has not been a massive issue in the UK to date. Fentanyl analogues have been around here for a while, cropping up sporadically in drugs analysed (for example) by the drug identification service WEDINOS, but difficulties in detecting newer fentanyls make it hard to gauge their presence. It may be that they have been a factor in opiate drug deaths for longer than thought, and reviews of post-mortem samples are being conducted to see if this is the case. Routine drug testing and screening won't show up fentanyls and even fentanyl-specific tests won't detect all analogues.

While fentanyl is most likely to appear as a cut in heroin, it is also sold online as a white powder and has been offered in liquid and blotter forms. It can be smoked, snorted, injected, or taken rectally, and while all routes are risky, smoking carries the lowest risk of fatal overdose. At street level in the UK, it is most likely

Fentanyls – a comparative

Fentanyl is rated as approximately 100 times* the potency of morphine – so 1g of fentanyl is equivalent to 100g of morphine.

Some analogues are weaker: acetylfentanyl is around 15 times the potency of morphine. Others are far stronger: 4-fluorofentanyl is reported to be twice the strength of fentanyl – some 200 times the strength of morphine.

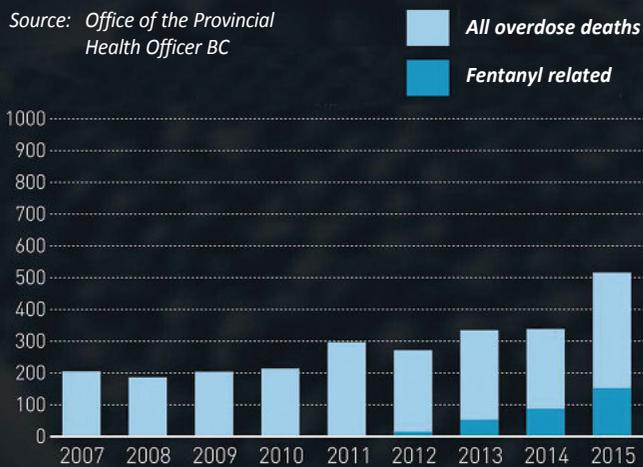
Carfentanil, legitimately used to tranquillise large mammals, is reportedly around 10,000 times the potency of morphine (100 times stronger than fentanyl). So, in theory, 1g of carfentanil is the equivalent of 10kg morphine.

**This dose equivalence is a very crude way of indicating relative potency. Variables such as speed of onset, duration of effect, level of analgesia versus level of sedation, and therapeutic index cannot be summarised by a simple drug A is x times stronger than drug B.*



Illegal drug overdose deaths in British Columbia

Source: Office of the Provincial Health Officer BC



Fentanyls need to be bulked out with a non-psychoactive filler agent, such as mannitol... Such mixing is at best prone to errors. When fentanyl is mixed with more granular substances, such as brown heroin, it is impossible to achieve a thorough mix, and so the risk of separation and 'hot-spots' is high.

to end up as a component in another drug, usually heroin. This may be in the form of typical brown heroin, with fentanyl added to make it feel more potent.

Fentanyl is sometimes referred to as 'synthetic heroin' or 'China white'. It is therefore essential to stress that buyers offered 'white heroin' or 'China white' are at present very likely to be getting fentanyl rather than old-school white heroin.

People seeking heroin are clearly the group most at risk of encountering fentanyls. However, they have cropped up in place of other products including benzodiazepines and stimulants such as MDMA or cocaine in the UK and Europe, and sold internationally mixed with crack cocaine. Becoming more widespread could impact not solely on heroin users, but people using any white powder drug – populations that are likely to be harder to reach with harm-reduction messages and less likely to have naloxone at point of overdose.

Issuing warnings about fentanyls is a finely balanced judgement call, as premature warnings about 'dangerous drugs' can be counterproductive. On the one hand, they raise awareness and highlight the dangers; on the other, they risk publicising a high-strength, low-cost alternative to street heroin and can make it a sought-after product. However, the string of deaths in the north of England, more frequent reports from around the UK and increased police seizures have acted as a catalyst for the NCA and PHE to issue alerts about fentanyls. This has triggered a flurry of articles in the mainstream media, so the cat is well and truly out of the bag.

This still doesn't mean that fentanyls are widespread or have penetrated the market at all levels. We need to try and develop locally relevant messages that don't inadvertently promote fentanyl: references to 'super strong' or 'high strength' are probably phrases to avoid.

WHERE NEXT?

We need to look urgently at the experience of North America, especially Canada, in the face of escalating fentanyl use. Experience in terms of detection, first response and educative messages will be invaluable.

In response to rising fatalities, drug consumption

room provision is being expanded in Canada. Such measures are long overdue in the UK and in the context of escalating deaths in the UK and the advent of fentanyls, similar measures are required here.

There's no evidence that harsher legal sanctions for adding fentanyl to heroin will deter suppliers. However, fear of police action may mean that suppliers holding fentanyl supplies try to offload stock quickly, with the risk that the drug will crop up in a more random fashion.

Ultimately, such measures are of course sticking plasters. We keep seeing the evidence that prohibition begets increasingly dangerous substances. The long-term solution is drug legislation reform, but until this happens we are obliged to wait for the next alert to flash up as a new, more potent substance enters the drug stream.

Kevin Flemen runs the drugs education and training initiative, KFx. Visit www.kfx.org.uk for free resources.

Harm reduction

While all use of street opiates brings a risk of overdose, the potency and variability of fentanyls bring an unparalleled level of risk. Scattergun warnings can reduce their credibility, and so assessing what is going on locally is important:

- **Engage with people who are using to determine what is being offered, and if 'white heroin' or other potential fentanyl-laced products are appearing on the market.**
- **Make bulletins up to date and locally relevant.**
- **Ensure that facts are established before cascading information by developing a local drugs warning protocol in conjunction with user groups, police and public health.**

'Fentanyl=death' messages are inadequate as, without access to licit compounds, people will still access the street market and so harm reduction is also essential.

Core opiate harm reduction messages remain relevant, and need to be re-stressed:

- **Smoking represents the lowest risk of fatal overdose and this should be emphasised, alongside provision of foil.**
- **Overdose risk increases when opiates are used alongside alcohol or other sedating drugs including benzodiazepines, z-drugs or gabapentin/pregabalin.**
- **Sampling batches before use and injecting slowly can reduce risk.**
- **Fentanyl overdoses can reportedly be very rapid.**
- **Use with company who can respond in the event of an emergency; if using together don't all use at the same time.**
- **Ensure availability of naloxone and a phone that works.**
- **It is imperative that an ambulance is called in the event of an OD.**
- **OD may require larger doses of naloxone than a heroin OD and distributors may need to review training and the number of kits distributed if fentanyl is a local issue.**
- **Encourage retention and submission of samples post OD for analysis.**

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN at the address on page 3. Letters may be edited for space or clarity.

'E-cigarettes are a game changer! Clients do not have to increase their stress levels by trying to quit an often very entrenched habit, but simply switch to using something that is hugely less harmful.'

SMOKE WITHOUT FIRE

Having worked in this sector for over ten years it never ceases to amaze me how little attention is paid to smoking cessation. Every drug and alcohol service is instantly recognisable by the small huddle of smokers near the door, and these are the professionals working there! Clients smoking is something that in my experience is hardly ever addressed, despite the huge health risks associated with it. The rationale is that our job is to work with clients to tackle their primary addiction to drugs and alcohol, and that trying to stop smoking could jeopardise tentative first steps to recovery.

That is why e-cigarettes are a game changer! Clients do not have to increase their stress levels by trying to quit an often very entrenched habit, but simply switch to using something that is hugely less harmful. This is why I was interested to read Professor Neil McKeganey's article in May's DDN magazine on the relatively low uptake of e-cigarette use, and the misconceptions around how harmful they are compared to normal cigarettes. This is despite PHE stating that vaping was 95 less harmful than smoking. McKeganey states that alongside confusion and dislike of the paraphernalia, this has led to only around 15 per cent of smokers switching.

I think it is our duty to encourage clients to try to switch to vaping, and ensure that they are aware of the facts and have access to the equipment. We could even be handing out free e-cigarettes and allowing clients to use them in services! By doing this we will be improving their health and wealth, which all goes towards a successful sustainable recovery.

Lucy Phillips, via email.

NO STICKING PLASTER

In response to 'The emperor's new clothes', (DDN, May, p19): People do not 'recover' from childhood trauma, entrenched behaviour and mental illness just by sticking a methadone or subutex script in front of them. Without long-term investment in proven therapeutic interventions that work with clients where they are at in that long, long recovery journey we will continue to see an increase in drug related deaths and low successful outcomes. I have worked in substance misuse for 20 years and services have got less client focused and less accessible to those with the greatest need. We need a revolution in service design and commissioning and some commissioners who understand the complexity of problematic substance misuse.

Daisy Flower, via DDN Magazine Facebook page

RESOURCES CORNER



Lessons from history

Griffith Edwards' enlightening text lives long in the memory, says **George Allan**

EVERY SO OFTEN, BY VIRTUE OF ORIGINALITY OR DEPTH OF UNDERSTANDING, a book will last long in the memory: for me, *Matters of Substance* by Griffith Edwards (2005, Penguin) is one such text.

Edwards was, of course, one of the major figures in the field during the latter decades of the 20th century and he brings a wealth of experience to the issue of how best society should handle substances. To answer this question, he explores the history of drug use and tries to draw lessons which can inform our present approaches. Drugs for Edwards are any mind-altering substances. Tobacco is given equal weight to heroin, alcohol is considered in parallel with cocaine.

A strength of the book is its focus on the cultural contexts within which problematic use occurs and how these shift over time. Culture includes attitudes, economics and the meaning of use and how these factors shape methods of control. We still place too much emphasis on the pathology of individuals with difficulties and not enough on the forces in society which shape use and problems.

Edwards is particularly enlightening on why drug epidemics emerge and then decline, the latter often occurring despite, and not because of, the measures a society has taken to address them. From the UK's opium wars with China to Marlboro Man, from prohibition in the USA to the rise of psychedelics in the 1960s, Edwards describes the ebbs and flows of use and attendant policy shifts.

In the final section, Edwards draws conclusions from history regarding how best to reduce the harms. He is highly critical of our laissez-faire approaches to the damage which alcohol wreaks; this leads him to adopt the precautionary principle in respect of loosening the law, particularly in respect of class A drugs, although he does consider the arguments for aspects of decriminalisation to be worthy of further debate. While this conservative stance is being increasingly questioned in the west, those in favour of relaxing the law would do well to test their arguments against the evidence Edwards presents.

As might be expected from its author, the book is erudite but accessible, witty and full of pertinent anecdotes. It is written for the enquiring general reader but those of us in the field should never forget the lessons of history.

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

'A strength of the book is its focus on the cultural contexts within which problematic use occurs and how these shift over time.'

KEEP IT PERSONAL

POST-ITS FROM PRACTICE



A responsive approach is as important as the right medicine, says **Dr Steve Brinksman**

I was recently involved in training shared-care GPs in Worcestershire. They wanted me to cover addiction to medicines, which fitted in with me having recently seen a young man at our practice with a dependency on over-the-counter medication.

Craig is 32, has a stressful job in IT and also has inflammatory bowel disease, which has been difficult to control and frequently flares up. He had been to the practice on three occasions in the past two months, complaining of low mood and stress and had been started on antidepressants. I was reviewing him about this and he told me he didn't think they were working and his bowel disease was much worse. As we started to explore this, he broke down and told me he had been buying painkillers from the pharmacy and over the internet, and was taking many more than the recommended dose.

He hadn't told anyone this, not even his wife, and he felt it had become a significant factor in his low mood and anxiety. He had started buying Nurofen Plus to deal with the pain from his bowels, but had soon found they helped him feel less stressed and so he carried on taking them even after his bowels settled. At the time I saw him he was taking 24 a day – he felt unwell if he stopped them and was very keen to try and do a managed withdrawal. After discussing the options he decided he wanted to use codeine [the opioid in Nurofen Plus] to gradually reduce, as he felt the use of methadone or buprenorphine would stigmatise him as a drug user to the pharmacist.

Things went well for the first few weeks and we reduced

'Our job is to facilitate treatment not impose it... we can build the effective therapeutic relationships necessary to engender long term change.'

his dose by about a third, but then he started buying additional medication again. Acknowledging his desire not to feel stigmatised, I explained how it can be difficult to reduce using the drug that causes the dependency, as he had already developed a response to stress by using more. He agreed we should try and stabilise him on OST, then do a managed withdrawal, so a buprenorphine prescription was initiated and he stabilised on a 6mg dose. He agreed to contact our local IAPT [improving access to psychological treatment] service and over three months we were able to reduce, then finally stop, his medication.

Craig is doing well, however his bowel disease still causes flare-ups and he remains concerned that he could relapse. I have told him that we can review him regularly and if he does have a further problem, we want to engage with him as soon as possible.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP, www.smmgp.org.uk

MEDIA SAVVY

The news, and the skews, in the national media



NEWS

VIEWS POLARISE OVER WAR ON CANNABIS



WHAT WAS GOING THROUGH SALMAN ABEDI'S MIND when he made that journey to Manchester Arena on Monday night?... Was he a psychopath? Was he evil? I do not know the answer but I do know, as the *Mail* reports today, that according to his friends Abedi was

a frequent and heavy cannabis smoker... For too long, we have ignored the terrible toll of this drug. Too many people have dismissed cannabis as harmless – something to help you relax and chill – and that an individual should be free to buy and use as they choose.

Now, more than ever, we need to wake up to a pernicious substance that ruins not just the lives of those that take it, but countless others around them in ways we might never have imagined.

Max Pemberton, *Mail*, 24 May

MAY'S FANATICAL AVERSION TO DRUG REFORM typifies the 'nasty' side of her state, an authoritarian nation, illiberal and ruled by alien hobgoblins and pre-

judices. In the past decade the 1971 Act has criminalised almost a million young Britons, ruining their chances in life. It has crammed prisons with drug-related offences, more than ever before, and slashed the community treatment that is the norm across Europe. For what? So populist politicians can posture against reason and common sense?

Simon Jenkins, *Guardian*, 11 May

DRUG LAWS GROW LAXER, in practice, every year. Personally, I think this is a grave mistake, just as the evidence comes pouring in that use of supposedly 'soft' cannabis is correlated with mental illness. But if we are to debate this matter seriously, those who call for weaker drug laws really must stop pretending the problems we have result from severe and stern enforcement, and the government must stop

pretending it is standing firm. The opposite is true. Our society is drenched in dangerous drug use because we no longer enforce our own laws.

Peter Hitchens, *Mail on Sunday*, 7 May

WE ARE WOEFULLY UNPREPARED to meet the needs of older people struggling with substance misuse. So what will happen in 2030, when members of Generation X – the twentysomethings who popped pills at warehouse raves in the 1990s – start to turn 65? Addiction in older age is not a problem that's going to go away. By 2030, nearly a quarter of the population in England will be over 65. That's around 12m people. We're sitting on a ticking time bomb, waiting for the inevitable fallout of each generation overindulging in its substance of choice.

Tony Rao, *Guardian*, 6 May

FINDING THE RIGHT VOICE

CGL has been consulting with young people on the best ways for its youth services to get their message across.

DDN reports on the outcomes, and the potential lessons for other providers

Promoting services to young people, particularly in an area like drugs and alcohol, can be fraught with potential pitfalls. It's important not to seem intimidating or off-putting, and to come up with something young people can relate to, but at the same time it's vital to avoid slipping into patronising or embarrassing 'down with the kids' territory – something that's likely to alienate your target audience even more.

Following the re-branding of change, grow, live (CGL) from Crime Reduction Initiatives (CRI) (*DDN*, February, page 11), the organisation felt that it still needed to do more to reach younger people. 'Prior to the national rebrand many of our YP services created their own local branding,' CGL's national head of operations for young people's services, Raj Ubhi, tells *DDN*. While the organisational rebrand ensured a 'refreshed visual identity and national consistency' in how services were marketed to service users and potential referrers, it didn't necessarily appeal to younger audiences in the same way as it did to adults, he says. 'We therefore decided to work with young people themselves to develop a specific, distinctive and recognisable brand which young people could more closely relate to and engage with.'

The process started around six months after the national CGL re-brand was introduced, and following a period of extensive consultation, development and implementation, all of CGL's services across the country adopted the new young person's brand from April this year. 'What young people want from a brand often differs from what adults want – I think there was a consensus that actually we can do something that better appeals to our younger audiences that's separate to something you might expect to see in an adult service,' he says. It was 'a big piece of work', however, involving more than 20 services working with varying ages, backgrounds and needs, all of which CGL wanted to cater for.

The organisation consulted more than 180 young people, but also extended the consultation to commissioners, professionals and partners, because 'a lot of the marketing material has to appeal to them as referrers also', he explains.

A key element to get right was one of the most basic – the actual naming of the services. 'One of the things that is central

to our values is service user voices informing and influencing the services we offer them – ultimately it's their service,' says Ubhi. 'Therefore, young people often inform what our services are named locally. We want something they can relate to and something that's going to appeal to them. Generally we go into local areas to consult through competitions or raffles to help determine service names, and it's important that a national brand has the capacity for localisation. So although the logo for all our services is now the same – and the design architecture that sits around it – the actual service names are going to be local. There are quite a few of our services named Wize Up – young people seem to like that name.'

Just as important were the visuals – an area it can be easy to get wrong. 'A lot of that came through in the consultations – young people didn't want a brand that contained patronising images, language and designs,' he says. 'Some of the key messages were that they wanted something that looked current, bold and minimalistic. They liked the dark backgrounds, black and white images and bright colours, so something quite striking but simple at the same time. We took into account national commercial brands that they were particularly fond of.'

They also wanted images that 'represented young people in general' rather than pictures of the type of people generally perceived as 'substance misusers', he stresses. 'They were against using young people's faces more generally because they thought that could stereotype the type of person that might access the service. There isn't a typical young substance user – most young people will have some level of interaction or relationship with substances, whether that be curiosity, recreational or more problematic use.'

It was important to try to increase visibility and accessibility for all these audiences by reducing stigma, he says, another reason to move away from 'traditionally deficit-based images that represent problematic drug use, or that scream out "drug and alcohol misuse"'. There may be a bit of resistance in terms of engaging with that type of service, depending on the young person, parent or carer – that was key feedback that we tried to take into account.'

On the subject of feedback, the reaction since the re-branding has been positive, he says. 'It's really good that young people were involved throughout – not only did we



do a consultation via a survey, we actually sat down with them to create the brief that we gave to the developers. We showed the final designs to the young people and asked if they thought it closely met their brief, and it did.'

Creating a brand that could appeal across the age ranges covered by the services isn't necessarily easy when that goes from as young as ten up to 25, not to mention parents, carers and the professionals who might direct young people towards the services. 'But it seems to have been effective in meeting these diverse needs,' he says. 'Visual identity is important to young people, and hopefully this brand will appeal to young people universally and encourage engagement where others may not have traditionally done so.'

In terms of the challenges facing young people's services generally, while cannabis and alcohol are still the main reasons for presenting, the key issue is 'not only the substances being used by young people who present, it's the substances being used by young people who don't present, and are at increased risk', he states. This could be down to a lack of awareness around services generally, or the simple fact that they don't see their substance use as an issue that needs addressing, he points out.

The substances falling into that latter category include NPS, PIEDs and even 'smart' drugs. 'This can be seen as more aspirational use to better themselves rather than engaging in any particular risk to their health. And where excessive alcohol and cannabis use is normalised in peer groups, or substances are used as a coping mechanism, there can be a reluctance to access services for support. Responding to this "hidden" risk is an important prevention agenda and the marketing of our services is a key factor here in terms of proactive engagement.'

To help achieve this, all of CGL's services now adopt a 'peripatetic' model, he points out. 'It's very rare that we operate from premises where we'd expect young people to come to us to access support or any kind of intervention. We go out to young people to offer one-to-one appointments, but we also try to increase visibility by being in places young people are – not in an intrusive way, but just so we can engage and open up conversations in a more meaningful way around drugs and alcohol.'

This could be in-reach work with partner agencies where

people could benefit from drug and alcohol advice, such as sexual health services, youth hostels, children's homes, A&E, or schools and colleges, or via traditional street outreach in the community, the night-time economy, festivals or fresher's fairs. There's also a major focus on whole-family approaches and delivering interventions to parents, carers and wider family members. 'For a lot of our young people their key protective factor is their parent or carer, so trying to involve them in any support that we offer the young person is in both their interests,' he says.

Perhaps crucially, the 'we won't judge you or tell you what to do' message is as prominent on much of the literature as the description of the service or contact details. 'When we've done consultations, often the reluctance to engage is because they may think they're going to get a lecture or be told to stop using substances. They're not always going to want to stop, and there might be young people who feel ashamed or guilty about their substance use, so that's a barrier to accessing services. So we thought we needed to address that one head on in some of our key branding messages.'

However good the branding is, there's little point unless it's used properly, however. 'We wanted to better understand how young people learn about our services – a lot are searching for information on substances or other support services online, so it's about how we make this brand compatible with a real sound, comprehensive digital presence,' he states.

'The national rebrand is to create a recognisable brand for young people, raising the profile of CGL as a specialist provider of young people's substance misuse support, information and advice,' he continues. 'Expert advice is important for young people – they told us that they're more likely to engage if they know that the service or worker "really knows their stuff" – more than they might easily be able to access online. I think that consistent brand will help young people recognise it and trust it for up-to-date, accurate, relevant advice. There's a whole host of information out there of varying degrees of quality, so that's something that we're really keen to do in terms of raising that profile and that trust and credibility among young people.' **DDN**

They... wanted images that 'represented young people in general' rather than pictures of the type of people generally perceived as 'substance misusers'

MARKET FORCES

A strong message from Addaction's Mortality Matters conference was that treatment services need to put competition to one side and challenge the conditions that are allowing drug-related deaths to rise. DDN reports

How should we tackle the alarming increase in drug-related deaths head on, asked Addaction's medical director, Dr Kostas Agath, opening the charity's one-day conference in Leeds.

'Drug-related deaths have been increasing year on year for the last three years... we haven't cracked it,' he said. The figures – 3,388 drug-related deaths in 2015 in the UK – didn't give the whole story. He spoke about Martin, who lost his life just recently – and about his mother, struggling to make sense of the gaping hole in her life. 'Someone, somewhere must begin to ask the right questions. The Martins out there must be someone's responsibility.'

We could take four steps to reduce drug-related deaths, suggested Alex Stevens, professor of criminology at the University of Kent, setting the scene through his keynote speech. The steps were to care, invest, innovate and integrate with other services. 'We know these would reduce DRDs. The question is whether we care enough to do something about it.'

There had been a significant increase in opioid-related deaths since 2012 and the government had reacted by banning things (such as psychoactive substances) rather than looking at the contributing factors.

We should be looking at the 'devastating' consequences of short-term commissioning and worsening socio-economic circumstances for vulnerable groups, he said. 'The government is

reducing the income of people who are most vulnerable to drug-related deaths.' And from talking to legal support charity Release, who provide help and advice, he confirmed that 'people are being given arbitrary changes to their treatment plans related to what their commissioners would prefer to provide.'

Changes in treatment and a focus on recovery had sidelined harm reduction, and there was pressure on services to achieve 'drug-free exits'.

So what should we be doing? Two of the clearest practical steps were to invest in high quality opioid substitution therapy (OST) at optimal dosage and optimal duration, and to provide naloxone to practitioners,

'Drug-related deaths have been increasing year on year for the last three years... Someone, somewhere must begin to ask the right questions.'

DR KOSTAS AGATH



peers and potential bystanders – anyone who comes in contact with a person who could be at risk of overdose.

'Naloxone should be available and I'm saddened and angry that commissioners haven't got the message,' he said.

The risks were much higher out of treatment, 'so we don't want to be pushing people out of treatment before they're ready, as this risks them dying,' he spelled out.

We need to innovate, he said, and give proper consideration to heroin-assisted treatment, medically supervised consumption rooms, and new routes for administering naloxone.

Better service integration could also make a significant difference. 'Pulmonary (lung) health tends to be very poor indeed,' he said. We needed to provide better access to smoking cessation, tobacco harm reduction services, housing, dental health – 'all the stuff that makes life meaningful'.

'Service users in drug clinics have a high burden of respiratory disease,' confirmed Dr Sandra Oelbaum, Addaction's associate medical director and primary care lead, who gave her experience of improving access to COPD diagnosis and treatment in Liverpool shared care.

The links between drug use and breathlessness meant drug users were three times more likely to be admitted to hospital with respiratory conditions, she said, 'so the impact on health services is very disproportionate'. There was very poor follow-up, with many feeling that they could not access care or go to their GPs.

Yet there were simple and effective measures that could engage people in treatment, such as putting spirometry (lung function tests) in drug treatment clinics. Trialing this in Liverpool shared-care clinics had achieved high levels of participation, diagnosis and treatment, with participants comfortable with the idea of having a COPD clinic located in drug treatment.

'Sometimes we need to go back to principles and make sure we're doing what we know works,' said Dr Jan Melichar, consultant psychiatrist and medical director at DHL, South Gloucestershire, who had been asked to talk about ways of maximising treatment to reduce opioid-related deaths.



‘We’ve changed our emphasis from what’s good for people to successful treatment exits,’ he said, and he had clear advice. ‘Get them on doses that work. Suboptimal doses make things worse.’

The optimal doses were usually between 60-120mg of methadone and 12-16mg of buprenorphine. However the average doses were 46.6mg of methadone, 10.6mg of buprenorphine and 9.3mg of buprenorphine/naloxone. So why was average dosing so low?

‘There’s fear of diversion,’ he said. But using buprenorphine as an example, 16mg was the best dose, as ‘at this dose it blocks. It lets them engage with getting better. Choose good clinical dosing and let people choose life.’

With representatives of some of the major treatment agencies in the room, the conference was an opportunity to debate sector-led solutions.

‘This is not a happy conversation to be having – it touches people’s lives every day,’ said Karen Tyrell, Addaction’s executive director of external affairs. It also had a huge impact on frontline workers, and ‘every organisation should be doing more about that’. To reduce drug-related deaths we needed to improve penetration rates – ‘make sure our services are easy to get into,’ she said.

With this in mind, a panel session brought together directors from Addaction, CGL and Turning Point, together with Paul Hayes of Collective Voice, the body representing the sector’s major treatment agencies.

‘We want to develop a shared statement,’ said Hayes. ‘We’re not just looking at overdoses, but excess deaths. This is a population with compromised hearts, lungs, mental health problems, who are in and out of prison and whom the rest of the population shuns.’

There were key areas to look at. These included helping service users to recognise who’s most vulnerable; improving clinical interventions and NHS engagement; and making pathways and appointments easier.

‘These things are difficult to navigate – God help you if you’re in your 40s and have had life experience that leaves you feeling compromised,’ said Hayes. ‘How do we make sure we have a system that has the

right balance between offering people recovery but not pushing them into it too early? How do we engage with people who are most at risk – people outwith the treatment system?’

‘We want to be able to move people at risk up the system,’ said Dr Prun Bijral of CGL. ‘Our key workers are really pushed right now – we need to help them.... We need to have ambition. There’s a lack of penetration – people are not seeing our services as attractive. We need to look at the evidence base and prioritise.’

Another challenge for providers, he said was ‘to factor in 30 per cent or 40 per cent for non attendance loss’.

Dr David Bremner of Turning Point agreed with the need to adapt to circumstances. ‘We have to look at what harm minimisation advice is, in the context of massively slashed budgets – people are sometimes late or angry and we have to take this into account.’

Bremner wanted to see better liaison to get things done. Getting commissioners along to morbidity and mortality meetings had ‘borne phenomenal fruit’.

‘We now have 100 per cent naloxone penetration,’ he said. ‘When there’s resistance to this, you have to hit it with a sledgehammer.’

Furthermore, he wanted providers to think outside of the usual competitive mindset. ‘We need to, as a group, set industry standards, so no one is scripted without naloxone. We also need to break the “dare to share” attitude,’ he said, rather than doubling up to all invest in new things from scratch.

Addaction’s executive director of operations, Anna Whitton, also spoke of the need to look past the competitive element. ‘This is about putting differences to one side, this is about people dying,’ she said. ‘If we find the right partnerships we can make quick differences to what’s happening.’

‘We need to listen to service users and facilitate access to appointments, particularly early in their treatment,’ she said. ‘How do we make the system more responsive to people? How can we work flexibly and smarter?’

In Bremner’s view, ‘things we’ve done very poorly’ included accepting payment by results. ‘There are people who are seen as “not engaging”, but they are

‘There’s a key message for the workforce... Your fundamental job is to keep people alive. Be as aspirational as you want, but keep people alive.’

KAREN TYRELL

engaging, such as with the pharmacist. They’re just not engaging with you. We need to be more clinically authoritative.’ Providers also needed to ‘push back against CQC’, he believed, adding ‘I haven’t come across any inspection that’s going to stop deaths’.

‘I’m a big fan of low threshold prescribing – but try and get that past CQC now,’ he said. ‘It got people on and into treatment. But I believe we’re moving back to a more robust harm reduction model and low threshold prescribing is part of that.’

‘There is a mood shift,’ agreed Hayes. ‘Harm reduction never went away but it became unfashionable. As the drug-related deaths agenda to dominate, it will be easier to talk in those terms.’

‘Some people just want a safe place to use,’ added Bijral. ‘We have to work with coroners and commissioners. We have to get people into treatment.’

‘Part of shifting the balance sits within treatment services,’ said Harry Shapiro, director of DrugWise, from the audience. ‘Harm reduction has become quaint, or a political watchword for legalisation. But we need to bring harm reduction back into the heart of the mainstream.’

‘There’s a key message for the workforce,’ concluded Karen Tyrell. ‘Your fundamental job is to keep people alive. Be as aspirational as you want, but keep people alive.’ **DDN**

DIALOGUE



NHS Trusts from across England came together to mark a vital new initiative in tackling drug-related deaths, as **Danny Hames** reports

KNOWLEDGE EXCHANGE

For a number of reasons 25 April was a significant date. In 1684, the patent was granted for the most sensible but useful of inventions, the thimble, but also it marked the formal launch of the NHS Substance Misuse Provider Alliance (www.nhssmpa.org.uk).

As a collaboration of a number of NHS trusts one of our key objectives has been to use the resources within our alliance to positively impact upon the drug and alcohol treatment sector. If as an alliance we can be half as useful as the thimble has been in avoiding harm we will be doing well. However, on a more serious note, this was a day when we were able to bring together service users and professionals from a range of backgrounds to share information and practical examples of service provision that we hope can contribute to reducing drug-related deaths.

The conference was hosted at Greater Manchester Mental Health Foundation Trust's (GMMH) Curve Conference Centre and started with introductions from colleagues at GMMH, Bev Humphrey, chief executive, and Richard Rodgers, strategic lead for substance misuse. The challenge that was posed to all delegates was to ensure that we do not allow the marketisation and competitiveness of the drug and alcohol treatment sector stop the sharing of best practice – particularly important when sharing expertise and understanding between the drug and alcohol treatment sector and mental health. As Bev Humphreys said, this was a key reason why GMMH have remained in the sector – a reason that would apply to many of the NHS trusts across the country.

Dr Emily Finch, chair for the conference, introduced Professor John Strang who delivered the keynote speech alongside presentations from Steve Taylor of Public Health England and Dr Tim Millar from the University of Manchester. Professor Strang talked about the need for better action in preventing opioid deaths – a call to arms for the sector in responding to where the risks are and applying a broad range of remedies. This includes ensuring the availability of naloxone and also the many related factors, such as ensuring that family groups are not overlooked and are supported in how to manage overdose.

Steve Taylor provided a national overview of the

impact of drug-related deaths, highlighting that although the majority of these are still male, female deaths are also steadily rising. Dr Tim Millar gave a useful insight into the cause of service users deaths that are not directly related to the use of a substance: a user of substances over the age of 45 was 27 times more likely to die of a homicide than someone in the general population and the risk of suicide was also very significant. His research also posed some interesting discussion points for service providers and commissioners; for example, the evidence would indicate that for those solely in psychological treatment the risk of drug-related death is no different to those who are not in treatment.

The morning concluded with a presentation from colleagues at Pennine, Derbyshire and Greater Manchester NHS Foundation Trusts providing their findings from drug-related death audits they had completed independently over the last few years. Again, the prevalence of suicide was notable in these audits.

The afternoon sessions were very much focused on initiatives that are provided at a service level and can be taken away and developed. This included a lung health pathway in Lambeth by South London and Maudsley NHS Foundation Trust; presentations from Inclusion about their take-home naloxone project nationwide; and then in collaboration with the Hepatitis C Trust, a presentation of their P2P:peer mentor and hepatitis C project from Hampshire, which included a moving and inspirational film about the reasons for this work.

Mike Linnell walked us through the important work regarding early warning systems that has been happening in the Manchester area, and delegates also benefited from understanding the highly effective hospital liaison services working with alcohol users that GMMH and Salford Royal Foundation Trust are providing.

The purpose of the conference was to provide an insight into what is causing so many of the people we work with to die early through what are also often



We must not allow the marketisation and competitiveness of the drug and alcohol treatment sector stop the sharing of best practice.

avoidable deaths. It was also meant to have a practical application, whereby the NHS organisations and partners who provided their expertise on the day gave the opportunity to make contacts and take away tangible and realistic innovations that can be applied in their services. From feedback on the day, the conference and launch of the NHS SMPA did this – but this is only the start, and we look forward to this being the first of many such events.

Danny Hames is chair of the Substance Misuse Provider Alliance

For more information about the day, contact candie.lincoln@sssft.nhs.uk



Who cares?

Like so many others, Darren's death was preventable, says **Dr Chris Ford**

Both the local service and his GP turned him down, saying they [benzodiazepines] were very addictive. Darren found it easy to get them from the internet so his habit increased enormously, mainly to try and curtail his alcohol.

I STILL CRY WHEN I THINK OF DARREN

months after his death. He was young and had done well in treatment – I felt I must discover why he had died, as so many others die, and drug-related deaths in the UK continue to rise.

I first met Darren in 1997. He was 17 years old and registered to ask for help with his heroin problem. He was also a charmer with a cheeky smile, but he looked unwell. He had been injecting for about six months and realised he couldn't manage without heroin. He also told me he had an alcohol problem, which had improved since he took up heroin – he had been drinking up to two bottles of vodka a day but now only drank beer. The other drug he liked was diazepam, which he could pinch from his mother on occasions.

His request was to go on methadone and then become drug free. I said that was possible, but asked if I could see his injecting sites first. Darren rolled up his sleeves and revealed the worst injecting tissue damage I had ever seen. My first job was to teach him how to inject.

Darren settled well into treatment and after about nine months of methadone maintenance, he felt ready to become drug free so we discussed the pros and cons. He reduced over about six months and was very pleased. He agreed to continue counselling and to come back if he was at risk of relapsing.

After six months he relapsed – first on alcohol and benzos, and then heroin, and repeated this pattern for about 14 years. Mostly he would do outpatient detox with us, but did have two attempts at rehabilitation. For most of the time on maintenance, he worked as an apprentice in a butcher's. He loved the work and dreamed of having his own shop. His relapses were usually started by increasing his alcohol, but

a couple were when he found crack.

Having relapsed again in early 2011, Darren once again settled quickly on methadone maintenance. He had been drinking a lot and we discussed that as he had chronic hepatitis C, perhaps he should think more seriously about treatment. He smiled and said he would think about it. But early in 2012, having learnt that I was retiring, he said he must detox now as other services 'may not understand me so well'.

Piecing together what happened in the four years leading up to his death made me angry. He had again relapsed on alcohol and benzodiazepines and was determined not to relapse on heroin, so presented asking for benzodiazepines. Both the local service and his GP turned him down, saying they were very addictive. Darren found it easy to get them from the internet so his habit increased enormously, mainly to try and curtail his alcohol. He started to feel more unwell and realised that his drinking was not helping his hepatitis C, so changed to heroin. He lost his job, split up with his girlfriend and had rows with his mum, so presented for help at the local service.

He was told to come back a week later for an assessment and was ten minutes late, so was made to come back the next day. He was told buprenorphine was the best drug for him, disagreed – and this almost got him excluded for a month. He decided to give it another try and presented in the morning in withdrawals. After four attempts he got his first dose.

Darren soon realised it wasn't going to work, but the service insisted he continued. He dropped out of treatment, his alcohol and benzodiazepines went out of control, and he added crack and heroin. After several months, heroin helped him reduce his alcohol and he started to buy methadone

off the street. He was even able to start work again. He tried the local service again and this time they agreed to continue methadone. All continued well for several months but after a series of missed appointments, he again dropped out of treatment, took up alcohol, lost his job and was thrown out of his flat. Darren's last year is hazy but he seemed to isolate from friends and family, drank all he could get hold of and injected any drugs.

He was found dead in a stairwell with a needle in his arm and a can of strong lager by his side. He was only 36 years old.

The USA tops the chart in terms of opioid overdose deaths, increasing 255 per cent between 1999 and 2015. In England and Wales the rate increased by 35 per cent between 1999 and 2015, and then by a shocking 64 per cent linked to heroin and morphine over the last two years – the highest since records began. The UK now has the highest proportion (38 per cent) of the European total.

Australia, Germany, Luxembourg, Norway, Switzerland, Greece and Italy are reducing overdose deaths. What do they have in common? Extremely good access to opioid substitution therapy (OST). What else helps? Drug consumption rooms (DCRs), heroin-assisted treatment, measures to reduce homelessness, and take-home naloxone.

What do I think killed Darren? People not seeing him as a person and services not seeing him as an individual – as well as the UK government replacing extremely effective harm reduction with abstinence. Overdose deaths can be reduced – the science is easy. It's the policies that need changing.

Chris Ford is clinical director at IDHDP www.idhdp.com



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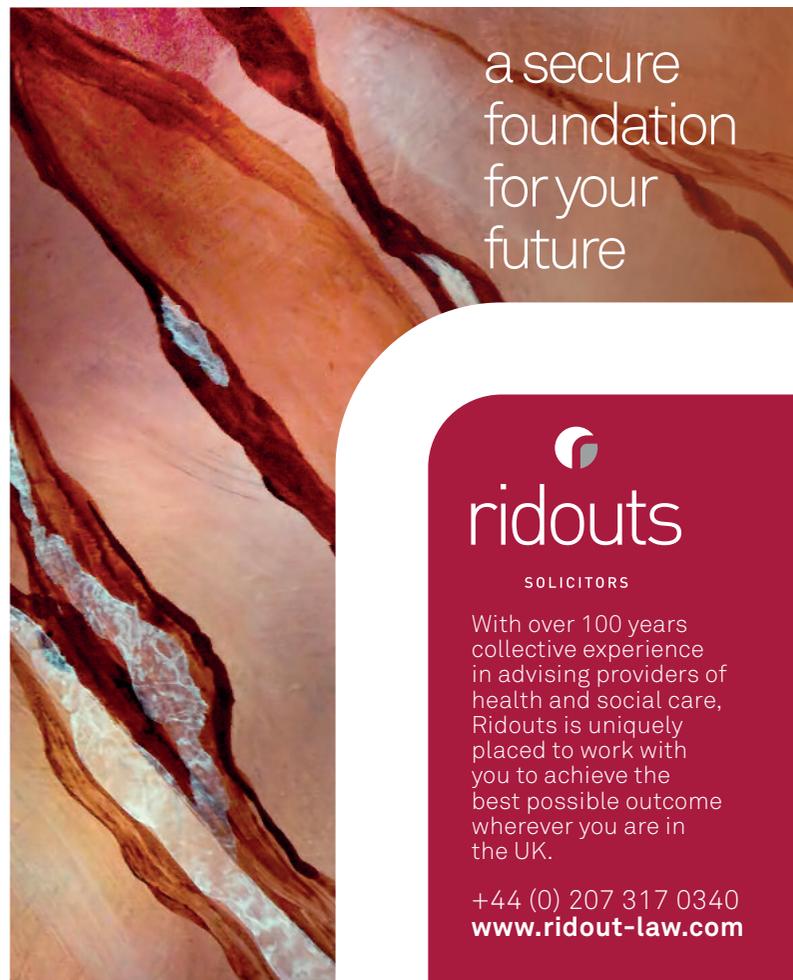
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