DRINK AND DRUGS NEWS ISSN 1755-6236 DECEMBER/JANUARY 2019

DDN

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EDITOR'S LETTER

'How difficult, when stigma adds to the pain'

It's harder than usual at this time of year for any of us who have lost loved ones or who are struggling to support them through illness. How much more difficult must it be when stigma adds to the pain and heartbreak? Katie's decision to share her story (page 6) is a courageous one that will help to tackle prejudice on many levels.

Storytelling is particularly helpful in the context of family support, as John Taylor discovered when he suggested the idea to his clients at the DAWS Family and Friends service. He found that many had even stopped talking to people closest to them and were working through their trauma alone. Tapping into this form of peer support can offer a valuable source of strength that deserves our encouragement.

As the year comes to a close, conference season has been in full swing and we have reports from HIT Hot Topics (page 12) and the GPs' conference (page 16). Our write-up of the LJWG's event on hepatitis C will be in our next issue. The themes may be recurring but there are many new ideas, fresh inspiration and invigorating debates. At HIT there was an interesting discussion about the 'othering' of people in society and an invitation to re-examine preconceptions.

And in this spirit of contemplation, we reflect back on another year of cuts and chaos, where we have felt powerless to halt the rise of drug and alcohol-related deaths. But we are also reminded of some important things that make a difference – strong harm reduction, good commissioning, and a commitment to learning from each other.

I hope you enjoy a safe and peaceful festive season and we'll be back for the February issue. Keep in touch with us over the break – and don't forget to secure your ticket to the DDN conference on 21 February!

Claire Brown, editor

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

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website:
www.drinkanddrugsnews.com

Website support by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by GMVozd/iStock

DDN is an independent publication, entirely funded by advertising.
Proud to work in partnership with:
addaction · Blenheim · Release · NHS Substance Misuse Provider Alliance · Alcohol Research UK · fdap · Adfam · Social Interest Group · INTUSA · Phoenix Futures · cgl · Alcohol Concern · SMMGP · Turning Point

‘HEALTH APPROACH’ FOR NEW SCOTTISH DRUGS STRATEGY

SCOTLAND’S NEW DRUGS STRATEGY will take a ‘health approach’ and address wider problems such as housing, mental health, family support and employment, the Scottish Government has announced. *Rights, respect and recovery* also aims to ensure that services ‘treat people as individuals’.

The document replaces the 2008 strategy *The road to recovery*, and follows the new *Preventing harm* alcohol framework (see facing page). The Scottish Government will produce an action plan for the strategy early next year, it states. This year saw Scotland once again record its highest ever number of drug-related deaths, at 934 (*DDN*, July/August, page 4), with its fatality rate the highest of any EU country.

The strategy takes a ‘human rights-based, person-centred’ approach, with a focus on those who are most at risk. Families will receive proper support and ‘be closely involved in their loved ones’ treatment’, while people who use drugs will also be diverted from the criminal justice system ‘where appropriate’. The strategy also places an emphasis on education and early intervention for young people and those at risk of developing problems.

Stigma remains a significant issue, it says, and ‘needs to be challenged across the sector and society’, with integration of services also requiring improvement. While the Scottish Government remains supportive of consumption rooms ‘in response to clear evidence of need’, allowing them would require legislation from Westminster. ‘The Scottish Government will continue to press the UK Government to make the necessary changes in the law, or if they are not willing to do so, to devolve the powers in this area so that the Scottish Parliament has an opportunity to implement this life-saving strategy in full,’ the document states.

‘Improving how we support people harmed by drugs and alcohol is one of the hardest and most complex problems we face,’ said public health minister Joe FitzPatrick. ‘But I am clear that the ill health and deaths caused by substance misuse are avoidable and we must do everything we can to prevent them. This means treating people and all their complex needs, not just the addiction, and tackling the inequalities and traumas behind substance misuse.’ The strategy would be supported with an ‘additional £20m a year on top of our considerable existing investment in drug and alcohol treatment and prevention’, he stated. ‘We want to see innovative, evidence-based approaches, regardless of whether these make people uncomfortable. This money mustn’t just produce more of the same.’

‘I am clear that the ill health and deaths caused by substance misuse are avoidable.’

JOE FITZPATRICK

The focus on reducing ‘preventable overdose deaths’ was welcomed by the Scottish Drugs Forum (SDF). Deaths had ‘doubled over the period of the last strategy’, said SDF CEO David Liddell, and the new document contained key elements that could help to respond to what amounted to a ‘public health crisis’, such as faster access to opioid replacement therapy and cutting the numbers of people ‘forced out, or allowed to otherwise drop out’ of treatment. ‘Only time will tell whether this is effective but the indicators of success or failure will be clear and stark, and thousands of Scots’ lives depend on it,’ he said.

Strategy document at www.gov.scot

HEADS DOWN

THE CLOSURE OF ‘HEAD SHOPS’ since the implementation of the Psychoactive Substances Act has seen a ‘large-scale shift away from retailers’, says a government review, with street dealers now the main source of NPS – particularly synthetic cannabinoids. ‘This blanket ban was supposed to cure the UK’s “legal high” problem, including Spice,’ said Transform’s Martin Powell. ‘But as experts warned before the new law was implemented, beyond the cosmetic success of ending legal sales in head shops, little positive has been achieved.’

Review of the Psychoactive Substances Act 2016 at www.gov.uk

‘Little has been achieved’.

MARTIN POWELL

DEADLY DRINKING

LAST YEAR SAW 7,697 ALCOHOL-SPECIFIC DEATHS in the UK, according to the latest ONS figures, with death rates highest among 55-59 year-old women and 60-64-year-old men. While Scotland continues to have the highest rate of alcohol-specific deaths, it has also been the only UK country to experience a ‘statistically significant’ reduction since 2001. Scottish men, however, are still twice as likely to die from alcohol-related causes as those in England. Widening the scope of deaths related to alcohol consumption, however, puts the English figure at more than 24,000, according to PHE.

Alcohol-specific deaths in the UK at www.ons.gov.uk

FOBT OFF

THE GOVERNMENT HAS ABANDONED ITS PLANS to delay the reduction in the maximum stake on fixed odds betting terminals (FOBTs) from £100 to £2, following a rebellion by MPs and the resignation of sports minister Tracey Crouch. While the reduction was announced earlier this year (*DDN*, June, page 4), in her resignation letter Crouch stated that the original decision to delay its implementation was ‘due to commitments made by others to those with registered interests’.

CONSUMPTION CASE

THE GOVERNMENT HAS REITERATED ITS OPPOSITION to the opening of a drugs consumption room (DCR) in Glasgow, following a letter from the Drugs, Alcohol & Justice Cross-Party Parliamentary Group setting out the case for a DCR in the light of record drug deaths (*DDN*, July/August, page 4). ‘Our position on DCRs has been clear for some time: we have no plans to introduce them,’ said crime minister Victoria Atkins. Consumption rooms did not form part of the drug strategy’s approach of ‘preventing drug use in our communities’, she stated, with the government ‘not prepared to sanction or condone activity that promotes the illicit drug trade and the harm that trade causes to individuals and communities’.

CAPTURED CANNABIS

SEIZURES OF HERBAL CANNABIS ROSE by more than 140 per cent in 2017-18 compared to the previous year, according to ONS statistics, while cannabis resin seizures increased by more than a third. The volume of crack seized was also up by 64 per cent, to 64kg. Overall drug seizures were down by 2 per cent on the previous year, however, the sixth consecutive annual fall.

Seizures of drugs in England and Wales, financial year ending 2018 at www.gov.uk

SCOTS LOOK TO BAN TV ALCOHOL ADS BEFORE 9PM

THE SCOTTISH GOVERNMENT'S NEW ALCOHOL STRATEGY includes a range of plans to tighten marketing regulations. The Scots will 'press the UK government to protect children and young people from exposure to alcohol marketing on television before the 9pm watershed and in cinemas – or else devolve the powers so the Scottish Parliament can act,' states *Alcohol framework 2018: preventing harm*.

Alcohol misuse now costs Scotland £3.6bn per year, the equivalent of £900 per adult, says the document, which also includes proposals to consult on alcohol marketing in public spaces and online. The 50p minimum unit price will also be reviewed after 1 May 2020, it says, while alcohol producers will be urged to include health information on labels.

The framework also states that while the government will work with the drinks industry on projects that 'can impact meaningfully on reducing alcohol harms' it will not do so on health policy development, health education or health messaging campaigns – Public Health England's recent partnership with industry-funded body Drinkaware proved highly controversial (*DDN*, October, page 5).

'Our new alcohol framework sets out our next steps on tackling alcohol-related harm,' said public health minister Joe FitzPatrick. 'We need to keep challenging our relationship with alcohol to save lives. These new measures build on the progress of our 2009 framework which has made an impact by tackling higher-risk drinking, but we want to go further. Scotland's action is bold and it is brave and, as demonstrated by our world-leading minimum unit pricing policy, we are leading the way in introducing innovative solutions to public health challenges.'

There was 'strong support' from the public to limit alcohol marketing and clear evidence that 'exposure to marketing drives consumption by children and young people,' said chief executive of Alcohol Focus Scotland, Alison Douglas. 'We believe plans to consult on alcohol marketing restrictions are a positive step towards protecting the vulnerable and challenging alcohol's prominent role in our society. Likewise, we are pleased to see that the Scottish Government are committed to improving alcohol labelling. It is clearly unacceptable that more information is required on a pint of milk than a bottle of wine.'

Meanwhile a new report from Manchester Metropolitan University and Aquarius urges health and social care practitioners and substance use professionals to 'rethink the needs of older people with drinking problems'. Increasing numbers of older people are drinking to 'harmful or mildly dependent levels' says *Older people and alcohol: a practice guide for health and social care*.

'Exposure to marketing drives consumption by children and young people.'

ALISON DOUGLAS

'Older people seeking treatment for alcohol use are often in poor health and have a range of complex social, health and other care needs associated with their substance use,' said professor of adult social care at Manchester Metropolitan University, Sarah Galvani. 'Evidence suggests that the complex health and social care needs of older people with problem alcohol use require a different approach.'

Alcohol framework at www.gov.scot
Report at www2.mmu.ac.uk

ALL CHANGE

A NEW ALCOHOL CHARITY has been launched following the merger of Alcohol Concern with Alcohol Research UK (*DDN*, April 2017, page 5). Alcohol Change UK's mission is to 'significantly reduce serious alcohol harm in the UK', it states, with an aim of creating 'five key changes' of improved knowledge, improved drinking behaviours, shifted cultural norms, better policies and regulation, and more and better support and treatment. 'Too often, we in the UK remain blind to the sheer scale of serious alcohol harm taking place across our communities,' said CEO Dr Richard Piper. 'This harm is massive, but it is not inevitable and it's not acceptable. Alcohol Change UK's name, identity and deeply held values reflect this fundamental belief.'
www.alcoholconcern.org.uk

'We remain blind to the sheer scale of serious alcohol harm.'

DR RICHARD PIPER

COUNTY CONCERNS

ALL CHILDREN, not just the most vulnerable, are at risk of criminal exploitation, says a new county lines report, and agencies should 'not underestimate the risk of criminal exploitation in their areas'. The report, from Ofsted, CQC, HMI Probation and HMI Constabulary and Fire & Rescue Services, stresses the importance of learning from past mistakes. 'Tackling child criminal exploitation, including county lines, is a big challenge for agencies and professionals nationally and locally,' said Ofsted's national director for social care, Yvette Stanley. 'Agencies must make sure that they have the building blocks in place to work quickly and effectively.'
Protecting children from criminal exploitation, human trafficking and modern slavery at www.gov.uk

DRINK MYTHS

AN ALCOHOL-FREE CHILDHOOD up to 18 is 'the healthiest and best option' and if children are going to drink it should never be before the age of 15, says Balance's *What's the harm* campaign. It is a 'myth' that allowing children to drink at a younger age makes them less curious about alcohol, the charity states. 'People mention the French way of giving children alcohol,' said Balance director Colin Shevills. 'But France actually has twice the rate of alcohol dependence than the UK.'
www.balancenortheast.co.uk

SMALLER STAKES

MORE 11-16-YEAR-OLDS had spent their own money on gambling in the past week than had drunk alcohol, taken illegal drugs or smoked cigarettes, according to a Gambling Commission report. Stronger partnerships between regulators and businesses are needed to protect children, says *Young people and gambling 2018*. Just under 2 per cent of 11-16 year olds are classed as 'problem gamblers', with 2.2 per cent considered 'at risk'.
Report at www.gamblingcommission.gov.uk

GET TESTED

PHE AND NHS ENGLAND have launched a nationwide exercise to identify and treat people who have previously been diagnosed with hepatitis C. While almost 25,000 people in England have accessed new treatments over the last three years – 95 per cent of whom were cured – 'tens of thousands' who were diagnosed in the past may not have done so. 'If you have been at risk of contracting hepatitis C, particularly through injecting drugs – even if you injected only once or in the past – then I urge you to get tested,' said PHE clinical scientist Dr Helen Harris.
Hepatitis C treatment monitoring in England at www.gov.uk

Katie's experience of stigma made her determined to help herself and others – the beginning of Adfam's *#StigmaMakesMeFeel* campaign. She shares her story

Finding a voice

My older brother has been addicted to class A drugs for the past 17 years. I was 12 years old when he began using drugs, and my younger brother was just ten. Needless to say, his addiction has affected my family in every way possible, but perhaps the worst part was how other people treated us – all because of the stigma surrounding drug addiction.

The stigma was ridiculous – nobody wakes up in the morning and says 'I think I'll become an addict today'. Yet why does it prevent so many people from speaking out?

Is it because they're worried that people will judge? Of course. Is it because people are worried that others will think they're an addict? Perhaps. Does it mean anyone has failed? Absolutely not. Does wider society realise the anguish that comes with having somebody who is addicted in the family? No. These are questions that I have been asking for 17 years now.

The first time I experienced stigma was when I was 13 years old. The day before we had had a horrible 'post-high comedown' drama with my brother. He was incredibly violent and the police were called – and of course being in a small village, that meant that our neighbours watched the drama unfold.

While I was looking at the magazines in the village post office, treating myself to an escape for the afternoon, I overheard three fellow villagers saying, 'I don't want a family like that in the village, I don't want my children growing up surrounded by drug addicts.'

I calmly walked around the corner and corrected their perception, making it quite clear that my family were not a 'bunch of addicts', but incredibly hardworking and respectable people who were going through tremendous pain and heartbreak supporting someone with an addiction, and that they should be ashamed of themselves for being so naïve. I didn't get an apology, but was met with rather embarrassed looks and silence. After that day I never returned to the shop.

That's why Adfam is so important to me. Stigma has had a huge impact on me – it silenced me for 16 years, and those who know me, know I am not easily silenced!

All the years of not being able to speak openly about something that has several times come close to destroying my family and me was released, and I am incredibly grateful to Adfam for giving me the confidence to speak out against stigma. I hope this campaign will not only bring people together, but go some way for us, as a group, to have a voice and influence policy.

Through *#StigmaMakesMeFeel* we are determined to help others and get our voices heard.

Strength in narratives

Helping families and friends to tell their stories has been an effective way to offer support, says John Taylor

I was reading a recovery stories book, full of inspirational stories of how service users found recovery from substance misuse. With that in mind, I thought 'what about the people around them – their families and friends? Do they not need some form of recovery and for their stories to be told?'

I started to ask my clients at the Daws Families and Friends service if they would be willing to tell their stories about how they found their own recovery with a 'loved one' in addiction, and the response I got was both positive and quite remarkable. Many said they would like to tell their story to help someone else to feel less alone.

Most felt when they came into the service that they were all alone in dealing with their loved one's addiction and that they couldn't tell anyone about what was happening in their life because they feel so much guilt and shame – hence it becoming a 'family illness'.

They stopped talking to people closest to them because they felt sick of talking about the same old stuff or they had received advice that wasn't useful to them, such as 'kick them out' and 'don't have them in your life'. They felt that those around them didn't understand about addiction and were quick to judge, adding to a sense of shame.

This is exactly why groups can work so well for

More on family support at www.drinkanddrugsnews.com

Adfam has embraced the opportunity to talk openly about stigma, says **Robert Stebbings**

Gaining momentum

Stigma has been a prominent theme for us at Adfam and something that we frequently encounter in our varied work supporting families affected by alcohol or drug use.

One family member spoke to us about how stigma is 'like being labelled with a big invisible sign that I can't see but others can'.

This isn't good enough. Families should feel able to talk about their experiences openly and live their lives without fear of judgement from others. Often stigma isn't malicious or deliberate; it's due to people misunderstanding the issue and what families are going through. That's why we have launched *#StigmaMakesMeFeel* – a campaign that gets stigma out in the open and tackles it face on.

We're aiming for 1,000 photos of people with our campaign boards writing their own personal messages of how stigma makes them feel and how it's impacted on their lives.

By talking about this issue openly and honestly, we believe we can make a huge impact and change the way people think about substance use and the families affected.

Since our launch earlier this year the response has been fantastic, with people across the country sending us a range of powerful and inspiring photos and messages.

How does stigma make you feel? You can get involved in our campaign to raise awareness of stigma experienced by families affected by drugs and alcohol through three simple steps:

1. **Download and print off our campaign board (pdf)**
2. **Write your own message on how stigma makes you feel**
3. **Take your photo and tweet it using the hashtag *#StigmaMakesMeFeel* (or email it to us at admin@adfam.org.uk)**

'By talking about this issue openly and honestly, we believe we can make a huge impact and change the way people think about substance use and the families affected.'

'affected others' just as they can support people tackling their own addiction. You can be with people who are just like you, get identification and lose the feelings of judgement and shame. It takes away the isolation that can come with addiction and make people unwell.

The result of this project to share experiences, the DAWS Families and Friends Recovery Stories book, is about these forgotten victims of addiction – people who rarely have a voice and who are often supporting loved ones to access treatment and find recovery from substance misuse.

My clients who attend DAWS have loved ones who might be in treatment or might not; they might be in their lives or they might not. Whatever the circumstance, if someone has been affected by another's substance misuse, they are welcome. In some cases their loved one has passed away as a result of addiction and they are left with the trauma. More than ever, they need support to help them process the loss that they are going through and they often experience a debilitating sense of guilt.

At DAWS we help them to explore how they are processing their thoughts and feelings. Our 12-week rolling programme covers setting boundaries, self-care, healthy relationships, looking at anger, building up resilience and social networks. The first half of the programme is a process group, where we work with whatever is brought up by clients.

The strength and courage that the families and friends show on a daily basis amazes me, and this shines through the book. These are stories of how people are watching their loved ones on a destructive path and unfortunately often end up on the path with them.

It's so very important to remember how substance misuse affects so many others around that one person. Figures from Adfam state that for every person in active addiction, eight people around them are likely to be affected. This highlights the problem we have and also shows how important it is for these people to get support and have their voices heard.

John Taylor is DAWS family and carers lead. The Drug and Alcohol Wellbeing Service (DAWS) is run by Blenheim and Turning Point.

Read the Recovery Stories book at https://bit.ly/2AUexFQ

Meaningful service user involvement is about give and take, says **Mark Pryke**

AN EQUAL PARTNERSHIP

MY ROLE IS TO HELP INCREASE OPPORTUNITIES AND CHOICES FOR SERVICE USERS. The more options we can offer people in terms of their treatment and structured activities, the more likely they are to choose one.

We want to avoid things being done to people, so the development of services should be an organic process – it's all about collaboration. I enjoy hearing about service users who have stood up and said, 'you need to hear this'. It's important to be receptive when a service user wants to say something and needs an answer.

People sometimes misinterpret service user involvement (SUI), believing it to mean that service users can have anything they want. In practice, because of regulations, safeguarding and resources, we can't always respond to every request as service users would like – but what we can do is give honest and frank reasons why we can't take an idea forward. This helps people to understand the reasons why they don't always get what they ask for.

I help people to share stories about what their challenges were and how they got round them. This can be incredibly motivating to tell and hear. I also attend communities and partner meetings – sharing the SUI approach and the ways it can be used to create positive change.

We need to make sure that the service user involvement feedback loop works effectively. Service users participate in surveys and changes, but often they don't hear what's happened to their input or the outcomes and results. This devalues the system. So when we have an outcome, we need to share it.

Anyone can be a service user rep and often they are ex users of the service. Reps support a more flowing and honest conversation as a staff presence may influence service user responses. You are more likely to share your story with someone like you. The regional SU councils come together to discuss and share resources, and the network helps people to talk to others in a safe and supported way.

Our services attract people from many different backgrounds, enabling us to access a massive bank of information – people with a wealth of knowledge and experience to whom we can ask questions and vice versa, and whose experience and creativity can help other people overcome their challenges. Service users get fulfilment from giving back and knowing they, and their opinions, are valued too.

Their feedback can also influence practice. Last year we became aware that service users were having difficulty getting their medication if they moved away for a few weeks or went on holiday – their prescription needed to go with them. Service users would come in say, 'I'm going on holiday on Monday and I need my prescription sorted,' and wouldn't be happy that we'd need more time.

To help resolve this we developed a 'Going away on holiday' poster to make it clear we needed four weeks to make arrangements for them to continue their treatment. We consulted on the poster with regional services and our national service user committee and the feedback helped us develop a clear visual and catchy strapline that tackled the problem effectively.

We've also redesigned our waiting areas, adding toys for people who need to bring along their kids and bike racks so people can cycle. Suggestions come through at a local level and then managers decide what's most appropriate for their service.

We should be asking questions in the places where service users go. We need to reach out using methods that are engaging, and improve our digital offer. People don't want to give their time without seeing the benefits or receiving some other type of incentive. It's got be reciprocal.

Meetings should be structured so service users can talk about what's affecting them and not have the agenda set for them. The agenda needs to emerge as part of the natural conversation so that they feel like they own that meeting.

'I help people to share stories about what their challenges were and how they got round them.'

Service user feedback can make a difference straightaway. For instance, in Gateshead we asked service users why they might have missed their appointments. One of the many people who had to travel right across the city to get to the service said, 'It's going to cost me a tenner to get the bus and it might not even turn up, so I have to get a taxi and on my way to the bus stop I've got to walk past the dealer or the off licence. So realistically where's that tenner's going go?' Staff realised the Tesco superstore next to the service had a community bus that did a regular circuit, so they made sure service users were given appointment times that coincided with the bus timetable. Everybody wins.

We try and tailor services to meet service users' needs but these often change and we're learning all the time that we need to facilitate options and choices. There are still many cohorts of service users who we'd like to hear from, such as individuals who access our street outreach services. We can't shirk the challenge. Instead we can work towards this in little steps, so it's meaningful.

Mark Pryke is national service user lead at Change, Grow, Live (CGL)

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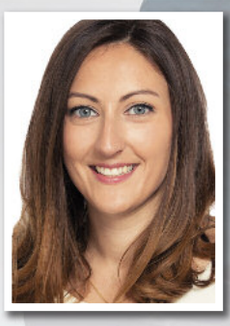


The right to challenge

Know your ground when contesting CQC inspection reports and ratings, says **Samantha Cox**

CQC now has the power to rate independent standalone substance misuse services and is currently rolling out its first wave of comprehensive inspections to establish a ratings baseline for future inspections. This is the first time such services are being rated by CQC. Adverse ratings can have a negative impact on the financial and operational viability of provider services and it is therefore vital that CQC get it right.

Providers are afforded the opportunity to challenge the content and ratings of an inspection report through official routes set out in CQC guidance. This includes the factual accuracy and rating review processes, which are set out in more detail below. Other potential routes of challenge include complaints to CQC and judicial review.

FACTUAL ACCURACY CHALLENGES

It is important for providers to challenge factual inaccuracies and misleading comments presented in draft inspection reports, to ensure an accurate picture is communicated with the public. If errors are not challenged, these will be deemed to be correct and any perceived areas of non-compliance with the regulations can lead to the requirement for the production of action plans or, in more serious cases, use of CQC enforcement action. Providers should therefore ensure they read their draft report thoroughly and, where relevant, ensure challenges are raised with CQC through its formal factual accuracy comments (FAC) process.

Once a draft inspection report has been received, providers have ten working days to submit any FACs to CQC. CQC provides a FAC table for providers to populate with relevant comments.

Providers should be aware that as well as challenging the accuracy of statements, they can also challenge judgements (including alleged regulatory breaches) and ratings through the FAC process, particularly if factual errors have been relied on to inform judgements. Where possible, providers should be supplying evidence to support their assertions.

FACs will be considered before the report is finalised and published on CQC's website. CQC will respond to the provider with a written response to any FACs, and the final inspection report is usually published within a couple of days of communication of its findings.

However, there is no clear consistency in when reports are published, and we have seen instances where publication has taken place on the same day the FAC response was sent to the provider and before the provider has had the opportunity to review the response. Ridouts has previously taken issue with this process as CQC's rush to publish reports can have an adverse impact on providers who are considering further legal challenge, for example through judicial review.

RATING REVIEW PROCESS

The second, and final, official route of challenge to inspection findings is CQC's rating review process. This can only be requested after publication of the final inspection report. Therefore, the report will already be in the public domain before a challenge has been considered. Consequently, for providers who want to avoid misleading ratings being published in the first place, the FAC process is crucial.

CQC requires providers to inform them of their intention to submit a rating review request within five working days from the date of publication of the report. Providers must submit their full, detailed request for a review of ratings within 15 working days of publication of the report.

The rating review process is very limited in its remit. It does not re-consider any factual disagreements or disputes over CQC's judgements. CQC is clear that the only grounds for requesting a rating review is that they have failed to follow their processes for making ratings decisions (*ie* the application of the ratings characteristics to CQC's findings as displayed in the final report). This process can be difficult to demonstrate and published CQC figures on the success of rating review challenges show that the vast majority of such challenges fail.

> 'Providers should ensure they read their draft inspection reports thoroughly and raise any challenges within CQC's set FAC timeframe.'

STAYING AHEAD

To avoid the potential adverse impact of having an incorrect inspection report placed in the public domain, providers should ensure they read their draft inspection reports thoroughly and raise any challenges within CQC's set FAC timeframe. This will ensure that any disagreements with evidence and judgements are on the record. Even if the FAC process does not produce the desired result, this could assist with any future arguments as to CQC's judgements and potential enforcement action. Following the receipt of an FAC response, providers should consider whether they wish to pursue submitting a rating review request, depending on the facts of the case.

At Ridouts we are experienced in supporting clients with challenges to draft inspection reports, and empower them to challenge CQC when a report is not truly reflective of their service.

Samantha Cox is a solicitor at Ridouts, a specialist law firm that has a core expertise in health and social care law, www.ridout-law.com

CZAR GAZING

As deputy drug czar for the Blair government, **Mike Trace** oversaw the expansion of today's drug and alcohol treatment system. In the first of a new series, he gives his personal view of the successes and failures of the past 20 years, and the challenges the sector now faces.

1. The golden years

IT IS HARD TO IMAGINE THESE DAYS, but from 1997 into the early 2000s, we had a government that saw drug policy as a top-level priority, that accepted the argument that treatment was the most cost-effective response and was willing to spend money on a nationwide system aimed at reducing the crime, health and social problems associated with problem drug use.

I had the privilege of working for the wonderful Mo Mowlam at that time, a period where we increased spending on drug treatment from around £200m to over £800m per year (it reached over £1bn by 2005). We sent this money to local drug action teams (DATs) with pretty tight guidelines on the range of services to commission, and set up the National Treatment Agency (NTA), to oversee spending and delivery.

With the benefit of hindsight, there are many things we could have done better, but the basic intention was sound – to offer a national system of care and treatment to marginalised people struggling with drug problems, with the aim of reducing drug-related crime, deaths and infections. We also hoped that this policy would help some of the most marginalised and stigmatised people in society to turn their lives around.

We wanted local partnerships to develop drug treatment *systems* (replacing a patchwork of unconnected services), consisting of a 'menu' of services that delivered four functions – supportive outreach and immediate care to encourage users in to contact with services; consistent case management and one-to-one advice; substitute prescribing for those dependent on heroin; and a range of options to motivate and facilitate recovery. We also developed specific procedures to channel users into treatment from the criminal justice system (arrest referral, drug treatment and testing orders, prison programmes).

The vision was of a well-funded national framework of health and social support to a marginalised and stigmatised group, to help them stay alive and healthy, and make positive changes to often harsh lives.

We know that, in the last ten years, the national political commitment to this strategy has dissipated, the NTA has closed down, the responsibility for sustaining it has been passed to local authorities, and the amount of funding available has gone down by at least a quarter. In this series, I want to ask the big questions - how much of our original vision has survived, did it achieve its objectives, how well has the sector managed the downturn to protect what matters, and how can we tackle the challenges we face now?

Mike Trace is CEO of Forward Trust

PARLIAMENTARY GROUP

HAVING THE VISION

Good commissioning goes beyond purchasing, hears **DDN**

A ROBUST DISCUSSION ON COMMISSIONING was the focus of the year's final meeting of the Drugs, Alcohol and Justice Cross-Party Parliamentary Group.

'The focus has been on austerity and shrinking funding, but the demand for our services has certainly not decreased,' said WDP chair Yasmin Batliwala, who gave a provider's perspective. Doing more with less meant that providers had to be innovative and 'think outside the box'. In turn, commissioners 'must give providers the best chance of success' by addressing inconsistency and subjectivity in tenders, she said.

Commissioning varied enormously from area to area, and a commissioning ombudsman (as proposed in the recent *Charter for Change*) would help to encourage standardisation, including minimum-term contracts, and 'eliminate questionable decision-making'.

All too frequently immediate cost savings were not taking into account longer-term investment, such as provision for youth services and healthy-living interventions. 'Since the NTA went, we assumed more wellbeing would be added to contracts, but this hasn't been the case,' she said.

'Too often commissioning falls to purchasing, but it's a design job.'

Mark Gilman had worked in the sector for 35 years before setting up the Expert Faculty of Commissioning with colleagues, as 'we were concerned we were losing the memory of commissioning and wanted to keep a repository of expert knowledge'. The faculty already works with around half of local authorities that commission drug services and aims to promote best practice.

'Too often commissioning falls to purchasing, but it's a design job,' he said. 'It's about having the vision to say, "What's the problem, who's in pain, and what should we do about it?"'

The most important thing was to get those who were not in treatment into treatment – 'and you get this if you give them a free opioid. Until sanity breaks in the war on drugs, give them OST... they want to get, as quickly as possible, a drug that keeps them alive.' The rise in polydrug use and the increase in drug-related deaths intensified the need for commissioners to understand this.

Anthony Bullock, drug and alcohol commissioner from Staffordshire, had been working with the faculty to share good practice. Among his recommendations were to make sure the narrative was much clearer: 'There are so many nuances to addiction and recovery – what is it we want to achieve?' Alongside this, we needed to shift the mindset 'from funding to investing' and 'be able to demonstrate the value of what we do'.

Treatment meant different things to different people and it was important to recognise that different elements were needed, including peer support. 'Our job as commissioners is to collaborate and coordinate,' he said. 'We need to support services to work together and have support around them.'

In the discussion that followed, Pete Burkinshaw, PHE's alcohol and drug treatment and recovery lead, commented that it was important not to generalise in associating bad practice with all commissioning, and that we needed to be 'careful, nuanced and precise.' **DDN**

The theme of this year's Hit Hot Topics conference was 'The Road Ahead'. As each speaker began to explore the theme, it became obvious that we needed to talk about the obstacles in our way. Pics by *Nigel Brunsdon*

DRIVING CHANGE

Drug law enforcement was bound to be at the top of the agenda for a conference that cares passionately about harm reduction. While drug use was 'ubiquitous, right across the population', drug law enforcement was 'a tool for social control', said Niamh Eastwood, executive director at Release. Furthermore, it had before a weapon against the poorest and most vulnerable, designed to 'push people out there'.

'We have to call out the "othering" of people in society,' she said. 'We have to end criminal sanctions for people in possession of drugs' and instead look at helping them back up into housing and stability.

Writer and researcher Imani Robinson asked us to think about the world we were born into. 'We're taught to give our trust and to normalise particular things. We believe what is told to us about drugs,' she said. 'Think about a time when you felt safe. Did anyone think about police, prisons and surveillance? Yet this is the narrative – that we need these things to feel safe. We normalise these ideas.'

The narrative had become contaminated with racism – not just structural racism, but internal racism, where you are 'born into a world that tells you are better' – 'a whole system of power and privilege'.

'You can't talk about drug policy reform without talking about racial justice because they are the same,' she said, and there was much to do on every level. 'Myths are used to tell children they're going to die if they take drugs. We act as if this is real, and that punishment is the best approach to deal with harm and violence.'

To make any progress we needed to take 'a level of stepping back and realising who we are'.

Neil Woods, chairman of the Law Enforcement Action Partnership (LEAP UK) brought particular experience to the argument for urgent drug law reform. As a former undercover drugs detective sergeant, he had come across corruption driven by the drugs black market 'a great deal' within the police force – of which the public knew little.

The only way to change the shape of this market was to accept the need for a radically different approach.

'At the beginning of the 1960s there was no organised crime related to drugs,' he said. 'If people had a problem they got help, and there was no association with theft. We've gone from the prescription pad to the hand grenade.'

A high proportion of drug crime was driven by people who used heroin – 'so the logic of using heroin-assisted treatment is that you take half of the market from organised crime, just like that.' County lines were mainly about the heroin market, 'so if you prescribe heroin you take away half of the market that drives child exploitation,' he said.

Woods believed we needed to be bold in our actions, adding 'history will judge society in the same way as we judge slavery or the treatment of homosexuality.'

'Prohibition lies need to be exposed and challenged,' said researcher and activist Julian Buchanan, who built the case for a human rights approach.

'There's never been a global drug problem, but a global drug policy problem,' which needed to be confronted, he said. Our attitudes and prejudices were built on a 'social construct'. 'Drug free' didn't exist because 'we all use drugs'. Alcohol, tobacco, caffeine and sugar had 'become the components of every social event' and as state-approved substances, were 'untouchable'. The idea of banning drugs was based on 'propaganda and racism'.

'Prohibition likes to blame drugs for cartels and gangs but they are only the inevitable outcomes,' he said. Prohibition targeted the poor, the indigenous, people of colour. It undermined public health, encouraged hostility and stigma, increased crime, facilitated lucrative markets and overcrowded prisons. It was an ideologically driven system of oppression, he said.

But when we were calling for legalisation, we needed to be clear about the model we were talking about. 'We must be united in our push to decriminalise all drugs – a simple step that could be enacted quickly, with little cost. This would enable us to explore full legalisation,' he said. 'All drugs should be made available at pharmacies and off-licences, and then through cafes, bars, restaurants and major events. It sounds like uncharted territory, but it isn't. Alcohol is a state-approved psychoactive drug.'

'We can do a better job of living with drugs,' he added, and changing the law would lead to 'wiser and better-informed choices'.

The distinction between decriminalisation and legalisation was demonstrated by Jay Levy, policy and advocacy officer at INPUD, who described the situation in Portugal, 17 years after decriminalisation. INPUD had held a consultation with the drug user community in Porto, and had found that there had been 'demonstrable improvements in public health', including a 'considerable' drop in drug-related deaths and a decrease in the prevalence of HIV.

'The lens has shifted from criminalisation to health,' he said, but the decriminalisation was only partial, with limits set. Drugs in Portugal were still not legalised, so drugs were still bought and sold on the black market, with their strength and ingredients unknown. So while Portugal was 'distinctly safer' for people who use drugs, with 'less violence, harm from police and stress with dealers', the situation was 'complex and nuanced'. Police could still stop and search, and there was still a mandate to confiscate drugs – even if it was just one dose for personal use, which wasn't a crime, but 'really problematic for people with little money'.

So while incarceration had given way to dissuasion, this different narrative was not benign. There was a new kind of stigma in focusing on drug use as a health issue. Before people who used drugs were criminals; now they were 'sick and unhealthy, needing some type of intervention and deviant in some way'.

So while a change in the law was 'an important first step', it was 'not a magic bullet and shouldn't be the end point in our advocacy,' he said. 'People like uncomplicated narratives, but people take drugs for lots of reasons.'

Creating the right kind of narrative was central to Fiona Gilbertson's work at Recovering Justice. As co-founder, she had spent time lobbying politicians and trying to bring people together to talk about policy reform. Much of the time she had been 'trying to engage with prejudice' to bring about change, and had realised that the best tool was the voice of personal experience.

'I'm tired of people not listening to each other,' she said. We needed to create spaces so people could make choices without being 'consigned to criminalisation'. 'Having conversations will be key – about freedom from oppression and stigma, a movement for peace,' she said. 'Recovery is a vibrant social movement – not about the absence of drugs, but about the presence of community. How we engage with it is up to everyone in this room.' **DDN**

See more of Nigel Brunsdon's work at nigelbrunsdon.com

Tackling public opinion

How can we help to challenge outdated narratives?

JOSHUA HADDOW is a filmmaker and journalist who has worked on the BBC series, *Drug Map of Britain*. Engaging with the people filmed for the series had helped him to understand their lives and made him think carefully about how to convey the truth of each person's situation.

'When you report on anything you have to make a decision – including whose story to tell in the first place,' he said. 'Humanising people who use drugs, and therefore their experiences, is the opportunity you have when you turn the camera on.'

But there was a great deal of vulnerability and journalists ran the risk of stereotyping, he said. Drugs in the media were 'either scandal or hush hush', but we needed to go beyond the end point of an article being 'she was on drugs'.

The best a journalist could do was to say, 'this is what I found'. And the value of personal stories was immeasurable in bringing truth and insight to the report, he said, adding 'if a reporter calls you, it could be a chance to change someone's life.'

Working as communications officer with Open Society Foundations had given Alissa Sadler many opportunities to explore effective ways to connect with difference audiences about harm reduction.

She offered a simple framework called GAME, to help a more strategic approach to communications.

G was for goal – what are we trying to do, where are we trying to get to, and what needs to happen next? 'It should be like a tube map, with stops along the way.'

A was for audience – who are we trying to get to, who do we need to talk to to get to the next stage? 'Profile them, meet them where they're at, bring them along.'

M was for messaging – what do we need to say to people? 'Hit the heart with the story, the head with the data, then take the hand to move them along.'

E was for evaluation: something to think about before you roll out communications. 'You need to constantly evaluate what you do, and if it's not working, change it.'

BEYOND THE

Prisons have a unique opportunity to introduce a life-saving naloxone strategy, so is the message getting through? **DDN** reports

Naloxone saves lives, and for people leaving prison it can be a vital component in their survival kit. We know that the first few weeks following release carry a much higher risk of dying from a drug-related overdose, as tolerance is low while the availability of drugs in social situations returns.

Despite the strong link with unacceptably high drug-related death figures, there has been an absence of clear strategy and accountability. Both Public Health England and the government have recommended that local areas need to have naloxone provision in place, but when John Jolly reviewed the situation in July (*DDN*, July/August, page 14), he found that it was rare for any of Blenheim's service users to have been provided with naloxone on release from prison.

Jolly investigated further and found that of the 36 prisons in England and Wales claiming to give out naloxone on release, many were failing to give out kits, citing 'operational difficulties'.

Since Jolly's research, the government has responded to parliamentary questions from Grahame Morris MP, stating that new data on prisons issuing naloxone is being collected and is 'expected to be published in January 2019'. Apart from that, any progress depends entirely on regional interest, with a continued lack of engagement on the issue from NHS England, according to Jolly.

'There is no national oversight and accountability for providing take-home naloxone to people released from custody,' says Zoe Carre from Release, adding 'It is therefore crucial that every prison strategy includes take-home naloxone programmes.' Many unnecessary deaths could be prevented if all prisons adopted the strategy, but 'while some prisons are leading the way, sadly others are still not making this life-saving medication available,' she adds.

In Scotland, where a naloxone programme was made an important part of public health policy in 2011, there has been effort to adapt to the challenges of making it a part of prison culture. Naloxone kits are given to people at risk of overdose, or likely to witness overdose, on release from all 15 prisons in the country.

'This is a crucial component of the programme due to the increased risk or overdose for individuals within the first four weeks of release,' says Kirsten Horsburgh, strategy coordinator for drug death prevention at the Scottish Drugs Forum (SDF). The results speak for themselves: 'The percentage of opioid-related deaths within four weeks of prison release is substantially lower now that it was pre-implementation of the programme,' she says.

The programme depends on a clear strategy in place to be effective, she stresses, and that includes key stakeholders being fully engaged in the process. 'The majority of the obstacles faced in a prison setting are operational and should be addressed with clear communication, training and guidance.'

In a paper published in the Australian journal, *Drugs and Alcohol Review*, Horsburgh and co-author Andrew McAuley gave a detailed account of the challenges involved in implementation. These included availability of staff (for escorting prisoners as well as co-facilitating sessions), and problems around a group format for training sessions – the subject under discussion had the potential to be emotive for those involved, as 'the majority of people who use drugs will have had personal experience of overdose or experienced the loss of friends and loved ones'.

Bringing in peer education had helped, giving the choice of a one-to-one training session delivered by peers themselves as well as the option of a group session. This had also achieved collaborative working between prisoners and staff.

The other area highlighted for attention had been staff training throughout the prison. Once a prisoner had been trained, nursing staff needed to label a naloxone kit and deliver it to the reception area for prison officers to add it to prisoners' valuable property, ready for them to collect on release. It was vital that prison officers knew what this medication was, so there was no disruption to a streamlined process of release.

The authors concluded that the naloxone programme had been an 'important milestone' in drug policy in Scotland and that prisoners on release were 'reaping the benefits in terms of reduced opioid-related mortality'.

Karen Blatherwick, nurse manager at Turning Point's substance misuse services at HMP Leicester, underlines the risks during the first two weeks after release, particularly for those who inject.

'We encourage service users to carry the naloxone kits at all times, so if they are found with signs of overdose a friend or family member can use the naloxone on them,' she says. 'We also train service users to use the naloxone and encourage them to use it on other people if necessary.'

The need for a clear strategy seems to be working its way into the infrastructure of some of the larger providers of prison healthcare, including Care UK Health in Justice.

GATE

Image: Mark Harvey/Alamy Stock Photo

'A number of the prison healthcare services we manage give training in naloxone use to prisoners close to their release dates,' says their national medical director, Dr Sarah Bromley.

She calls the training sessions 'critically important to saving lives' as they also teach participants to recognise symptoms and respond to people who are experiencing an overdose, supporting them until the emergency services arrive.

'These group sessions are set to increase nationwide as more NHSE commissioners ask us to incorporate the training and dispensing into broader community strategies,' she says, adding that the commissioners' understanding and buy-in has been crucial: 'We believe that commissioners recognise that prison healthcare is in a unique position to teach and reinforce messages on preventing overdose deaths at a time when prisoners are more stable than at other points in their journey.'

Elsewhere there are also signs that naloxone has a firm footing in prison healthcare. Inclusion, part of South Staffordshire and Shropshire NHS Foundation Trust, were early adopters and pioneers of naloxone strategy, including in their prison-based services. 'We have been issuing naloxone with Birmingham and Solihull Mental Health Trust at HMP Birmingham since 2005,' says head of Inclusion, Danny Hames.

When Change, Grow, Live embraced naloxone strategy, they made it 'an objective to ensure that those integrating back into society from the prisons with which we work are provided with take-home naloxone kits, as well as guaranteeing that they receive advice, information and support around access to local community services,' says CGL executive director, Mike Pattinson. 'We have been taking this approach in our prison-based services for some time and shall continue to do so as part of our overall harm reduction plan.'

For Forward Trust, whose substance misuse work spans 18 prisons, 'a more organised and structured approach to promoting naloxone', began at HMP Lewes. By having a designated 'naloxone lead' in the team, they make sure each new service user is added to the naloxone waiting list, regardless of whether their release date has been set. They also make sure clients who are ready for release are booked in for an appointment in the two weeks before they leave.

They believe the scheme is working well because of the staff and client training, good organisational skills, and efforts to improve communication – between Forward team members and with other departments in the prison. Keeping a database of staff members who have completed their training helps them to analyse progress.

'Sometimes clients refuse the naloxone or training when we first offer it, but change their minds later on,' says Forward's Amy Williams. They are offered more chances to engage including, crucially, when they are close to their release date, which 'lets them know that even if they don't think they will need it, it could be used to save the life of someone else. This ensures that we are not only helping them on their recovery journeys in prison, but out into the community too.'

> The naloxone programme has been an 'important milestone' in drug policy in Scotland. Prisoners are 'reaping the benefits in terms of reduced opioid-related mortality' after release.

WDP's substance misuse team have also come across the issue of prisoners refusing naloxone, during their work at HMP Woodhill. As part of each prisoner's release plan they are offered training, harm reduction advice, and a kit on release.

'Some inmates who are on a stable dose of methadone, or who have recently detoxed, may decline the offer of a kit, saying that they feel that they have achieved stability or detox in the prison and have no intention of using drugs or associating with their drug-using former associates,' says WDP's Kate Bonner. 'But they are reminded that prison is a false environment and that while they may be perfectly capable of managing their own lives, they have no control over who they might meet on the street or who might come to their home.'

From those who have come to realise the value of naloxone as they prepare to leave prison, there is gratitude. Whether all prisons will extend this safety net to their inmates in the new year remains to be seen.

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

‘The road to recovery – political destination or patient journey?’ was the theme of this year’s RCGP and SMMGP primary care conference. **DDN** reports

Final destination?

‘None of us need reminding about shrinking budgets and decommissioned services,’ said clinical lead for alcohol and drug misuse at NHS Nottingham, Dr Stephen Willott. Issues like the rising cost of buprenorphine were making matters worse, he said, and ‘while we’re told there’s an extra £20bn coming for health, my worry is that it won’t come anywhere near local councils and drug and alcohol services’. Many people, however, were doing the best they could for a vulnerable group. ‘We need to help people to find softer landings. Sure, if we had more money we could do more.’

There were some grounds for cautious optimism, however. While the latest drug-related death figures were still the highest ever there was ‘at least a flattening of the increase’, he said. ‘We need to make sure that people are seen in a timely manner, that there are no forced exits before someone is ready, and no unnecessary hurdles. We need more roads to recovery and we need to be able to help a wider range of people.’

In terms of drug harms there remained serious questions about why certain drugs were illegal, said Professor David Nutt of Imperial College. ‘The main reason why drugs are illegal is because that’s what the media and politicians want.’ One paradox of working in the field was that drug harms did not correlate with their control, he argued. ‘By far the worst harm comes from alcohol, and it’s legal. The Misuse of Drugs Act is supposed to be evidence-based, but it’s not.’

In terms of OST, treatment optimisation was crucial, SMMGP clinical director Dr Steve Brinksman told delegates. ‘We have to ask ourselves why more people are dying, and people in OST are at much reduced risk. We need to properly understand lapses – people will generally blame themselves, but we need to start thinking about measuring craving as well as withdrawal when we talk about dose optimisation. We shouldn’t make people who are comfortable and doing well in their lives feel ashamed that they’re having evidence-based treatment. I’ll support anyone who wants to work towards abstinence, but I will not force people to come off treatment.’

Public Health England (PHE) was working on an OST good practice programme, its alcohol and drug treatment and recovery lead Pete Burkinshaw told the conference. ‘We’re doing this for all the right reasons and, at the moment, it’s a blissfully politics-free zone. It’s building on what’s gone before but asking what we can do better. People talk about the jewel in the crown of the UK treatment system being the very low HIV prevalence, and I agree with that, but there’s also the 60 per cent treatment penetration. Internationally that’s very good – but it could be better.’ We need to hold the centre and focus on what’s important in the current operating context, and what constitutes quality treatment. That’s more important than ever.’

Resources were hugely constrained, he acknowledged, and there were challenges such as increasing levels of crack use and falling numbers in alcohol treatment. ‘The system needs to respond to all those things, but the people taking up most of the capacity are still opiate users.’ The programme’s initial topics would include prescribing practice, psychological and social interventions and the segmentation of the treatment population, he said, through the filters of service user experience and implementation barriers. ‘Let’s look at what are the absolute must-dos, and take it up from there.’

When it came to policy and practice, we were ‘at a turning point’, said professor of addiction medicine at Edinburgh University, Roy Robertson. ‘We’ve got new drugs, patterns of drug use we haven’t seen before, demographic change.’ In terms of the high rates of drug-related deaths, policy was ‘a bit tricky’, he stated. ‘Things like time-limited treatment and trying to get people off methadone are damaging, and the UK government has no intention of allowing consumption rooms.’ People who use drugs had also been ‘framed’, he stated – characterised as reckless, indulgent, violent and responsible for crime.

‘The upshot of that is that we have a marginalised treatment population. There is neglect, reluctance and a lack of innovation.’ Studies of drug-related

deaths could, however, lead to advances in care, he said. 'It shines a light on the range of morbidities this client group is suffering from.'

The new Scottish drug strategy (see news, page 4) also had 'some good things in it', he added. 'It endorses things like human rights, take-home naloxone, lived-experience advocacy and it takes a swipe at the UK stance on consumption rooms.' However, while it was evidence-based that evidence was 'highly selective', he argued. 'There's stress on the "recovery journey" but, to my mind, at the expense of the NHS.'

While Scotland's take-home naloxone programme was well-received and discussed internationally it was still not possible to see a 'causal effect' in preventing drug-related deaths, he said. 'But it has clearly had an impact in that super-high risk period of the first few weeks after release from prison, so there is clear evidence that it can work.' On the issue of consumption rooms, 'we really do have to make some progress on this', he stressed. 'The international evidence is there, and they're part of a whole spectrum of treatment. You wouldn't have a hospital without an A&E or intensive care unit.'

Deaths involving 'festival and party drugs' were increasing alongside those involving opiates, director of The Loop, Fiona Measham, told the conference, with purity levels for ecstasy at their highest ever level. Her organisation had been carrying out festival testing for the last three summers, and there was 'an opportunistic element' to festival drug use with people tending to take more drugs than they normally would. 'There's polysubstance use, and a significant group of older people who only ever take drugs at festivals and may be unaware of the higher purity levels.' One in 20 MDMA samples from this summer were actually n-ethylpentylone, a very long-lasting cathinone, she added, with festival dealers twice as likely to be selling contaminants and substances of concern. 'They can sell anything and get lost in the crowd.

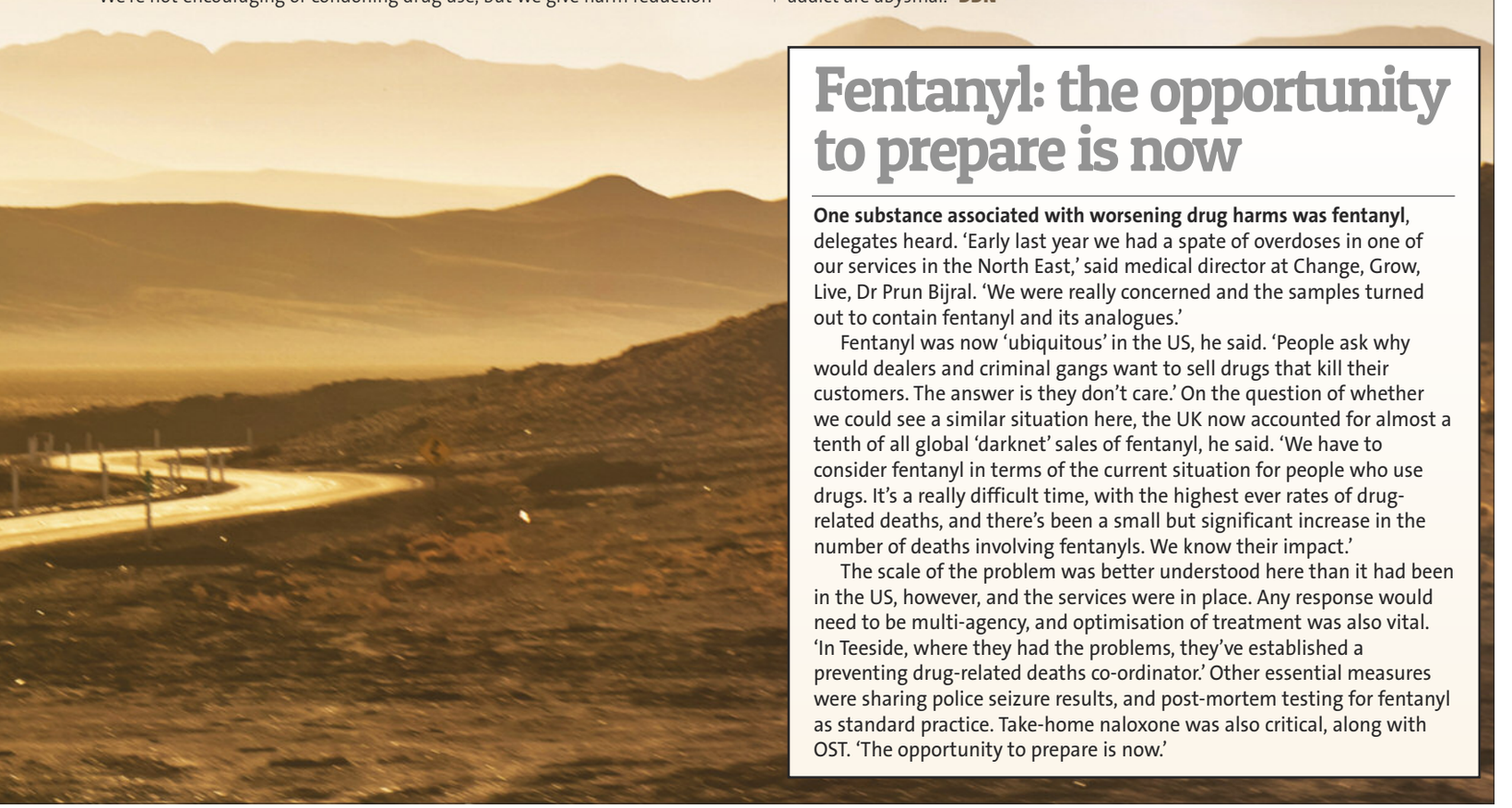
'We're not encouraging or condoning drug use, but we give harm reduction advice – 90 per cent of our service users have never spoken about drug use to a healthcare professional so we're reaching people at the very beginning of their drug-taking careers. We can monitor trends in local drug markets and remove high risk substances from circulation.'

The Loop had also been involved in setting up testing in consumption rooms in Copenhagen and Vancouver, and would soon be operating in Bristol and Durham city centres. 'This is something that should be available to all drug-using communities.'

The human cost behind the statistics, however, was brought home powerfully by author and journalist Poorna Bell, who told the conference how her husband Rob had taken his own life in 2015. 'He struggled with chronic depression and addiction. They tore at him to the point where he couldn't see anything getting any better.'

She'd known nothing about addiction, she said. 'My mind reeled with the horror that it had been heroin. We have this incorrect hierarchy of substances, and heroin seemed the worst of the worst. I stayed with him and helped with his recovery but ironically I felt I couldn't tell my family and friends, which shows the isolation faced by people and their loved ones. The resources for someone whose loved one is an addict are abysmal.' **DDN**

> 'People talk about the jewel in the crown of the UK treatment system being the very low HIV prevalence.'



Fentanyl: the opportunity to prepare is now

One substance associated with worsening drug harms was fentanyl, delegates heard. 'Early last year we had a spate of overdoses in one of our services in the North East,' said medical director at Change, Grow, Live, Dr Prun Bijral. 'We were really concerned and the samples turned out to contain fentanyl and its analogues.'

Fentanyl was now 'ubiquitous' in the US, he said. 'People ask why would dealers and criminal gangs want to sell drugs that kill their customers. The answer is they don't care.' On the question of whether we could see a similar situation here, the UK now accounted for almost a tenth of all global 'darknet' sales of fentanyl, he said. 'We have to consider fentanyl in terms of the current situation for people who use drugs. It's a really difficult time, with the highest ever rates of drug-related deaths, and there's been a small but significant increase in the number of deaths involving fentanyls. We know their impact.'

The scale of the problem was better understood here than it had been in the US, however, and the services were in place. Any response would need to be multi-agency, and optimisation of treatment was also vital. 'In Teeside, where they had the problems, they've established a preventing drug-related deaths co-ordinator.' Other essential measures were sharing police seizure results, and post-mortem testing for fentanyl as standard practice. Take-home naloxone was also critical, along with OST. 'The opportunity to prepare is now.'

POST-ITS FROM PRACTICE

NOW TELL ME YOURS...

Different lives require different approaches to treatment, says **Dr Steve Brinksman**

I HAD THE PRIVILEGE of speaking at the annual RCGP/SMMGP conference at the end of November. I have been attending these for 20 years now and the knowledge I have gained, alongside the peer support, has been invaluable in my career working with people who run into problems with their alcohol and/or other drug use.

I was talking about treatment optimisation. By that I don't mean just increasing the dose of OST prescribed, but also increasing the psychosocial interventions and making sure that all aspects of treatment are in place long enough for people to make sustainable change.

There has been – to my mind – a climate change over the past decade or so where increasing pressure is being applied to get people out of services and signed off as 'treatment complete'. This prevailing paradigm has the knock-on effect that anyone who is taking OST in the longer term almost feels they should be ashamed of it.

We should not feel guilty for providing good quality evidence-based treatment that protects and supports people and gives them the space to establish and manage their own recovery.

Jake came to see me at the surgery for a review. He had started in treatment three years ago and his buprenorphine had been titrated up to 16mg at which point he had stopped using heroin completely. His relationship with the mother of his two sons had improved and he had started a college course with a view to becoming an electrician.

About nine months after starting OST his recovery worker suggested he try reducing his dose. He managed to cut down to 10mg daily – but at that point he started using heroin again. His dose was titrated back up and he again stopped using heroin. Six months later he tried reducing again and the same thing happened.

By the time he came to see me he had made four attempts at reducing and he felt he was failing in treatment. He was guilt-ridden that he lacked willpower, because as he couldn't cope with the craving, he had to use heroin when his dose reduced.

He seemed slightly surprised when I suggested to him that not only do we put his dose back up but that we leave it at that for an extended period of time. Six months on, he is well and happy and feeling confident in treatment. He has started work in a warehouse, sees his sons regularly and has them overnight every other week. He hasn't used heroin since our last appointment.

He does say he would like to come off his OST at some point in the future but feels that time isn't now. We will discuss this whenever we meet and I will always encourage him. However, it will be up to him to make the decision when – or if – he wants to undertake this.

Aneurin Bevan, one of the founders of the NHS, once said: 'This is my truth, now tell me yours.' I feel this encapsulates beautifully the different approaches to how we all live our lives and I think it adapts to our field. So to paraphrase, 'This is my recovery, now tell me yours.'

Steve Brinksman is a GP in Birmingham, clinical lead for SMMGP and RCGP regional lead in substance misuse for the West Midlands

IN IT TOGETHER

The GPs' conference showed the power of a united front for better treatment, says **Lee Collingham**

AFTER A DECADE of attending the RCGP conference, I was in London for this year's event. I've learnt that to get the most from the programme, it's handy to go through the running order for the two days and see if there's anything or anybody that I must see. Otherwise you spend your time nipping from session to session and not particularly learning anything new.

With this in mind, I identified sessions which matched my own personal goals. These included reducing drug-related deaths, the testing of substances to eliminate contaminants, and inclusivity for those working in or using the treatment. Whether the goal is abstinence or the approach is focused on harm reduction, I believe it is important for us to work in partnership and together, rather than being a foghorn alone.

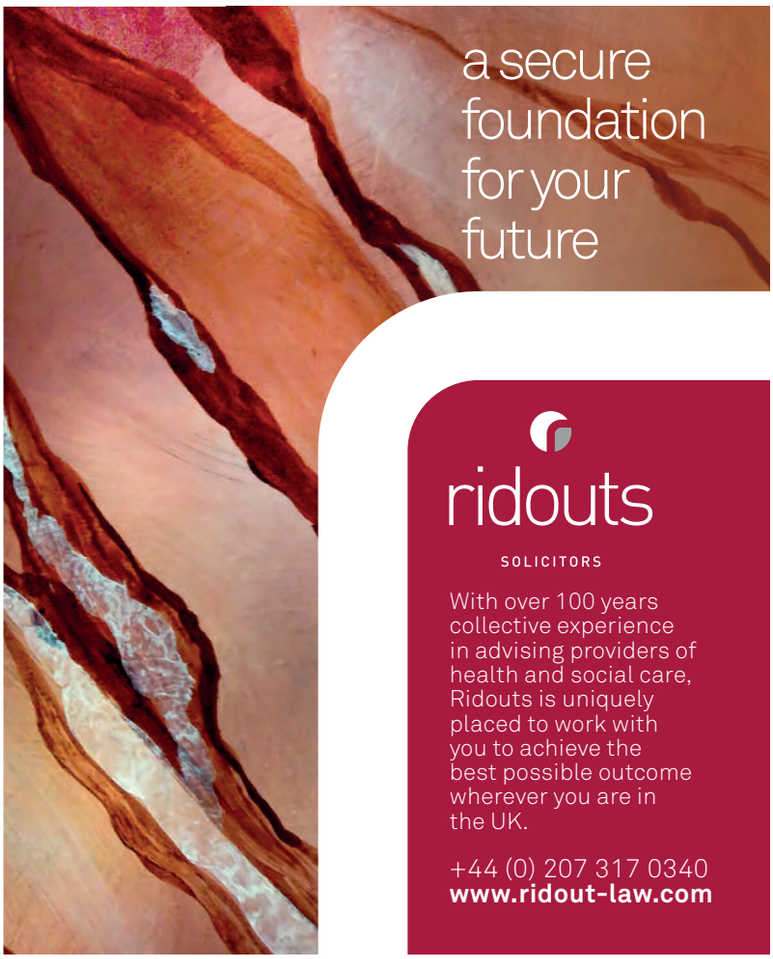
'It is important for us to work in partnership rather than alone.'

One of the sessions that caught my eye was by Professor Roy Robertson from Edinburgh University who spoke about the recently released Scottish drug treatment strategy. Although not entirely relevant for England or Wales, it does however give us good indicators of what is and isn't working and what the overall aim is. It was unclear whether the provision of naloxone in the community had made any difference to drug-related deaths; however it had been a success with those leaving prison. He made welcome suggestions that treatment should be person centred and lead with a multidisciplinary approach.

Of personal interest to me was finally meeting Fiona Measham, who discussed the growing success of The Loop in giving festival guests and nightclub users the opportunity of having the drugs they'd purchased tested. The team was shocked to find the increase in strength of MDMA, some with over 90 per cent purity, and they also found a number drugs being missold as other things. The initiative had been a success, not just with service users who were having second thoughts about what they were taking, but also the police and organisers. They planned to do at least 18 events in 2019 and were looking at working with more nightclubs.

Other than the moving tributes given to both Rob Bell and Beryl Poole, two of the many we have lost, the final highlight for me was attending a presentation on the future face of recovery from Annemarie Ward of Favor UK. She highlighted the challenges and problems service user groups and organisations often face when it comes to raising funds – particularly if we're fighting against each other, rather than together, for the same resources. All too often, she pointed out, it's left to a team of motivated individuals and volunteers to ensure the success of such projects, and I could identify with that.

Lee Collingham is a service user activist and advocate



AT THE CUTTING EDGE

DDN looks back at a year that saw cuts continue to bite, deaths continue to rise, 'county lines' become headline news – and a G7 country legalise cannabis.

JANUARY

A predictably downbeat start to 2018 as, after years of shrinking budgets, the latest *State of the sector* document warns that the field's ability to absorb cuts through efficiency savings and service redesign has been 'exhausted'. The report uncovered 'worrying signs that potentially serious damage' has been done, says Adfam chief executive Vivienne Evans. Meanwhile, Release warns that levels of naloxone provision by local authorities are 'chronically inadequate' and PHE announces its review of the 'growing problem' of prescription drug dependency. On a more positive note, the NHS states that its hepatitis C strategy could see England become the first country to eliminate the virus.

FEBRUARY

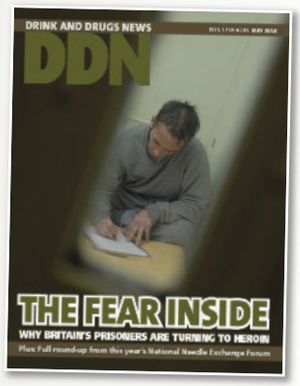
Get Connected, DDN's eleventh annual service user conference, sees another vibrant day of debate and networking in Birmingham. In a measure of how far the event – and user involvement – has come, SUIT's Sonny Dhadley tells delegates that 'I can remember coming to a *DDN* conference for the first time about a decade ago, not long out of detox – I didn't understand that this world existed. But if you're championing something you believe in, you'll do anything to make it happen. There's so much energy and potential in every one of us.'

MARCH

MPs warn that 'significantly greater' numbers of people will need to be tested, diagnosed and treated if the NHS is to meet its hep C elimination target, and the National Crime Agency reveals that it is seeing a dramatic increase in modern slavery cases as a result of county lines activity, with referrals of minors up by two thirds between 2016 and 2017.

APRIL

The government announces that its serious violence strategy will include a £3.6m county lines coordination centre, citing the drug trade as an 'important driver' of rising incidences of knife and gun crime. Meanwhile, in what is seen as a landmark move, the Royal College of Physicians (RCP) issues a statement backing drug decriminalisation. 'The RCP strongly supports the view that drug addiction must be considered a health issue first and foremost' it says, adding that it had been 'alarmed' by rising rates of drug-related deaths.



MAY

In what could help show the way forward in eliminating hep C, a report from the London Joint Working Group (LJWG) reveals that a four-month community testing pilot project in pharmacies with needle exchange facilities has seen 50 per cent of people testing positive. Significantly, almost 60 per cent of participants were also unaware that the virus could now be treated with oral tablets rather than interferon. Meanwhile, minimum pricing finally comes into force in Scotland after years of legal wrangles and last month's 12-step article by Alex Boyt, 'All or nothing', fills the *DDN* letters pages with reactions ranging from 'brilliant' to 'reading this has ruined my day'.

JUNE

EMCDDA's annual *European drug report* identifies the UK as among the biggest consumers in a 'buoyant' cocaine market, with purity levels at their highest for a decade, while Kevin Flemen wonders in *DDN* if the recent growth in crack use indicates a move towards social acceptability. 'I'm probably more anxious about crack this time around than I have ever been working in the field,' he writes. 'I hope I'm wrong.'

JULY

In what is becoming a depressing annual event, Scotland again records its highest ever number of drug-related deaths. The 'sheer toll' of deaths represents a 'staggering weight carried by families and communities and the wider Scottish nation', says Scottish Drugs Forum CEO David Liddell. Drugs are also behind the 'huge increase' in violence across the prison estate over the last five years, says the annual report from the chief inspector of prisons. Meanwhile the government is urged to overhaul drinks marketing legislation as campaigners warn that social media is creating 'unprecedented alcohol marketing opportunities'.

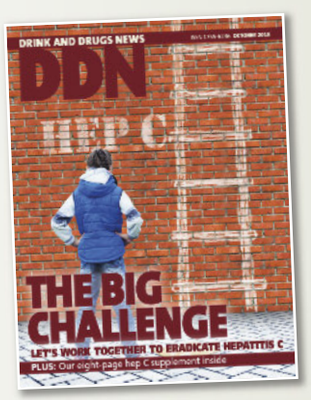
AUGUST

Following last month's Scottish statistics, ONS figures again show record drug deaths for England and

Wales. A cautious note of optimism is struck by the fact that, while previous increases had been 'statistically significant', rates since 2015 are only increasing slightly and remain 'broadly stable'. Fentanyl-related deaths continue to rise, however, and deaths related to cocaine have now increased for six years in a row.

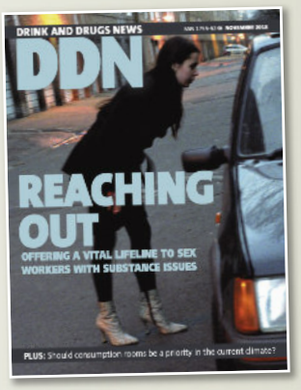
SEPTEMBER

As a WHO report states that one in 20 global deaths are now caused by alcohol, PHE launches its 'Drink Free Days' campaign in collaboration with Drinkaware as a 'clear to follow, positive and achievable' way for middle-aged drinkers to reduce their health risk. Partnering with the industry-funded body, however, leads to concern from some in the treatment sector and the resignation of PHE's alcohol leadership board co-chair Sir Ian Gilmore.



OCTOBER

Canada becomes the second, and largest, country to legalise the recreational use of cannabis, with justice minister Jody Wilson-Raybould stating that this 'progressive public policy' would help keep cannabis 'out of the hands of youth and profits out of the pockets of criminals'.



NOVEMBER

Scotland pledges a 'person-centred, health approach' in its new drug strategy, *Rights, respect and recovery*. Meanwhile, the impact of price increases associated with ongoing buprenorphine supply problems continues to be felt, compounded, as PHE's Pete Burkinshaw tells *DDN*, by 'the financial pressures local authorities and services are currently under. We will continue to do everything we possibly can.'

August: Fentanyl-related deaths continue to rise, and deaths related to cocaine have now increased for six years in a row.

DECEMBER

As the year comes to close preparations are well underway to bring people together for DDN's 2019 conference, Keep on Moving. See you on 21 February!

MEDIA SAVVY

The news, and the skews, in the national media

IN THE UK, ALCOHOL IS A NATIONAL TREASURE. While advocates against the status quo should continue to unroll startling health data to the public, we have another task that is equally important: dismantling the glorification of alcohol. Regulating the messages on billboards and products and, more perniciously, on card racks and in gift shops. The messages on t-shirts, candles, coasters, and fridge magnets; everywhere you look. The endorsement and enabling of binge drinking sells, because so many of us do it.
Catherine Gray, *Lancet*, 1 November

THE ADVERSE EFFECTS OF EXCESSIVE ALCOHOL ARE LEGION. The Alcohol Health Alliance, a group of more than 50 medical organisations, says 23,000 deaths a year are linked to alcohol... The unpalatable truth is that the NHS itself militates against individual responsibility because its core assumption of healthcare entitlement is a one-way street. People will only alter their risky behaviour if they have to contribute to the cost of treating the consequences. That means replacing the NHS with some kind of European-style social insurance system, with higher premiums for self-destructive lifestyles.
Melanie Phillips, *Times*, 6 November

TRACEY CROUCH, THE SPORTS MINISTER, earned widespread admiration this week for her principled resignation over gambling machines. She wants a law to cut the maximum stake from £100 every 20 seconds to £2, and was furious when Philip Hammond in the Budget announced it would be delayed until October next year. I haven't seen a single good reason for the delay... In the welter of negativity about politics, it is easy to forget that many politicians have principles, and that some of them are even prepared to stand by them. My view is that most politicians are more idealistic and sincere than most people think. Thank you to Tracey Crouch for reminding us of that.
John Rentoul, *Independent*, 4 November

'It is easy to forget that many politicians have principles, and that some of them are even prepared to stand by them.'

GAMBLING IS A SIMPLE BUT SOCIALLY WASTEFUL BUSINESS where the amount of money made by the industry varies according to the losses made by the punters. And when it becomes addictive – as it often does – there are higher healthcare, welfare and criminal justice bills to be paid. The government will never eradicate problem gambling but it can take steps to minimise it.
Larry Elliott, *Guardian*, 8 November

THANKS TO THE 'COUNTY LINES' BUSINESS MODEL of the gangs, huge quantities of coke are now flooding Britain's market towns and villages, bringing bloodshed in their wake. As the wave of violence sweeps the UK, those who snort this drug cannot maintain their moral blindspot.
Clare Foges, *Sun*, 7 November

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