INSIDE – AUTUMN 2014 RESIDENTIAL TREATMENT DIRECTORY

DDN
Drink and Drugs News
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TOUGH LOVE

ADFAM: 30 YEARS OF SUPPORTING FAMILY MEMBERS

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Why are drug death rates north and south of the border going in different directions? p8

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How do we effectively combine substance misuse and mental health services? p16

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PROGRAMME

9.00 – 10.00AM **REGISTRATION, TEA AND COFFEE**

10.00 – 11.20AM **SESSION ONE**

VIVIENNE EVANS OBE, CEO ADFAM: A retrospective of the last 30 years of family support.

MICHAEL O'KANE, PUBLIC HEALTH ENGLAND – SUPPORT FOR CARERS: The importance of family members in recovery. What does the care bill mean for carers of those with drug and alcohol problems?

LUCIANA BERGER, SHADOW MINISTER FOR PUBLIC HEALTH: How families can fit within the policy framework.

11.20 – 11.40AM **TEA AND COFFEE**

11.40AM – 12.45PM **QUESTION TIME PANEL**
A lively interactive panel discussion chaired by Radio 4's **EDDIE MAIR**.

12.45 – 1.45PM **LUNCH AND NETWORKING**

1.45 – 3.00PM **SESSION TWO**

PROPS – FAMILY SUPPORT: A BRAVE NEW WORLD. Examining current challenges for family support providers, and looking at ways to meet clients' needs in a world of competitive commissioning, with **CLAIRE ROBINSON**.

CNWL – SPECIALIST SUPPORT: Challenges for women drug users, and families with complex needs, with **ANNETTE DALE-PERERA**.

ONLINE SUPPORT: HOW TECHNOLOGY CAN HELP. A look at innovative ways that family members can gain advice and support in a virtual world.

3.00 – 3.20PM **TEA AND COFFEE**

3.20 – 4.00PM: **SESSION THREE**

EMMA – A FAMILY MEMBER'S PERSPECTIVE: A daughter describes the impact of prescription drugs on her mother and the effect on their relationship.

VIVIENNE EVANS OBE, CEO ADFAM: Close.

Adfam's photo exhibition, '30 faces from the other side of addiction', will be on display throughout the conference.

Thursday, 23 October 2014 – CENTRAL LONDON

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Targets that matter

Why inclusion should be top of the table

These are anxious times for all of us – the money's not going into core services, the political agenda feels like a straw in the wind, and treatment services are battered by targets and tendering.This month's issue reminds us of the reasons to fight on for the best standards of individualised care.

While recovery month is well and truly celebrated by the vibrant walk in Manchester, and the inspiring stories on page 20, there are important notes to listen out for. Kaleidoscope's Barry Eveleigh (page 14) demonstrates how they planted harm reduction firmly at the centre of their recovery agenda, with naloxone training at the top. Alistair Sinclair (page 15) makes the point that recovery should be about instilling hope and optimism rather than just celebrating years abstinent. The point is that we don't have to accept the political dictum that abstinence must now drive the treatment system to the exclusion of the clients who need it most. Dr Steve Brinksman (page 9), treating homeless and vulnerable patients, says that working with people who use drugs needs a multidisciplinary approach, including carers (see cover story, page 6), peers, medical professionals, counsellors and key workers. Within DDN's readership we have a virtual network of shared care. If we don't fight for the wellbeing of our most vulnerable, who will?

This issue

FEATURES

REGULARS

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NEWS IN BRIEF

AGEIST AGENDA

Better knowledge is needed of what works in the identification, treatment and prevention of drug problems in older people, according to a report from the Big Lottery Fund, along with improved collection and reporting of data. Drug use among older people is being 'systematically ignored', says *The forgotten people: drug problems in later life*. 'Tackling ageist attitudes' and improving the knowledge and skills of professionals were also necessary, said report author Sarah Wadd, as well as 'making sure that drug treatment services are accessible and meet the needs of older people'. *Report at www.biglotteryfund.org.uk* *See news focus, page 6*

CHALLENGING TIMES

The scale of the new psychoactive substances problem may be 'even greater than estimated', with services ill equipped to cope, according to a report from the Royal College of Psychiatrists (RPsych). Users may be reluctant to access help, while staff may not ask about the drugs during routine drug assessments 'or have the skills to deal with problems when they arise', says *One new drug a week: why novel psychoactive substances and club drugs need a different response from UK treatment providers*. The challenge was to 'keep pace with this growing problem, while continuing to meet the demands of more established substance misuse problems associated with alcohol, heroin and crack cocaine', said Owen Boden-Jones of CNWL's club drug clinic. *Report at www.rcpsych.ac.uk*

HEP FEEDBACK

A global patient survey to reveal how hepatitis C is treated around the world has been developed by the World Hepatitis Alliance. HCV Quest is 'your platform to share your thoughts about your care, the impact of HCV on things like your work and lifestyle and the sources you trust for credible advice about your health', says the alliance, with the results used to inform policy-makers, doctors and pharmaceutical companies. *www.worldhepatitisalliance.org/en/hcv-quest.html*

STARK STATS

Greater Manchester sees an average of just over 19 emergency hospital admissions for alcohol-related liver disease every week, according to figures from the Health and Social Care Information Centre (HSCIC). Areas of the North West and North East of England have the highest admission rates in the country, says the centre, with hospitals nationally admitting more than 10,000 cases of alcohol-related liver disease in 2013/14 – more than 200 a week. Alongside Greater Manchester, Merseyside and Lancashire were the areas with the highest rates of emergency admissions, with around eight and nine per week on average respectively. *Statistics at www.hscic.gov.uk* *See this month's Exchange, page 13.*

England and Wales see sharp rise in drug deaths

Nearly, 2,000 drug misuse deaths were registered in England and Wales in 2013, according to figures from the Office for National Statistics (ONS).

Male drug misuse deaths involving illegal drugs rose by 23 per cent, from 1,177 in 2012 to 1,444, while female deaths were up by 12 per cent to 513. The upward trend is in contrast to Scotland, which saw deaths fall by 9 per cent over the same period (*DDN*, September, page 4).

Heroin/morphine remained the substances most commonly involved, up 32 per cent to 765 deaths, while 220 deaths involving the synthetic opiate tramadol were also recorded. Overall, nearly 3,000 drug poisoning deaths – including those involving legal drugs – were registered in England and Wales in 2013, more than 2,000 of them among males. In England, the North East was the region with the highest mortality rate from drug misuse, while London had the lowest.

The number of deaths involving new psychoactive substances was up by 15 per cent – from 52 to 60 – although the increase 'was not as steep as that observed between 2011 and 2012', says the document.

DrugScope expressed 'serious concerns' over the figures, which marked a 'reversal of the recent downward trend and appear to show the sharpest increase since the early 1990s', said chief executive Marcus Roberts. 'Of course, this is about more than just numbers; each death represents a tragedy for the individual concerned, their family and friends.'

The charity also urged the government to review the timetable for its proposed roll-out of naloxone provision – currently scheduled for October next year at the earliest – so that 'this life-saving medication can be used as soon as possible, to prevent more people from dying'. Commenting on the release of the Scottish figures last month, community safety minister Roseanna Cunningham pointed out that nearly 4,000 naloxone kits had been issued in Scotland in 2012-13, 'potentially saving more than 350 lives'.

Deaths related to drug poisoning in England and Wales, 2013 at www.ons.gov.uk

See news focus, page 6

CQC pledges to focus on 'the issues that matter'

The Care Quality Commission (CQC) has set out its new approach to inspecting drug and alcohol services, which will 'reflect national priorities' and 'put people's recovery at the heart'. Also central to the inspection regime will be a 'commitment to tailor inspections to the issues that matter to people using substance misuse services', it says.

The CQC's aim is to ensure that people are able to 'quickly access high-quality services that assess the whole individual', it states. The commission will 'seek to ensure that services are safe, caring, effective, responsive to people's needs and well-led'.

CQC will be responsible for regulating hospital inpatient-based services that provide assessment, stabilisation, and assisted withdrawal, as well as community-based services and residential rehab. Alongside therapists, doctors, psychologists and pharmacists, the commission's 'specially trained inspection teams' will include 'experts by experience', it says, and will also use information from service users, their families and carers. 'Key relationships' for corroborating its decisions, meanwhile, will include Public Health England (PHE), NICE, local authorities and other relevant bodies.

'It is vital when looking at substance misuse services that the views, opinions and experiences of people who use them are listened to and that any judgement that we make about those services reflects what we have heard,' said CQC's chief inspector of hospitals, Professor Sir Mike Richards, who will lead the inspection programme. 'I am determined that this experience of care and treatment form a central part of the future inspection of services.

'I will be giving ratings to substance misuse service providers so people can be clear about the quality of services and to help drive improvement,' he continued. 'Where we can, we will align our inspections of substance misuse services with other sectors we regulate, such as community mental health or learning disability services, community services, primary care services and acute hospitals.'

CQC is also consulting on its guidelines for health and social care services 'to set the bar below which care should not fall', including what providers should do when things go wrong and how to ensure staff are fit for their roles.

Consultation at www.cqc.org.uk/content/consultation-our-guidance-help-services-meet-new-regulations, until 17 October.

A fresh start for the regulation and inspection of substance misuse services at www.cqc.org.uk

See David Finney's article, DDN, July, page 16.

Time to stop criminalising drug users, says global commission

A new report from the Global Commission on Drug Policy has called for an end to the criminalisation of drug use and possession. Among the recommendations in *Taking control: pathways to drug policies that work* are that health and community safety be prioritised by 'a fundamental reorientation' of policy and resources away from punitive approaches, and to 'allow and encourage diverse experiments' in legally regulating markets for drugs – 'beginning with, but not limited to, cannabis, coca leaf and certain novel psychoactive substances'.

The commission, members of which include the former presidents of Brazil, Chile, Colombia, Mexico, Poland, Portugal and Switzerland, is 'the most distinguished group of high-level leaders to ever call for such far-reaching changes', it says. The report also wants to see 'equitable access' to opiate-based pain medication, an end to the imposition of compulsory treatment and alternatives to prison for 'non-violent, low-level' participants in illegal drug markets, such as farmers or couriers.

'It is time to change course,' said former UN secretary general and convenor of the West Africa Commission on Drugs, Kofi Annan. 'We need drug policies informed by evidence of what actually works, rather than policies that criminalise drug use while failing to provide access to effective prevention or treatment. This has led not only to overcrowded jails but also to severe health and social problems.'

Meanwhile, the Liberal Democrats are to discuss ending the use of imprisonment for possession of drugs for personal use at the their annual conference in Glasgow this month, along with moving the 'drugs and alcohol policy lead from the Home Office to the Department of Health'.

The proposals are contained in the party's 'pre-manifesto' document, which also states that they would establish a commission to look at the effectiveness of UK drug laws and alternative approaches, including 'further work on diverting users into treatment or into civil penalties that do not attract a criminal record which can seriously affect their chances of employment'.

Taking control: pathways to drug policies that work at www.globalcommissionondrugs.org

Pre-manifesto 2014 at www.libdems.org.uk

Have your say

DrugScope's *State of the sector 2014* surveys (*DDN*, September, page 8) are now live.

Mainly intended for local service managers from the NHS, voluntary, community and private sectors, as well as social enterprises and partnerships, the aim of the surveys is to create 'a snapshot of the drug and alcohol treatment sector in England' and enable DrugScope and the Recovery Partnership to 'provide an informed voice to influence future policy implementation and development'.

There are separate questionnaires for managers of adult community and residential services, young people's services and prison-based services, which have been developed in consultation with service providers and others. All responses are confidential, and the surveys will be open until mid-October.

Surveys at http://bit.ly/1rAo8H3

RED CARD: Work and pensions secretary Iain Duncan Smith used his speech at last month's Conservative Party conference to outline plans to pilot a pre-paid benefit card scheme, which would be targeted at people with addiction issues to stop them spending the money on drugs, alcohol or gambling. 'I have long believed that where parents have fallen into a damaging spiral – drug or alcohol addiction, even problem debt, or more – we need to find ways to safeguard them, and more importantly, their families, their children,' he said. 'That means benefits paid should go to support the wellbeing of their families, not to feed their destructive habits.'

NEWS IN BRIEF

METH MIGRATION

Methamphetamine manufacture, traditionally concentrated close to major markets in North America and East and South East Asia, has now spread to other countries, according to a report from UNODC. Iran, Kenya, Nigeria, South Africa and Guatemala are among the countries where manufacture is taking place, says *Global SMART update 2014*, while it is also spreading across Europe, 'though at low levels'. *Report at www.unodc.org*

PREMIUM PLANS

Public Health England (PHE) is consulting on aspects of the Health Premium Incentive Scheme (HPIS) – which rewards local authorities for public health improvements in line with indicators from the public health outcomes framework – and public health funding allocations for 2015-16. *Consultation at www.gov.uk/government/consultations/health-premium-incentive-scheme-and-public-health-allocations until 23 October*

ACUTE ISSUES

A study of specialist alcohol health workers in hospitals has found that 'the work is often precarious and underfunded', with more investment and better research needed. 'The government's alcohol strategy identified hospital-based specialists as key,' said James Nicholls, director of research and policy development at Alcohol Research UK, which funded the study. 'It is vitally important that this role is adequately supported.' *Report at alcoholresearchuk.org*

FAMILY FUNDS

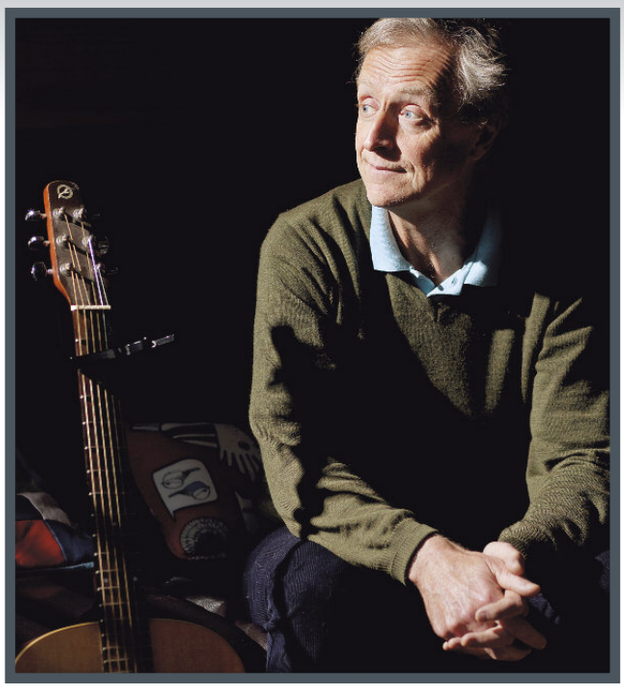
A £120,000 funding package to support families affected by drug and alcohol problems in rural areas has been announced by the Scottish Government. The money will go towards a small grants scheme administered through the Lloyds Partnership Drug Initiative, which promotes voluntary sector work with vulnerable young people. 'It is vital that everyone has access to these services no matter where they live,' said community safety minister Roseanna Cunningham.

BLUE SKY THINKING

Prison drug charity RAPt is to merge with Blue Sky Development, a social enterprise providing employment to offenders. Blue Sky's jobs will be targeted at RAPt graduates, 'giving them a step on a career path to support their continued recoveries.'

BENEFIT BLUNDERS

Welfare sanctions can have unintended consequences including distancing people from support, negative impacts on third parties – particularly children – and 'displacing rather than resolving issues such as street homelessness and anti-social behaviour', according to a report from the Joseph Rowntree Foundation (JRF). Sanctions also disproportionately affect those under 25, as well as homeless people and other vulnerable groups, it says. *Welfare sanctions and conditionality in the UK at www.jrf.org.uk*



HIDDEN FACES

To commemorate 30 years of supporting family members affected by loved ones' drug and alcohol use, Adfam has launched a photo exhibition that celebrates 'the tough love that gets up to fight another day'. **Rachael Evans** explains

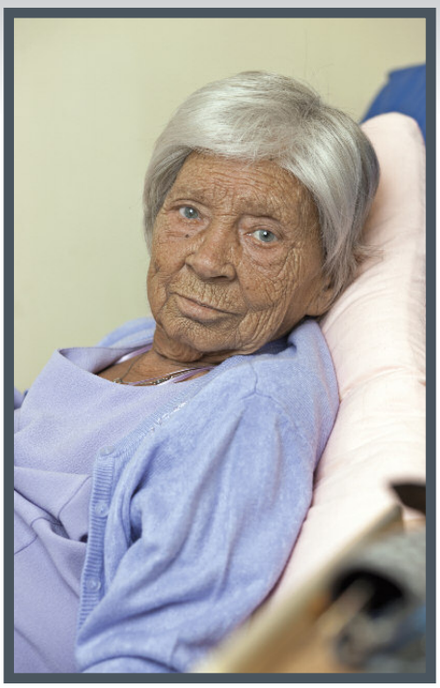
Adfam is a charity founded in 1984 by the mother of a drug user who could not find the support she needed to cope with her son's addiction. From humble beginnings as a grassroots organisation, bringing together worried mums and dads, we have come a long way. Today we inform policy development, campaign nationally and locally for improved family support services and carry out regional development work with services and practitioners throughout the country. We have grown in size and influence to become the national umbrella organisation working to improve support for families affected by a loved one's addiction. We work closely with local support services, partner organisations, professionals, government and, of course, families themselves to ensure that no family in need of support goes without it.

We at Adfam are always looking for ways to reduce the isolation of the families we support; so to mark our 30th birthday this year we are running a campaign to raise awareness of the stigma that these families so often suffer. Through this we will encourage people to speak out about their experiences and problems in an attempt to combat the stigma surrounding addiction, felt by both users themselves and their families.

Stigma comes from an assumption about an individual or a group and results in people being treated differently or seen as a stereotype. The person is dehumanised and is perceived not only as behaving differently from 'us', but actually being different to 'us'. Families as well as users are stigmatised, sometimes seen as being responsible for their relative's addiction or assumed to be 'bad families'.

We believe that families are often the unseen victims of drug and alcohol use, facing not only the impacts of their loved one's addiction, but also grappling with

'I had to keep my son's drug use from the rest of the family, have heard the derogatory way people talk about drug users, and I've seen the look in people's eyes when they find out about my son's addiction.'



the stigma and shame they feel from friends, family, neighbours, their communities and wider society. However, rather than being to blame for their loved one's addiction, families are often an essential source of support and ambition for substance users, and play a crucial role in their recovery. Stigma discourages families from coming forward to seek the support they so desperately need, negatively impacts on their health and wellbeing, leads to isolation and renders them less able to support their loved one. What is required is an understanding of the difficult predicaments these families face and the potential for recovery.

To this end, the highlight of our campaign will be our 30th birthday portrait exhibition, *The other faces of addiction*, where we will showcase 30 portraits – 30 portraits for 30 years – of families who have experienced, or who are still experiencing, the rippling effects of addiction. We have worked with an excellent photographer, David Collingwood, to capture their strength and humanity and to reach out to those who are feeling alone and helpless, encouraging them to come forward for support.

'I came to this project aware that no two families are affected by addiction in the same way,' says David. 'I expected sad stories – and there were plenty – but the people I met were funny, fierce, angry, proud, elated, frustrated and hopeful. What impressed me most was the positive energy of the mothers, fathers, grandparents and siblings: the tough love that gets up to fight another day, and another.'

The stories we've heard along the way have sometimes been heartbreaking while others have made us laugh out loud. But they are all undeniably inspiring and touching. Adfam would like to thank all of those who have shared their experiences with us and bravely spoken out on this crucial issue.

We came to better understand the true impact that stigma has on families, as one of our participants, Nicola, explained: 'I had to keep my son's drug use from the rest of the family, have heard the derogatory way people talk about drug users, and I've seen the look in people's eyes when they find out about my son's addiction. Luckily, I have friends who see the person he is, rather than the drug user.'

Another of our exhibition participants, Amanda, expressed her eagerness to be involved in a campaign such as this: 'We want to show that these issues happen to all kinds of families. It's good to know there is work going on out there to support carers, friends and families with the emotional as well as the practical impacts that substance misuse can have on a family.' One lady who came forward to be a part of our portrait exhibition, while feeling very passionately that she wanted to be involved in the campaign, nonetheless felt unable to give her real name or even reveal her face in the portrait because of, she said, 'the shame and stigma that still surrounds drug use today.'

Speaking to these families and hearing their stories has shown that the issue of stigma is a real one – and is in need of addressing. We wanted our campaign to bring everyone together in support of this cause, so we have encouraged local family support organisations to hold their own awareness and fundraising events and provided them with campaign packs containing advice and ideas. We received an excellent response from local organisations wanting to be a part of our celebrations by promoting awareness of Adfam and their own local services, and there will be exciting events taking place throughout the country over the coming months, from drop-in advice sessions in Peterborough to games nights and cake sales in Scunthorpe!

Delighted with the level of enthusiasm for our campaign and portrait exhibition, we decided to spread the message by offering organisations around the country the opportunity to replicate our *The other faces of addiction* exhibition locally – and services were quick to snap this up. 'This is a fantastic idea! The replica exhibition would be a fantastic opportunity to involve other agencies and organisations in supporting families,' said one of our supporters, who works for a small family support service.

Again, we were thrilled with the overwhelming response from our supporters, and our exhibition will now reach a much wider audience, as it's being showcased at the *Feminism in London 2014* conference, various regional events and beyond. These exhibitions will run from October until the end of the year – and possibly into 2015 – with the portraits displayed in libraries, county halls, reception waiting rooms and at local fundraising events all over the country. We even hope to get them displayed in the House of Commons, taking our message of hope to the heart of Westminster. Many of you should therefore have an opportunity to drop into one of the exhibitions and see the impressive results for yourself.

You can read more about Adfam, the campaign and the local activities taking place over the coming month at www.adfam.org.uk.

Rachael Evans is research and policy coordinator at Adfam

COUNTRIES APART?

Are the rates of drug-related deaths north and south of the border really going in different directions?

ALL EYES WERE ON SCOTLAND last month in the run-up to the vote on independence, and, although the country eventually opted to stay part of the UK, there are signs that its drug-related death rate may be starting to head in a different direction.

Deaths were down by 9 per cent last year, to 526 (*DDN*, September, page 4), following a 2011 peak of 584 (*DDN*, September 2012, page 4) and just three fewer the following year. In England and Wales, however, the news was more grim. Male deaths involving illegal drugs were up by 23 per cent – to 1,444 – with female deaths up 12 per cent to 513 (see news story, page 4). There were 765 deaths involving heroin/morphine in England and Wales, while 220 involved the synthetic opiate painkiller tramadol – an all-time high.

As the Scottish Drug Forum (SDF) pointed out, however, the Scottish figures are no cause for complacency. Still the fifth highest ever recorded, the total was 66 per cent higher than a decade ago. Heroin and/or morphine were implicated in, or potentially contributed to, 221 deaths while methadone was implicated in 216.

When the Scottish figures were released community safety minister Roseanna Cunningham was quick to point out that – while the country still faced 'a tough challenge' – fewer young people were taking drugs and there were signs that the government's approach was working. One of the key aspects of that approach is a national programme of naloxone provision, with nearly 4,000 kits issued in 2012/13. So how much of a role did that play?

'Certainly we have evidence of a significant amount of naloxone use, and obviously a proportion of those kits issued will have been lives saved,' SDF director David Liddell tells *DDN*. 'I think it's very hard to be definitive about naloxone, but we're very encouraged by the roll-out and what's happened, and the government providing funding to drive that as a national programme.'

However, the deaths data tend to suggest a 'levelling off' rather than an actual decline just yet, he points out. 'Alongside that is a caveat that – just like in England – there's an increasing number of older problem drug users and certainly, from some of the work we've done, what we're seeing is a number who are quite isolated and living alone. So obviously naloxone is not going to impact on those individuals.'

Clearly, problems of failing physical and mental health, alongside social issues, will continue to be a factor for this group, he adds. 'That's where the cautious optimism comes from. We've turned little bit of a corner here, but we can hardly be complacent with that number of deaths.'

What's the best approach when it comes to that older population – renewed determination on the part of services to engage them and keep them engaged? 'We've had all those issues of "parked on methadone" and so on – and certainly our sense is that that represents quite a small proportion of the overall population who've been long-term on methadone – but I do think there is an issue for people who've been in services a long time,' he states. 'That they've almost become like the wallpaper, and if they're not causing any major hassle and are relatively stable then they're maybe not given the level of support that they could usefully get.'

SDF research in this area has raised some interesting issues, he adds. 'Some of our interviews did highlight things such as how an older user might benefit from having an older worker, for example. There were some suggestions that the older users found it hard to relate to very young workers, who they perhaps thought were a bit wet behind the ears. So it's just about services just looking more specifically at the needs of this population.'

That population is far from homogenous, he stresses. 'In our European study we talked about over-35s, which some people would think was actually very young, but you might be talking about someone who's been using for 20 years. So I think there are those kinds of issues for services, and also for local planning structures and governments. There were quite interesting examples of services for older users in countries like Germany, such as dedicated residential services. Also, something that's starting to happen is better links between addiction services and services for older people, so that there's a better understanding across the sectors of what the issues are now but also projecting five, ten, 15 years ahead.'

'We have evidence of a significant amount of naloxone use, and obviously a proportion of those kits issued will have been lives saved.'

David Liddell

Figures for deaths relating to new psychoactive substances (NPS) now make headline news, but the picture can be slightly more complicated than the media make out, he points out. Of the 60 Scottish deaths in which NPS were implicated, or potentially contributed to, in 39 cases 'the only NPSs present were benzodiazepines (usually phenazepam)', says the document, compared to 19 cases in which NPS like AMT, BZP or PMA were present (and two in which both types were present).

So if in around 67 per cent of the NPS cases, the only NPS used was a benzodiazepine – and usually in combination with other drugs including alcohol – could there be a popular misconception about this new trend?

'Yes, I was quite frustrated with some aspects of the Scottish coverage of our figures,' he says. 'It's not to say that new psychoactive substances isn't a major issue – of course it is – but it's the representation of the deaths almost as if there's a new problem emerging while the old one has sort of gone away. Which of course is not the case.'

Drug-related deaths in Scotland 2013 at www.gro-scotland.gov.uk

Deaths related to drug poisoning in England and Wales, 2013 at www.ons.gov.uk

NEW RESEARCH ON NON-FATAL OVERDOSES

A group of academics from the University of South Wales has published research on the prevalence of non-fatal overdoses among drug users in Wales

'Attention should be paid to the less common drugs implicated in overdose...'
Professor Katy Holloway

PROFESSOR KATY HOLLOWAY, PROFESSOR TREVOR BENNETT AND JASON EDWARDS, from the Centre for Criminology, carried out a unique national survey exploring how many opiate users experience a non-fatal overdose each year, the causes of non-fatal overdoses and how they can be prevented.

The academics were commissioned by the Welsh Government to carry out a study of non-fatal opiate overdose comprising two parts – a questionnaire of injecting opiate users to find out the prevalence of non-fatal overdose, and interviews with some of the respondents to find out the nature and circumstances of overdose events.

The key findings of this research were that almost half (47 per cent) of all opiate users said that they had overdosed at least once in their lives, and 15 per cent said that they had done so in the past 12 months. There was little difference in the prevalence of non-fatal overdose among male and female respondents, and no difference in the likelihood of non-fatal overdose among younger and older users.

There were wide variations in the prevalence of overdose across locations, ranging from 0 per cent in one scheme area to 75 per cent of respondents recruited from a city centre hostel. On average, respondents who reported overdosing in the last 12 months stated that they had overdosed twice in that time. Naloxone was administered by one or more persons in 38 per cent of all cases of a non-fatal overdose.

These findings are unique because there is no equivalent information available on this topic in Wales. The existing data which is available on drug-related deaths, hospital admissions and patient episode only show the numbers of those users who have come to the attention of the recording agencies. The USW research project has sought to identify the dark figure of non-fatal overdose that might not otherwise have been officially discovered.

'We believe on the basis of this research that there are several actions that could be taken that might reduce non fatal overdose,' said Professor Katy Holloway.

'First, opiate users should receive more information on how to recognise early signs of an overdose in themselves as well as others, through improved training. Second, attention should be paid to the less common drugs implicated in overdose, such as mephedrone, amphetamines, benzodiazepines and anti-depressants, and third, attention should also be paid to the effects of drug mixing, and appropriate advice should be given through advertising campaigns or naloxone training programmes.

'Fourth, the role of alcohol in drug misuse should be investigated more closely and appropriate advice offered on safe levels of use. And finally, some attempt should be made to identify the purity of current street heroin and to devise an early warning system that could inform users when purity levels are unusually high.'

POST-ITS FROM PRACTICE

The golden key

Working with people who use drugs is a multidisciplinary landscape with key workers at its heart, says Dr Steve Brinksman

FOR THE PAST SIX MONTHS my practice has been providing the medical cover for some of the homeless and vulnerable persons' drug service sessions in Birmingham. Because the doctor who usually covers these clinics is on sabbatical, it has been my privilege to do these clinics for the last three months.

Most of the patients are IV poly-drug users, many are rough sleeping, there are high rates of hepatitis C, and much higher rates than usual of HIV. A lot are groin injectors; DVTs and cellulitis are common and we had one patient recently who had a femoral artery pseudo-aneurysm rupture but fortunately survived.

The police have started to clamp down on begging and many of the patients have received criminal anti-social behaviour orders and are banned from large chunks of the city centre, which makes collecting their prescriptions and attending appointments a breach of their orders. There are no safe places to inject, so under flyovers, on flat roofs and in bushes by car parks there are needle litter and desperate people hurriedly injecting with all the risks that entails. This may make grim reading and sound very negative, and indeed much work is needed to change some of the attitudes within the authorities.

However my time there has felt incredibly positive, as despite these problems the staff are highly motivated and committed to working with this group, both through key working and support from the clinic, but also outreach. I was buoyed by their resilience and enthusiasm and reassured to see how individualised the care was for each and every client.

For me this has emphasised again the essential role the key worker has in an individual's treatment journey. For the first 12 years I attempted to treat people with problematic drug use at my practice. They had to go elsewhere for key worker support, and this disconnection meant much higher dropout rates, difficulty in communication and multiple journeys and appointments for the patients. The day when the shared care system in Birmingham formally launched, and we had key workers in our GP surgeries, was probably the most effective change that has happened in my career.

I have come to realise over the years that while a prescriber's role is important, what we do by providing a prescription for OST is to give people a choice. Without a script they have little option but to use drugs. On a script they have a choice to not use, however the confidence and ability to do that comes from within them and is usually a result of the strong therapeutic relationship that effective and caring key work brings.

Working with people who use drugs problematically needs a truly multidisciplinary approach. The bedrock of this is carers, peers and social support, but within treatment systems it needs doctors, nurses, pharmacists, counsellors and key workers who care about their clients and who communicate and work together to deliver the needs identified by the individual patient across the whole spectrum of treatment – from harm reduction to supporting abstinence.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP. www.smmgp.org.uk. He is also the RCGP regional lead in substance misuse for the West Midlands

LETTERS

UNFAIR ODDS

I was encouraged and pleased to read the article 'Loaded dice' in your September edition (page 6). It echoed my thoughts in terms of there not being enough help for the thousands of people in the UK suffering from gambling addiction/issues. My biggest gripe is that the government need to do more in terms of providing support and funding for the NHS, so that we can have more referral outlets that are able to offer the services greatly needed to tackle this ever-increasing social problem.

Be sure that this is a national problem that affects everybody and anybody. Not only does gambling addiction bring on other mental health issues such as depression, but it has a massive affect on those individuals' families and friends, breaking down relationships and friendships with the very people who are close to us.

I'm one of the lucky ones who came out the other side, but believe me there are many who are not so fortunate. I lost over £500,000, and it took me a long time to come to terms with the fact I had a problem. If you feel that you may have a gambling issue, please get professional help before it's too late. Denial is a major factor in a gambler's DNA so I can fully understand why we keep silent and not let our family and friends in, but, believe me, in the long run you will be relieved you found the courage and strength to break that silence. It could save your life.

I have just set up my own company, and we aim to provide a service for the thousands of sufferers out there, and not just on the therapy side but just as importantly the prevention side, which we will do through our presentations throughout the UK.

It's imperative we all work together to raise awareness and support those who are in real need of help, as it's a crying shame that as a country we are not doing enough to stop thousands from a life of debt, illness and misery. That has to change and change quickly.

Tony Kelly, by email
Author of *Red Card*,
www.kellysredcardconsultancy.co.uk

CUP OF CHEER

I wish to share with your readers the growing benefits of the social enterprise café run by our addiction recovery charity, the Spitalfields Crypt Trust (SCT).

Two years ago we launched a coffee-bookshop, Paper & Cup (*DDN*, March, page 7). It provides an open door to the local community in order to de-stigmatise addiction. It gives people in recovery a place to learn barista skills and gain work experience, while building social skills and self efficacy.

Paper & Cup has been a huge success and has enabled us to work in a new way with our service users, while creating relationships with local people and businesses.

There are no notices on the walls about addiction. Many customers come and go without realising that they have been served by someone who was homeless and in the grip of a serious substance addiction. Others pick up on our aims by chatting or by picking up our small leaflet. They all encounter recovery in an environment that is non-threatening and attractive.

In the past month a new chapter of the Paper & Cup story has begun. With funding from Comic Relief, we are opening as a 'recovery café'. At 7pm each Wednesday, Paper & Cup turns into Choices Café – a coffee shop run by service users with greatly reduced prices, board games, fellowship literature and more focus on our recovery community aims.

These evenings provide a social space for people in recovery to meet, share ideas, form friendships and have fun.

Our recovery steering committee are keen to make Choices Café open to anyone and local people come in, keen to pick up a bargain coffee. We are delighted to see this 'de-ghettoisation' happening, giving people the chance to take that brave step Bill W. [William White] called 'a bridge to normal living'.

Brent Clark, addictions therapist and community development manager, Spitalfields Crypt Trust, www.sct.org.uk

Championing recovery

Throughout September, more than 100 vibrant activities took place across the country for Recovery Month

JOIN THE CELEBRATION

Elly Sanchez recaptures the fun and inclusivity of RDaSH's Recovery Carnival

INSPIRED by the success of last year's recovery games, the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) drug and alcohol services team in Doncaster held a recovery carnival in Doncaster.

Visitors braved the dreary September drizzle to join in the fun and games at the all-day event at Sandall Park, which celebrated mutual aid and recovery, while helping to reduce stigma.

The day increased knowledge about access to treatment, and helped sustain addiction-free recovery and what works beyond medical treatment. Organisers reached out to those who are still suffering with addiction who may fear accessing treatment, by demonstrating it is possible to recover and contribute to society.

Designed to be family friendly and fun, the event included activities and attractions like human table football, a space hopper relay and a 'lob a welly' competition, as well as street entertainment (magic and fire eating), music from local bands and a recovery walk.

'The event brought together local communities, families, carers and friends to raise awareness of mutual aid and peer-led support networks,' said service manager, Stuart Green.

'No one sets out to have a drug or alcohol problem. Recovery is beyond prescription; this is as much a healing of the community as the individual, and we demonstrated that not only is there is a life after drugs, but also that recovery is infectious and motivating.'

Elly Sanchez is medical secretary at RDaSH. Anyone seeking help or advice can contact www.drughub.co.uk

WHAT YOU'RE SAYING

From the DDN website, www.drinkanddrugsnews.com

On our cover story 'Loaded dice?', September, page 6...

I had a fruit machine addiction since my school days up into my late 30s. It was a real battle to stop throwing my money away – for me the real thrill was the losing, which happened on the rare occasion I won the jackpot. I could not wait to get those pound coins in quick enough.

With the right help and good people in support I overcame this. I want to say that this is a very real, addictive problem. We need to ban these machines that the government have allowed in every social situation. Kids get hooked young as I did, spending my dinner money then, as a man, my wages. It can and should be banned.

Patrick

On 'The whole detox', April, page 16...

Homeopathy has never shown any effect on any medical condition under any circumstances. What is most concerning here is that we have an apparently non-medically qualified person using a method she apparently just 'made-up' – which hasn't undergone any scientific studies. She is then using this on people with genuine addictions who should be receiving professional treatment, rather than something that has never been shown to work for anything.

A very, very concerning situation.

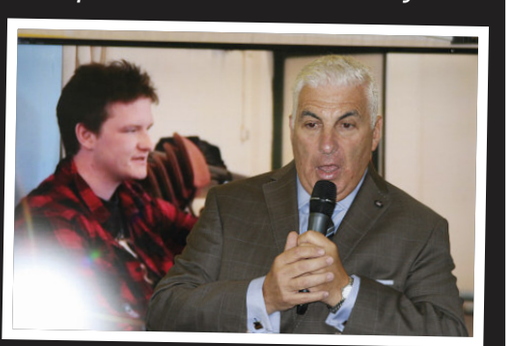
Simon (@flatsquid)

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

LIGHTS, CAMERA, ACTION

The Recovery Street Film Festival showed ten shortlisted films at events up and down the county



WITH 'DESERVING A FUTURE' as its the theme, the Recovery Street Film Festival's aim was to highlight the challenges that those living in recovery – and their family and friends – face when trying to find their place back in society. A joint project between the major treatment agencies, it was open to anyone, regardless of their film-making ability, who could show the determination and courage of individuals overcoming addiction.

Mitch Winehouse opened the festival at the official launch in Borough Market, London, on 10 September before the festival toured to other major cities including Birmingham and Glasgow.

'This film festival is another great example of Britain's recovery community giving something back to society and reaching out to share their stories, and hopefully in turn save lives. In doing so they humbly shine a light on themselves and expose the incredible people they are today,' he said.

The judges will select one lucky winner from the ten shortlisted films, also to be announced by Mitch Winehouse, to receive £1,000 worth of film-related prizes.

To find out more and view the films, visit www.recoverystreetfilmfestival.co.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The economic commoditisation of human pain is dangerously close to victim-blaming. Such an approach can send the destructive message: see how much money you cost everyone, you broken person? Its dark heart is that the state's only interest in its citizens is as economic units, occasionally broken and in need of quick and efficient repair, in order to slot back into the corporate design.
Alex Andreou, *Guardian*, 10 September

Stephen Fry, BBC favourite and darling of the new Establishment, noisily confesses in a rather sad and attention-seeking new book to possession and use of cocaine in Buckingham Palace. The official penalty for this offence is seven years in jail and an unlimited fine. Could there be better proof that the elite know perfectly well that the laws against drug possession haven't been enforced for years, and exist only on paper?
Peter Hitchens, *Mail on Sunday*, 28 September

Fry's world is not the dark estate alley, his confreres are not the ten-year-old runners, the swaggering gang boys who will cry in prison cells for their wrecked futures, or the girls they trade and rape as part of an urban social ecology intimately entwined with the drug trade.
Libby Purves, *Telegraph*, 27 September

I'm pretty sure it's a political confection, the visceral hatred of criminals this government exhibits. It doesn't indicate any serious reflection on who is actually in prison, what happens to them during their sentence, or what it will take for society to reabsorb them when they're released... The problem is a government that can write off some of its citizens as beneath its care. It's a dangerous cruelty with implications far beyond the prison walls.
Zoe Williams, *Guardian*, 15 September

Prison is not meant to be comfortable. It's not meant to be somewhere anyone would ever want to go back to. But the language being used by some pressure groups and commentators to talk about prisons bears little relation to reality.
Chris Grayling, *Guardian*, 18 September

It is too easy for GPs to write a script for a benzodiazepine when confronted by a patient who is in distress, or suffering with anxiety or insomnia. But the pills barely provide a sticking plaster for the real problem and can do far more harm than good in the long run.
Max Pemberton, *Telegraph*, 15 September

Like a mutating parasite, tobacco companies respond to public health efforts by exploiting weaknesses and compromising the global response... If tobacco corporations stopped resisting public health efforts, we could end tobacco use in a generation with a range of well-known, widely endorsed and effective measures.
William Savedoff, *Guardian*, 1 September

No matter that e-cigarettes are used by people to help them give up smoking; the WHO likes to imagine that they will lead paradoxically to more people doing it. Although, as the organisation admits, there is no evidence of children being tempted to take up cigarettes after trying electronic ones, it fears that this may not always be the case... You would think that the WHO had enough real health problems to deal with without needing to protect the world against imaginary dangers that may not even exist.
Alexander Chancellor, *Spectator*, 6 September

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VITAL CARE

Gordon Hay talks to *DDN* about RADAR, a new pathway for alcohol-related A&E admissions into residential alcohol detoxification in Greater Manchester.

AN ESTIMATED 35 PER CENT of A&E attendances in North West England are alcohol related. More generally, one in eight acute hospital admissions are due to alcohol. Manchester has one of the highest rates of alcohol related hospital admissions in England, significantly increasing over recent years. Many present recurrently at A&E, resulting in multiple short-term admissions which only address the acute effects of alcohol, such as withdrawal symptoms, and do not address the underlying cause.

RADAR, Rapid Access (alcohol) Detoxification Acute Referral, is an innovative new pathway from A&E into specialist alcohol detoxification facilities within the Chapman Barker Unit at Prestwich Hospital. Developed by a team within Greater Manchester West Mental Health Foundation Trust, the pathway was established in November 2012, and in the first year of operation it was rolled out across 12 A&E departments in Greater Manchester.

RADAR works closely with alcohol nurse specialists, who identify patients presenting to A&E with alcohol-related problems requiring detoxification, suitable for immediate admission into the RADAR ward. The 'rapid' part of the name does not just make a memorable acronym – with the ability to accept referrals 24 hours a day and transport available, people can be admitted to the RADAR ward in a matter of hours, avoiding an overnight stay in the acute hospital.

Specifically tailored alcohol detoxification begins immediately, taking between five to seven days before discharge and referral to community alcohol services. While in the RADAR ward, patients have access to a multidisciplinary team providing 24-hour medical support, and individual and group psychosocial interventions. The aim of these evidenced-based interventions, along with a strong focus on engagement and aftercare planning, is to provide better outcomes from detoxification and reduce re-presentation to acute hospitals.

A team within the Centre for Public Health at Liverpool John Moores University is working with RADAR to explore whether the pathway is meeting its four clearly defined aims to: reduce the burden on acute trusts; improve clinical outcome; improve patient experience and demonstrate cost effectiveness.

The main reason for presentation at A&E was withdrawal (eg seizure), with mental health issues, including suicidal ideation, self-harm or depression, also prominent. Many patients had three or more admissions to A&E within the preceding six months and a minority were in contact with a community alcohol or mental health service.

Outcomes from RADAR are impressive. Three months after discharge, more than half who could be contacted reported being abstinent or being controlled drinkers. This reduction in alcohol consumption resulted in far fewer contacts with acute hospitals, with reductions reported in the number of A&E attendances and nights in hospital. Early findings from the evaluation suggest that the pathway is cost-effective, with substantial savings relating to reduced alcohol-related hospital admissions following discharge from RADAR.

Dr Chris Daly, the consultant addiction psychiatrist at the Chapman Barker Unit notes, 'through the development of this pathway we are seeing real benefits in terms of improved patient outcomes and improved experience of detoxification following an acute presentation to A&E. One of the most important aspects is the ownership of the pathway by colleagues in acute trusts. In developing this pathway we have demonstrated that we can reduce the immediate and long-term impact of alcohol in acute trusts and more importantly, that patients respond positively to alcohol detoxification provided at the moment they need it most.'

Underneath the statistics are real people with personal accounts of their relationship with alcohol. Many patients admitted to RADAR have chronic and severe alcohol problems, often with other health complications, therefore successful outcomes are not across the board.

There have, however, been many encouraging stories. RADAR patients interviewed were overwhelmingly positive about their experience, in particular about the opportunity to talk to people who have been in the same situation. This is due to volunteers within the unit, many of whom are ex-patients of RADAR. Craig, an ex-patient who had more than 140 admissions into acute care before attending RADAR, and now volunteers in the unit, spoke of his patient experience, saying: 'it not only saved my life, but gave me hope, strength and willpower to turn it around. To be met by a caring member of the RADAR team who knew and understood how I was feeling was paramount to my stay and early recovery.'

Manchester has one of the highest rates of alcohol related hospital admissions in England.

The evaluation team have been struck by the enthusiasm that patients and staff have shown for RADAR. The main negative comments relate to issues that are part and parcel of residential detoxification, such as missing friends, family and pets.

What makes RADAR unique is the immediate admission into residential detoxification straight from A&E, when the patient needs it most. From the initial findings of the evaluation, this appears to be one of the more positive aspects of the pathway that could be considered for rolling out more widely across England.

Gordon Hay is a reader at the Centre for Public Health, Liverpool John Moores University

TURNING THE TABLES

People with drug and alcohol problems can be used to a cycle of punishment and low self-esteem. Kaleidoscope used a recovery awards event to reverse the mindset of service users, as **Barry Eveleigh** explains

Having worked in the field of substance misuse for more than 25 years as a practitioner, manager and commissioner, it's always struck me how we constantly 'punish' people with drug and alcohol problems – withholding prescriptions, placing people on supervised consumption or reducing doses for non-compliance. Granted, these measures are for clinical governance and safety reasons, but ask yourself this: how often do we actually reward and acknowledge the successes of the people who, at the end of the day, pay our wages?

When I was commissioning, a study of our clients' profile was undertaken. What was particularly interesting, but perhaps not surprising, was that most people in treatment had low-level academic achievement. Most had left school at an early age without any qualification whatsoever, or didn't get any good grades if they did take exams (80 per cent fell into the former category). People who used our service also had a long history of loss, breakdowns and punishment.

Looking at these facts and how we worked with our service users, I began to question whether we simply affirmed a sense of hopelessness and failure within a group of people who already had significantly low self-esteem.

When I moved to Kaleidoscope in Wales I was shocked, having worked previously in larger inner cities, to see how little rural treatment services had available – not just in funding terms, but also in relation to things like access to transport, employment and leisure opportunities. Despite these barriers I was amazed at how people who used our services overcame them. Just getting to our services deserved a medal. And that's when the penny dropped – perhaps we ought to consider an awards ceremony that recognised people's achievements? Combining this idea with the recovery agenda seemed the perfect opportunity to establish such an event, so this was how the first recovery awards event in July 2013 came into being.

We all know that recovery is a journey – or at least is meant to be – and should not purely focus on those individuals who had made and sustained abstinence (which is brilliant, don't get me wrong). With a small group of staff who volunteered to get this off the ground we looked at where someone's recovery journey started and finished and how we could incorporate this journey into a variety of awards. Rightly or wrongly, we decided that getting naloxone training should be the first award or first step to recovery, as this was where someone, who may not be stable or even in treatment, took responsibility for themselves and for others. From thereon in things started to flow and we ended up with a total of 14 awards *(see table)*.

We tried to make the awards as inclusive as possible. Not only did we want to award recovery success, but we also wanted other service users to witness recovery success. Venues, transport and buffet were ordered – the next hurdle was making nominations and inviting guests along. This might sound easy, but in a rural community people are still very anxious about going public over a drug or alcohol problem. For some people who had left the service, their days of coming into contact with drug and alcohol users were over and they were quite adamant that they did not want any further contact with us.

We finished up with 100 people getting awards and with a total audience of more than 200 people, including service users, members of the public and professionals. Each nominee would be called out – just like a graduation ceremony – and be given a certificate by our chief executive, Martin Blakebrough.

The event went well and the atmosphere was both relaxed and charged with excitement. The reception people gave each other as they went up for awards was so encouraging and emotional, especially as most people didn't know each other. For a lot of people, this was the first time they had ever received a certificate or formal recognition of their achievements of any kind.

One service user who won the 'Inspiration to others' award, having conquered homelessness, severe alcohol abuse, poor health, antisocial behaviour and become abstinent alone, commented: 'It was nice to feel valued and acknowledged as a person.'

For staff too, the event helped them to see improvements in their clients from a different perspective, when working with what they would often see as an unchanging caseload. 'It was nice to see that we are making an impact,' was a comment from one worker.

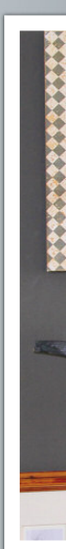
The event has made a difference to both staff and people who use our service and as a result we ran our second event last month. Staff were really keen to nominate individuals for this year's awards, and in terms of clients' recovery the event does seem to be contagious – our DNA (did not attend) rates have improved, more people are cutting down and more people are stopping. Word has spread and clients are really happy to be nominated this time around.

Staff have become so enthused with the recovery agenda that we have expanded from the recovery awards to a recovery month, in line with the UKRF, with staff working to produce a programme of events for each day of September. We tried to make the events open to service users, their families, the public, and community groups, to spread the recovery message. The month was called 'My Month – My Recovery' and events included a recovery photo competition with an exhibition of works that will travel across the county, country walks, litter-picking, gardening and allotment schemes, a ghost walk, an awareness event for faith group leaders, as well as bowling and sporting events. For a rural community with limited resources, this has been an exciting challenge to which everyone has risen and I am proud of everyone's commitment in getting this off the ground.

From just one event, it is amazing the impact that this has had on both the people who use our service and staff. It has improved the motivation of all the people involved with Kaleidoscope in Powys and we can only see our recovery movement going from strength to strength. **DDN**

Barry Eveleigh is team leader at Kaleidoscope Project, North Powys

RECOVERY AWARDS
Naloxone training
Best improved attendance/engagement
Alcohol reduction
Cessation of illegal drugs
Methadone/subutex reduction
Completing HG2G foundation groups
Completing HG2G groups
Drug/alcohol-free 3 months
Drug/alcohol-free 6 months
Drug/alcohol-free 12 months
Volunteers
Best progress
Inspiration to others
Carers

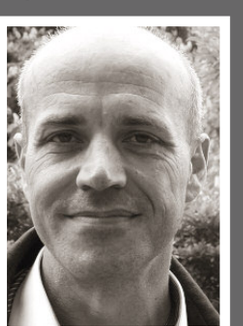


September's event was called 'My Month – My Recovery' and events included a recovery photo competition with an exhibition of works that will travel across the county...

VOICES OF RECOVERY

RECOVERING HOPE

Recovery should be about empowerment and instilling optimism – not about treatment effectiveness and 'number of years abstinent', says **Alistair Sinclair**



IT WAS UK RECOVERY MONTH IN SEPTEMBER. Not a lot of people know that, and those who do probably have very different views on what it means. There have been recovery months in the US for years and until pretty recently they focused primarily on 'recovery from addiction' and 'treatment'.

Early on it was called 'treatment effectiveness month' and there remains a US focus on services alongside a relatively recent expansion of the month to encompass mental health and 'behavioural science'. It's the US approach, perhaps a reflection of the difficulties getting access, particularly if you're poor, to even the most basic of services. I've seen echoes of this perspective in the UK, tweets referring to #addictionrecoverymonth, attempts within some social media to follow the US lead and frame UK Recovery Month as a celebration of the abstinent and treatment.

Somehow this doesn't sit right with me. People end up in 'addiction' because of a huge variety of issues. Many issues remain, and indeed perhaps new ones arise, once people stop using particular substances and become abstinent. Does a primary focus on addiction (framed around cessation of particular forms of unhealthy consumption) deny major realities in people's lives? Surely those that 'reclaim' their lives have recovered from much more than 'addiction'? Is 'recovery' more than 'treatment effectiveness' and a number of years abstinent? If we look at the mental health recovery movement we find that 'recovery' is all about 'assuming control... becoming empowered... challenging stigma... instilling hope and optimism'.

This is my kind of recovery, not some medicalised, treatment-led drug-obsessed distraction from the inequality and poverty, material and spiritual, that's strangling us. I'm with Professor Phil Hanlon at Glasgow university. We need to recover from 'economism', reducing people and communities to economic formulas, commodifying others in 'payment by results' matrices. Recover from 'materialism and consumerism', reducing ourselves to units of economic 'worth', buying, watching, consuming, empty. Recover from 'individualism', reducing ourselves to dislocated fragmented lonely shadows, separate, anxious, tapping away at screens. We need to recover from fear and find some hope; some sense that things can change for the better.

I see hope in the UK recovery movement, young as it is, confused as it is. I see it in the recovery walks, big and small, that have mushroomed across the UK since Liverpool in 2009. I see it in the passion and the strengths I encounter in small community groups scrabbling for existence in shabby service annexes and church halls. I see hope in harm reductionists coming together to redefine 'SU activism' and hesitantly forming links with the 'purple-clad recovery brigade'. I see it in service folk and community activists working tirelessly alongside the marginalised and the excluded. I see hope in the UK Recovery Month, 102 events this September, bringing all kinds of different people together, and that's why I think we need it. We need a month that celebrates hope, a month that celebrates our similarities as human beings and our diversity and the belief that we can, all of us, recover.

You can check out the 102 UK Recovery Month events here: http://www.ukrf.org.uk/index.php/recovery-month/events

Alistair Sinclair is a director of the UK Recovery Federation (UKRF)

SCRATCHING THE

There's much to be done to bring together substance misuse and mental health services so we can offer effective care for dual diagnosis, says **Taf Kunorubwe**

'Before we can offer you a psychiatric assessment, you need to be abstinent for a minimum of two months.'

HOW OFTEN DO SERVICE USERS RECEIVE SUCH RESPONSES? My experience of working in mental health care, IAPT (the Improving Access to Psychological Therapies programme), substance treatment services and as a mindfulness teacher has shown me that this happens all too often. The most simplistic explanation of dual diagnosis is experiencing one of a range of mental health problems in conjunction with substance misuse. However I would caution against relying on a literal interpretation as multiple, complex and interdependent needs are often involved.

Unfortunately dual diagnosis has been a diagnosis of exclusion, with service users omitted from mental health services for substance misuse and substance treatment services unable to offer the level of support needed. This is despite widespread recognition that this client group has multiple needs, worse social outcomes and the need for holistic approaches. This is recognised by many studies and documents, including the Department of Health's *Dual diagnosis good practice guide; making every adult matter* (a coalition of four national charities – DrugScope, Mind, Clinks and Homeless Link); the *Dual Diagnosis Toolkit* produced by Rethink and Turning Point; and IAPT's *Positive practice guide*.

In the space of an article I could not adequately explore the various definitions, historical context, prevalence, service user experiences, or therapeutic interventions relating to dual diagnosis. Rather, I am aiming to share some helpful practice and to contribute to the discussion around how to support such service users.

Firstly, I cannot advocate training strongly enough; even basic awareness or assessment skills will benefit service users and boost workers' competencies and confidence, and basic training should be available as part of everyone's induction process. If this isn't currently provided, you may wish to consider self-directed study or free e-learning packages such as the *Dual diagnosis, making progress e-learning resource* http://www.celecoventry.co.uk/projects/dualdiagnosis/. For those regularly involved I would recommend further development via advanced practitioner training, which you may be able to access as part of your professional development plan, through bursaries or self-funding.

Not only would training help workers to better support service users, it can also be a catalyst for culture change in services, shifting from attitudes such as 'don't ask don't tell', exclusion and non-compliance, towards non-judgemental positions, empathy and support. This will hopefully allow service users to be open and honest about their experiences and help engagement, allowing services to come to a shared understanding with them about recovery. Also, at a professional level, this more integrated culture should help to move us closer to a feeling of cohesion instead of 'us and them'.

With non-judgemental, empathetic and supportive attitudes, we can embark on engaging more with service users. By this, I do not mean simply allowing access to services, but removing additional barriers and encouraging active engagement. Experience of this at the pre-assessment stage has been through outreach work, health promotion or working in conjunction with services that are first points of contact, such as food banks. During assessment we can actively engage by using therapeutic skills and entering into a conversation about how their substance use and mental health interrelate, psychoeducation and therapeutic treatment options – all of which will help to reach a joint decision and enable any subsequent work to be towards a joint view of recovery.

Once in treatment, I have often found a crossover of interventions, which aids engagement as we are addressing underlying processes. An example of this is in CBT sessions: we explore the impact that negative automatic thoughts have on depressed moods and how to challenge these. By the end of therapy, these coping strategies can effectively challenge negative automatic thoughts in relation to substance misuse.

In instances where we possibly require further expertise, joint work can be helpful, and it doesn't require superhuman effort to collaborate with mental health services. In my experience this can be as simple as attending team meetings, joint care planning, outreach, risk management and supervision. Not only does this aid active engagement with all the services involved, but it also means we have a shared culture of recovery, avoid repetition for clients, help to achieve integrated interventions and contribute to staff being supported. An example of this was through joint outreach with mental health services. We re-engaged with a high-risk service user and helped him to stabilise; whereas before when he disengaged, he deteriorated until he was detained under the Mental Health Act.

Not only does joint work benefit clients and aid engagement, but it is also helpful in developing an awareness of services, the treatment approaches available, referral routes, screening measures and the support they offer. I found this helpful when considering additional support for service users and enabling

SURFACE

them to make an informed decision. For example what's the difference between IAPT, psychotherapy, and psychosocial interventions? Does the IAPT employment retention service accept external referrals? Such information can be shared by open lines of communication developed through joint working.

'I cannot advocate training strongly enough; even basic awareness or assessment skills will benefit service users and boost workers' competencies and confidence'

Another useful practice is to consider the impact that both the mental health and substance misuse may have on a service user's level of risk, so we can create a more holistic and comprehensive risk assessment and management plan. When assessing risk I often consider the following: risk to self, risk to others, risk from others, neglect, safeguarding, escalating substance use, deteriorating mental health and social functioning. For those interested in more information, there are good practice guides such as the *Clinical risk management: a clinical tool and practitioner manual* (2000) or *Best practice in managing risk* (2007).

Equally important is how relapse prevention is a crucial ingredient in recovery from either substance misuse or mental health problems, with a lack of integration meaning that one lapse often leads to another. As such, a holistic relapse prevention plan involving the service user and mental health services can be helpful. This plan can incorporate early warning signs, effective steps and smart goals, and should be followed by effective support from aftercare services.

This undercurrent of integrated care can effectively match the needs and goals of service users, avoiding the prescriptive approach that can overwhelm dual diagnosis service users and hamper engagement. By joint working, we can offer a range of support matching the care plan driven by the service user, regardless of service restrictions such as limits on the length of treatment.

Unfortunately, some services tend to be driven more by their own needs (and limitations) than the needs of service users. One recent example I came across was of a service user (who had significantly reduced her alcohol use) who had been encouraged into residential treatment for her drinking, after losing her accommodation because of noise complaints when she responded to voices. Soon after her admission we received concerns about her mental state and reports that other residents were frightened, and she was discharged as the rehab was 'not equipped for dual diagnosis'.

Unfortunately, such experiences are all too common and illustrate some of the challenges that professionals face, which can contribute to compassion fatigue and burnout. As such, the provision of adequate levels of supervision and support is of utmost importance. Regrettably, my experience is that substance misuse services only provide limited supervision, which often focuses more on management issues such as targets and repercussions. Commissioners and managers need to be proactive in facilitating supervision, and professionals should feel comfortable requesting it. I often found it helpful to receive supervision or support through link work with other services, peer support or even using a buddy system. I cannot express enough gratitude to current and previous colleagues for providing these excellent, never-ending reserves of support, as I wouldn't have coped without them.

*****

My final suggestion relates to coping with the challenges professionals face, by practising self-care. I have personally found it useful to use the same interventions that I suggest to service users, such as cognitive restructuring, worry time, behavioural activation, transition from work to home, assertiveness, and practising mindfulness. For those interested in mindfulness, I recommend the three-minute breathing space. This can be summarised as – step one: becoming aware; step two: gathering and focusing attention; and step three: expanding attention. There are some useful free online resources that you can use for this.

In this article I have only been able to scratch the surface of the many helpful practices that can be introduced to support dual diagnosis service users and the professionals who work with them. My hope is to raise much-needed awareness, and share some helpful insights, alongside my passion for good practice. If nothing else, it is a call to arms to raise the profile of this challenging work and I look forward to hearing other perspectives. Some final words to managers and commissioners: please offer more support and strive to improve standards of care. **DDN**

Taf Kunorubwe is a mindfulness teacher and a locum working at a CBT service within the NHS.

Street wise

The links between problem drug use and street sex work are well known, with street sex workers particularly vulnerable to violence and assault, most of which has tended to go unreported. Run by the UK Network of Sex Work Projects (UKNSWP), the National Ugly Mugs (NUM) scheme was launched in 2012 with the aim of warning sex workers about dangerous individuals and helping the police gather intelligence on serial offenders. This year the scheme was not only winner of the Paolo Pertica Award – which recognises innovation and contributions to public health in a criminal justice context – but also won in the 'small charity, big achiever' category of the Third Sector awards.

'We were quite surprised as that was a really glitzy award ceremony, and we're not used to getting that kind of mainstream attention,' says NUM's director of services, Alex Feis-Bryce.

Around 20,000 sex workers are now engaged with the scheme, with more than 1,000 incidents reported so far, and while all but a few victims are happy to share information anonymously with the police only 25 per cent are prepared to make a formal statement. 'That means the police are getting vital intelligence they'd otherwise be unaware of,' he says.

The 'ugly mugs' concept originated in Australia in the mid-1980s, when sex workers in Victoria began circulating descriptions of violent men. While the first UK schemes – in Birmingham and Edinburgh – began at the end of that decade, NUM is still the only nationwide, integrated scheme of its kind.

'The UK Network of Sex Work Projects, ever since they were formed in 2002, have been advocating for a National Ugly Mugs scheme,' says Feis-Bryce. 'The Home Office funded a development project, which was basically a big consultation, and then they provided funding for a one-year pilot – it was three months to set up and operational for nine months after that.' The pilot ended in March 2013, and the scheme has run independently since then.

'So it's the first time there's ever been government funding involved, and the first time it's ever been national,' he says. 'Obviously we're completely independent of the police, but we do have formal links in terms of sharing data – if we've got consent – and that kind of thing. We're the first of its kind in the world, really.'

The scheme also gets funding from the police, he says, but on an ad-hoc basis. 'There's quite a lot of devolved power to every police force, which means we have to go to each individual force, and there are 43 in England and Wales.' The scheme does have a good working partnership with the police, however, although the partnership is stronger in some areas than others. 'Some force areas value the scheme more than others, I suppose, but a lot of it is just getting in there and raising awareness.'

Was it easy to establish those relationships – were the police onside from the beginning? 'We had top-level senior police officers supporting the scheme from the start,' he says. 'Part of the consultation process was with the police and the National Crime Agency's serious crimes analysis section, so that helped us, and ACPO [Association of Chief Police Officers] were also very supportive. But it's still a slightly different relationship with every force. That's one of the challenges – knowing exactly who to go to, and how it's going to be dealt with.'

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A number of high-profile cases over the years have highlighted poor police attitudes when it comes to investigating violence against sex workers. Are those views on the way out now? 'We still encounter it every now and then, I have to

An award-winning scheme has been protecting vulnerable drug-dependent street sex workers from attack. Its director of services, Alex Feis-Bryce, talks to **David Gilliver**

'An evaluation of the pilot found that 16 per cent of the 20,000 sex workers engaged with the scheme said that they'd avoided an individual directly as a result of one of our warnings.'

say,' he states. 'We probably hear more positive than negative stories now, but we still do hear things that are absolutely shocking.' While officers investigating serious sexual offences are specially trained, there can still be issues with 'first responders' to incidents, he explains. 'But most of the officers who are experienced in investigating sexual offences have no interest in whether the victim's a sex worker – they just want to solve the crime.'

The stigma around problematic drug use can take its toll, and that's something that can be massively compounded when sex work is involved. 'Absolutely,' he says. 'Most of the research shows that it's about 90-95 per cent of female street sex workers who are dependent on drugs and/or alcohol – it tends to be the major driving force of why they're on the streets working, along with issues of homelessness. Because some of them will already have had run-ins with the police, the levels of trust are really low, and you do get officers who aren't very respectful. With the other sector of sex workers – escorts and things like that – rates of problematic drug use are incredibly low, but it's the sex workers working on the streets who are most targeted by the type of perpetrators we deal with.'

And the least likely to report it? 'Yes, and that's not just about trust. We've had incidents where they want to report it but the court process – particularly with something like sexual assault – is just not set up to deal with people who have chaotic lifestyles. They might be keen to make a statement but often the courts and police aren't very flexible about how the statement is taken, so there are lots of barriers. I've been involved in a serious sex offence trial as a witness, and even for someone who's able to get the train and make all the meetings it's an absolute nightmare. So that is a real challenge.'

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The project has forged excellent links with treatment agencies, he explains, with around 320 national members including specialist sex work projects. 'Most projects working with street sex workers will either have strong partnerships with drug treatment agencies or they themselves will provide services like needle exchange and so on,' he says. 'We work really closely with them.'

In areas without a specialist sex work project there will be drug services that regularly encounter sex workers, which means raising awareness of the scheme is vital, he stresses. 'It might only be small numbers of sex workers engaging with them, but what we do is a resource that's always available.'

A former political advisor, he was faced with a decision about whether to stay in politics when the MP he was working for suddenly died. 'I'd been volunteering with the Albert Kennedy Trust, which works with young LGBT homeless people, and a lot of the young people they supported did turn to sex work to survive, so I was aware that sex workers were a particularly stigmatised group. I realised that I didn't want to stay within politics for that much longer, but I had skills from doing that work that I was able to take to something that had a more direct impact on people's lives. With politics it can be a bit abstract, but this was an opportunity to do something more hands on. The challenge, but also the impact, of working with a particularly stigmatised group had always appealed to me.'

The scheme has already led to 16 convictions that NUM is aware of, and the actual figure may well be much higher, he points out. 'Once someone makes a formal report to the police they aren't very good at keeping us informed of the progress, because we have so many that go through to them.'

One conviction earlier this year, however, saw a man sentenced to ten years for a knife-point rape, with the way the case was handled recognised as a model of good practice. 'She was a Romanian escort who was adamant that she didn't want to report it to the police, or even tell anyone, but she went for a routine health check with a nurse who was aware of the scheme, and it was part of the process to say, "has anything happened to you that we should report?" A couple of weeks later the police came to us and said, "we think we may have identified the perpetrator – can you go back and ask these questions, and she can still maintain her anonymity?" It was a credit to the police how flexible they were, so she started to believe that they were taking it seriously, weren't interested in the fact that she was a sex worker, and didn't disrespect her.'

Eventually she made a full report and, supported by specialist advisers and a translator, went to court. 'The police use it as an example of why the scheme is important, because they just wouldn't have known about it otherwise,' he says.

Despite positive outcomes like this, however, and having just two full-time and two part-time staff, plus a volunteer, funding has been a constant headache. 'It's the bane of our existence,' he says. 'The Home Office provided funding for the pilot but said "we won't ever be able to fund you after that". They can fund projects to seed but if they funded us beyond the pilot it would be seen as sort of double-funding the police, which is against Treasury rules.'

Another problem is that NUM tends not to qualify for a lot of big grants, he explains. 'We're more about sharing intelligence and best practice and information, and that's just not popular to fund. At the end of every financial year we don't know if we're still going to be running in a few weeks' time, and it's going to be like that again if we don't find some kind of sustainable solution.'

And if funding does dry up, the consequences could be grave. 'An evaluation of the pilot found that 16 per cent of the 20,000 sex workers engaged with the scheme said that they'd avoided an individual directly as a result of one of our warnings, which is almost more powerful than the criminal justice outcomes,' he says. 'That's a large number of crimes potentially prevented.'

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WALK THIS WAY

How does it feel to take part in the UK Recovery Walk? Four participants tell us about their experiences in Greater Manchester last month

'Could we live up to expectations?'

Waking up on Saturday morning with a view of an empty Castlefield Arena, my thoughts ran back over the five previous recovery walks and I thought to myself, 'could 2014 live up to the massive expectations?'

What was different for me about this year's walk was being a member of the Greater Manchester Recovery Federation (GMRF) the body who, 18 months pre-walk, set out on a dream of helping Greater Manchester to host the sixth UK Recovery Walk.

Any worries that nobody would attend were alleviated as the trucks delivering the stage arrived. Like soldiers, our members and volunteers set about putting together a mini-festival. Soon the many recoverists from around the UK descended, and our day sprang into action.

It was a great honour when Annemarie Ward, CEO of UK Recovery Walk, introduced me and the rest of the GMRF core group and invited us to welcome our guests from all over the country. There were so many people I knew personally from all corners of the UK during my six years in recovery.

Another great moment was leading the walk and carrying the GMRF banner with Kath, Julie and my twin brother Dominic. I will remember looking back down Deansgate at all the amazing banners that people had made.

The walk was amazing but we had an afternoon of highs still to come. The acts still to perform included our band, It's All About Me, which I'm part of with my brother Dominic, Jason and Lewis. After our act, I stood on the stage and officially closed the 6th UK Recovery Walk 2014, and my thoughts went back to the early morning when I had wondered if we would live up to past walks and be a good representation of our recovery movement here in the UK. I may be biased, but I think we did. It was an amazing day that will live long in my heart and mind as I'm sure it will for many people of Greater Manchester and beyond.

Special thanks to the UK Recovery Walk charity and all their members and we wish Dot, Mark and all at Durham the very best for 2015. And to my amazing friends at the GMRF, be very proud. We did it – let the legacy of the walk be that recovery in Greater Manchester will continue to thrive.

One love, we do recover. ***David Dakan***

'I felt pride I had never felt before'

As the morning of 13 September came I could not believe that all the organising, planning, meetings and conversation cafés would be no more and the sixth annual UK Recovery Walk was upon us in our very own city. This walk was the first that I had ever attended and it was made extra special to know that my family and my daughter of two years, whom I had when in recovery, would be there to attend and be part of an amazing day. As both an employee of the UKRW charity and a member of Greater Manchester Recovery Federation, many months of my life had been focusing on this incredible day.

On arrival at 8.30am I was able to see the transformation at Castlefield take place as the stage was built, marquees erected and people started to arrive. For the rest of my life I will remember looking out from the stage at thousands of faces, approximately 8,000 happy joyous people, free from substances, high on life, celebrating recovery. All the hard work that was put in was worth it. I felt a sense of pride I have never felt before and I felt part of this huge family that stood united, overcoming what I can only describe as one of my hardest personal battles. I could stand tall and say I had a part in that walk, however small, as did many other people – and for that I thank them.

The message, simply, is we can recover and we do recover. The legacy from this year's walk fills me with hope and excitement about the future of our recovery community and GMRF. What made my day extra special was I got to share it with the most important person in my life. As I stood on stage, Ava held by my mum had the biggest smile on her face, waving, shouting mummy and blowing kisses. That is priceless and a memory I will always remember, ever reminding me should I ever forget – my recovery is so worth it! ***Danielle Woolley***

'The message, simply, is we can recover and we do recover. The legacy from this year's walk fills me with hope and excitement about the future of our recovery community...'

'I was part of something amazing'

When we heard the news that we had won the opportunity to host the UKRW, a spark of enthusiasm was ignited. This grew and grew, and with the introduction of a conversation café at the planning meetings we had participation from hundreds of individuals who offered help, ideas or support. These fantastic people came from all of the boroughs of Greater Manchester. The GMRF had always wanted to find a way of uniting the ten boroughs and this was definitely working, proving that this was going to be the biggest UKRW and hopefully the best yet.

With each year that passes the UKRW has grown in popularity and the number of attendees has increased. They say there were 8,000 people at this year's UKRW, and everyone who I have spoken to says they have a new refreshed way of looking at recovery and what it means to them, their families and their communities. The language we use to describe ourselves and the positive statements have gone a long way in challenging stigma – not just what we see in the media and how we are referred to by Joe Public, but also in our internal voices and how we see ourselves 'fitting in'. The planning group gave everyone a chance to have a voice. Many of these people went on to volunteer on the day of the walk and we are so grateful to them all.

As part of the GMRF I was privileged to be at the very front of the walk, and there was a group of very talented drummers right behind us, providing us with music and a beat. This set the pace and the mood of the walk for me. At one point we were held at a waiting point while police and traffic management cleared the last of the traffic away. At this point I turned to face the crowd behind me and felt I was part of something truly amazing.

We spontaneously began clapping to show our appreciation, the police joined in and so did others and soon, with the drums, the clapping, the shouting and the whistling, the noise of a big city on a crowded Saturday afternoon was drowned out. I had goosebumps, and at that point I knew that no matter how hard we had all worked, I would do it all again in a heartbeat. ***Julie Lloyd-Holt***

'Hard work... but what a buzz'

It's all about today – 13 September. All the hard work done? Hehehe, not bloody likely! It's going to be great, in my element. Putting on a party for over 8,000 'recoverists' – amazing! Inspiring. I'm there. Right, as a core member of the GMRF I have a responsibility. What's that? Fill that big screen with walkers walking the walks? Right. No camera! No Wi-Fi! Oh dear. Time to shine, Oli – use what you know, think on ya feet.

'Excuse me bud, can I borrow you to do some filming? I need to fill that screen!'

'Sure bud, no problem. Waddya need?'

Great stuff! It's amazing what you can get if you ask. Ok then, let's join the throng!

We go to the front. People are gathering. People are smiling. People all in recovery, or friends and supporters of them, are together, joined as one, in unity, as a celebration. It's ok. It's good. Life is good. I may have bad days but it's not a bad life. And all these people show me this. I can see it in their faces. They are living it.

Three, two, one... and we're off. Get the shots? Run about? Jeez this is hard work! But so worth it. Get some great footage, easy as Rochdale go past, London, Brighton, Yorkshire, fellowship people, SMART. All representing the area where they live a life in recovery. It's important. Just being there and advocating in numbers. Members of the public look quizzical. Walkers inform and advocate. What a buzz.

Back to the stage. Edit the pictures, stick a graphic on the end, bung the MPEG on a stick. Can't wait to see the reaction.

Henry Maybury takes to the stage, second song in and 'voila!' It's on the screen and people are watching. They are laughing, pointing. I love it. This for me is what it's about. People in unison, walking that walk, loving recovery. Brilliant! ***Oliver Rice***

Henry Maybury is raising money for addiction and recovery charities with his single Lost Days, www.henrymaybury.com

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DDN Drink and Drugs News

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Havering
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The event will provide an opportunity for potential providers to:

- ***Learn about the changing needs and profile of Havering***
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- ***Network with other providers***
- ***Next steps***

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If you wish to attend please contact Georgina Warwick by email georgina.warwick@havering.gov.uk

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The invitation to tender will close on 10th November 2014 at 12 noon.

If you have any questions regarding the subject matter for this tender, please contact the Slough Drugs & Alcohol Action Team on 01753 875579 or email DAAT@slough.gov.uk

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