DDN
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SETTING OUR SIGHTS ON 2015

A FIGHTING CHANCE
A new approach to meeting the unique treatment needs of armed forces veterans p6

CLOSE TO HOME
A powerful illustration of why family support is worth fighting for p12

REVIEW
Never a dull moment: DDN looks back on another dramatic year in the drugs field p24

THE CHALLENGE:

GETTING IT RIGHT FOR EVERYBODY

8th DDN national service user involvement conference

We're under no illusions that service user involvement is meeting its toughest challenge yet. The DDN conference will bring together inspiration and ideas from all over the country, to debate what's happening, put forward ideas on surviving and thriving, and gain strength from networking.

Our programme covers meaningful activism, building social capital, the naloxone campaign, alcohol support, tackling BBVs, skills sharing, messages for politicians, practical service user involvement at all levels, therapy zones, and a lot of interaction and debate.

DON'T MISS IT!

19 FEBRUARY 2015, BIRMINGHAM

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Making Sense of Alcohol

Editorial – Claire Brown

Close to home

Can localism work in our favour?

The lack of clear and consistent information on naloxone has caused confusion and delays (page 10). The case is now very obvious for increasing access to the life-saving drug, yet there has been no central direction (blame localism, says PHE) and a postcode lottery of reaction to making naloxone distribution a reality in every area of the country. Let's hope that NAG's initiatives have the desired effect.

As DDN goes to press PHE has released a report indicating that 'drug recovery rates are showing signs of slowing'– after years of treatment service figures displaying a positive trend – and urging local authorities to 'fulfil their responsibilities to understand and address drug use and the harm it causes' and invest in helping people to recover from addiction. This is alarming on every level, but sadly not a surprise. On this month's letters page (page 18) our readers add voices to those who say it's time to make a stand and challenge disinvestment, warning of more pain to come and calling for a compassionate response.

Jacquie Johnston-Lynch's account of setting up Tom Harrison House for veterans (page 6-7) is an inspiring example of translating compassion into much needed local action. Times are tough but we have to believe that where there's a will there's a way. Festive greetings to you and a happy and peaceful new year.

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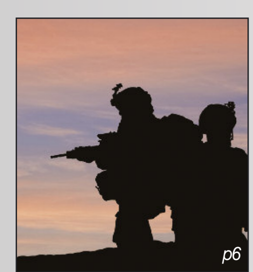

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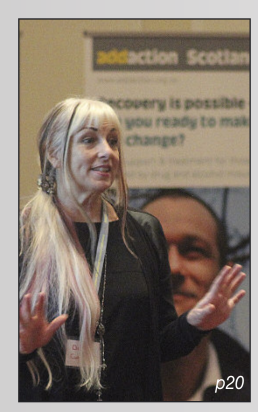

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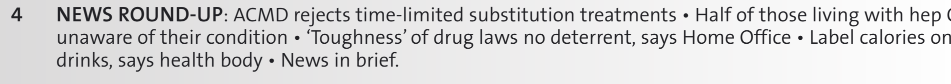

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NEWS IN BRIEF

OPIUM INCREASE
Opium poppy cultivation in Afghanistan rose by 7 per cent to more than 220,000 hectares in 2013, according to UNODC figures, with opium production this year potentially up by 17 per cent and prices falling as a result. 'We cannot afford to see the long-term stability of Afghanistan – and the wider region – derailed by the threat of opiates,' said UNODC chief executive Yury Fedotov. *2014 Afghanistan opium survey at www.unodc.org*

NALOXONE ALERT
A patient safety alert on the use of naloxone has been issued by NHS England, where the drug is used to provide pain relief following surgery. There is a 'risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment' says the warning, with the NHS receiving details of three patient safety incidents – two fatal – resulting from failure to follow British National Formulary (BNF) guidelines. *More information at www.england.nhs.uk/2014/11/20/psa-naloxone*

ON THE RADAR
Greater Manchester West Mental Health NHS Foundation Trust's RADAR (Rapid Access to Alcohol Detoxification Acute Referral) service has been named non-age specific psychiatric team of the year by the Royal College of Psychiatrists. The service takes referrals from 11 acute hospitals, with a 97 per cent successful detox rate on its eight-bed ward. 'Our RADAR ward is the first of its kind in the country and we are hugely proud of the service and the exceptional team who run it,' said the trust's director of nursing and operations, Gill Green.

CARER QUESTIONS
A ten-minute survey on professional training and development and the needs of carers has been launched as part of the Recovery Partnership/Alcohol Concern review of alcohol services. *The survey can be found at https://www.surveymonkey.com/s/XRPWR3J until the start of next year.*

ONLINE ANXIETY
A new online learning tool on anxiety disorders has been launched by NICE, aimed at drug and alcohol teams, mental health professionals and GPs. *Available free at elearning.nice.org.uk*

ACMD rejects time-limited substitution treatments

Time limits on heroin substitution treatment such as methadone would 'not benefit' drug users' recovery and would increase the possibility of relapse, according to a new report from the Advisory Council on the Misuse of Drugs (ACMD).

Imposing a time limit could also lead to other 'significant unintended consequences', it says, such as increased rates of overdose, blood-borne viruses and drug-related crime. The ACMD had been asked to consider whether there was a case for a maximum time limit by the Inter-Ministerial Group on Drugs.

Although there are no recommended time frames for OST maintenance in UK clinical guidelines, the issue of people being 'parked' on methadone has long been a controversial one. The report, however, found that while a 'small minority' of 10-15 per cent of service users received OST for five years or more, a larger minority 'may not be in OST long enough to derive long-term benefit'. OST use is 'episodic and relatively short' for the majority of people, it says, with nearly 40 per cent stopping within six months. 'The "being parked" analogy may not be correct,' states the document. 'Most people get out of the car and walk away.'

However, it was unhelpful to 'focus on the medication alone', stresses the report, with 'concomitant psychosocial interventions and recovery support' vital. OST should be seen as a 'stepping stone' on a path to overcoming dependency, said ACMD chair Professor Sir Les Iversen.

'All the evidence suggests restricting access to OST leads to an increased risk of people relapsing, turning to crime to fuel their habits – and even dying from an overdose,' said co-chair of the ACMD's recovery committee, Annette Dale-Perera. 'However, it is important to remember that medication alone will not lead to a successful recovery. OST should be delivered alongside therapy designed to change behaviour, as well as recovery interventions, to help people tackle their addiction and rebuild their lives.'

The findings were welcomed by DrugScope. 'The notion that somebody who has been in the grip of a serious drug dependency for many years could be successfully treated to an artificial timetable has always been deeply flawed,' said chief executive Marcus Roberts. 'It also goes against the widely held consensus in the drug treatment and rehabilitation field that recovery should be self-determined as it is in mental health.' However, his organisation remained concerned by anecdotal reports that some local commissioners 'may be indicating their preference for time-limited solutions in the tendering process', he said, adding that DrugScope would be 'monitoring' the situation.

The Home Office has also announced that it has accepted the ACMD's advice to control the new psychoactive substances 4,4'-DMAR – known as 'serotoni' – and MT-45 as class A substances, following concerns about their safety.

Time limiting opioid substitution therapy at www.gov.uk

Half of those living with hep C unaware of their condition

Around half of people living with hepatitis C infections are unaware that they have the virus, according to a new Public Health England (PHE) report. Nearly 14,000 hepatitis C infections were diagnosed in the UK last year, around 90 per cent of which were acquired through injecting drug use, says *Shooting up: infections among people who inject drugs in the United Kingdom 2013*.

Around two in five people who inject psychoactive drugs are now living with hepatitis C, says PHE, with half of the infections remaining undiagnosed, while about one in 30 of those who inject image and performance-enhancing drugs are also living with the virus. Interventions to reduce infections and diagnose them earlier need to be expanded, the agency stresses, with vaccinations and diagnostic tests 'routinely offered' to people who inject drugs and treatment made available to anyone testing positive.

Although reported rates of needle and syringe sharing have halved over the last decade, around one in seven people injecting psychoactive drugs still share needles and syringes and 'almost one in three had injected with a used needle that they had attempted to clean', says the document, with recent increases in the injection of drugs such as amphetamines and mephedrone also 'cause for concern'.

'With around half of those people living with hepatitis C still unaware of their infection, we need to do more to increase diagnosis rates,' said PHE infections expert Dr Vivian Hope. 'Ultimately, this will help reduce the current high level of infection we're still seeing among people who inject drugs. Obtaining blood from people living with hepatitis C who inject drugs can be difficult due to poor venous access. Dry blood spot testing is an alternative method that avoids puncturing veins, and which has been proven to be reliable and simple, and acceptable to both people who inject drugs and drug service staff.'

There are now almost 110,000 people living with HIV in the UK, according to another PHE report, although the number of people being diagnosed with a late stage of infection has fallen from 57 per cent to 42 per cent in the last decade.

Shooting up: infections among people who inject drugs in the United Kingdom 2013, and HIV in the United Kingdom: 2014 report at www.gov.uk

'Toughness' of drug laws no deterrent, says Home Office

There is 'no apparent correlation' between the toughness of a country's approach to drugs and levels of use, according to a Home Office study of international drugs policies.

Drugs: international comparators reviewed different approaches 'in policymaking and on the ground' based on a series of fact-finding missions between May 2013 and March this year. Ministers and Home Office officials visited Canada, the Czech Republic, Denmark, Japan, New Zealand, Portugal, South Korea, Sweden, Switzerland, the US and Uruguay, looking at issues including decriminalisation of possession for personal use, consumption rooms, heroin-assisted treatment, drug courts and supply-side regulation of cannabis.

'Without exception, every country we considered sees drug use as undesirable,' says the document, and while all were 'taking steps to disrupt, reduce, or regulate supply' there was a 'variety of responses to the individual user'. In terms of the effectiveness of drug laws, researchers studied Portugal, which removed criminal sanctions for personal use in 2001, and the Czech Republic, where possession of small quantities is treated as an administrative offence punishable with a fine. They also looked at Japan, which operates a 'zero tolerance' policy with possession of even small amounts of drugs attracting lengthy prison sentences, and Sweden, whose approach to possession 'has grown stricter over several decades'.

'While levels of drug use in Portugal appear to be relatively low, reported levels of cannabis use in the Czech Republic are among the highest in Europe,' says the report. 'Indicators of levels of drug use in Sweden, which has one of the toughest approaches we saw, point to relatively low levels of use, but not markedly lower than countries with different approaches.'

The report discusses evidence of 'improved health prospects' for drug users in Portugal, with the caveat that these 'cannot be attributed to decriminalisation alone' and adds that it is unclear whether decriminalisation 'reduces the burden on the police'. The country has, however, reduced the proportion of drug-related offenders in its prison population, says the report.

The document acknowledges that 'what works in one country may not be appropriate in another', with 'the legislative and enforcement approach' only one strand of a country's response. It also stresses that there is 'robust evidence that drug use among adults has been on a downward trend in England and Wales since the mid-2000s' and that the UK's 'balanced approach enables targeted demand-reduction activity, and good availability and quality of treatment. Indeed, while in Portugal, we were encouraged to hear that drug treatment in the UK is well-regarded internationally.'

In terms of supply-side regulation of cannabis the document states that the policies in Uruguay and the US are 'highly experimental', with no evidence so far to 'indicate whether or not they will be successful' in reducing criminality.

'The differences between the approach other countries have taken illustrate the complexity of the challenge, and demonstrate why we cannot simply adopt another country's approach wholesale,' said crime prevention minister Norman Baker. 'The UK's approach on drugs remains clear: we must prevent drug use in our communities, help dependent individuals through treatment and wider recovery support, while ensuring law enforcement protects society by stopping the supply and tackling the organised crime that is associated with the drugs trade.' Publication of the report saw Baker accuse Conservative colleagues of 'suppressing' the document, which had been ready for a number of months. Less than a week later he resigned, and has been replaced by Lynne Featherstone.

The Home Office has also published the findings of its expert panel study of new psychoactive substances (NPS), and the government's response which includes plans for a blanket ban similar to that introduced in Ireland in 2010, improved training for NHS staff and new PHE guidance for local authorities on integrating NPS into treatment, education and prevention work.

Drugs: international comparators; New psychoactive substances in England: a review of the evidence, and government response at www.gov.uk

Label calories on drinks, says health body

Calorie labelling should be introduced for alcoholic drinks, according to the Royal Society for Public Health (RSPH). More than 80 per cent of the public did not know – or incorrectly estimated – the amount of calories in a large glass of wine, says RSPH, while for a pint of lager the figure was almost 90 per cent.

While alcohol is currently exempt from EU food labelling legislation, the European Commission is to decide on whether to extend nutrition labelling, including information on calories, to alcoholic products. The RSPH is calling on both the EU health commissioner and the drinks industry to introduce calorie labelling, and says its research shows that 67 per cent of the public would support the move.

'Calorie labelling has been successfully introduced for a wide range of food products and there is now a clear public appetite for this information to be extended to alcohol to help individuals make informed choices,' said RSPH chief executive Shirley Cramer. 'With two in three adults overweight or obese, and given that adults who drink get approximately 10 per cent of their calories from alcohol, this move could make a major difference to waistlines of the nation. While we continue to back unit labelling for alcoholic drinks, we believe that many people find calorie labelling easier to translate into their everyday lives.'

NEWS IN BRIEF

COSTING IT OUT

A new online survey on drug prices and drug spending has been launched by 3D Research. British adults who've used cannabis or other illegal drugs in the last year are invited to take part, with all responses completely anonymous and confidential. *Survey at www.surveymonkey.com/S/UK_DrugCosts_2014*

NICE NALMEFENE

NICE has published its formal guidance recommending nalmefene, a drug that helps reduce cravings for alcohol in heavy drinkers (*DDN*, November, page 4). The drug, also called Selincro, is now available on prescription. 'We are pleased to be able to recommend the use of nalmefene to support people further in their efforts to fight alcohol dependence,' said director of NICE's health technology evaluation centre, Professor Carole Longson.

RECOVERY CASH

PHE has announced £10m of capital funding for recovery-focused services, with providers and local authorities invited to apply for a share of the pot. 'An outstanding range of exciting and innovative recovery-focused projects received funding last year,' said PHE's director of alcohol, drugs and tobacco Rosanna O'Connor. As *DDN* went to press PHE released a new report, *Drug treatment in England 2013-14*, which showed drug recovery rates were slowing and that 'there is a continuing need for increasingly tailored approaches to support a range of complex needs,' said O'Connor.

NITROUS NOTES

New guidelines detailing the enforcement options regarding nitrous oxide have been issued by the Home Office. Aimed at local authorities and police, *Guidance on restricting the supply of nitrous oxide for recreational use* lists the uses and risks of the substance alongside the different legislative options. *Document at www.gov.uk*

SMART MOVE

Former Alcohol Research UK chair, Professor Robin Davidson, has been appointed interim chair of UK SMART Recovery, formerly SMART Recovery UK. 'I'm pleased to report that it is business as usual,' said Davidson of the name change. 'UK SMART Recovery remains extremely grateful to the partners, volunteers, and staff for their continued support and commitment. People who have benefited from the programme will continue to benefit from unhindered access to SMART meetings and services as this transition is being implemented.'

A fighting ch

Military veterans do not tend to do well in traditional treatment settings. **Jacquie Johnston-Lynch** explains how Tom Harrison House is tackling the challenges head on

I met Peter and Simeon a few months ago, but both of them had been known to me, as they were always to be seen street drinking and sleeping rough in Liverpool City Centre. Peter had been on the streets for nearly 12 years. He served in Northern Ireland, and on returning to Liverpool after his eight years of military service, he felt like he never fitted in – that no one understood him, and no one really wanted to. Where his closest relationships had previously been with other squaddies, he soon found a new relationship with alcohol.

Now 46 years old, Peter is finally having a crack at this thing called recovery. The same for Simeon, 58, who has been homeless for nearly 20 years. Over the years, many workers approached Simeon to chat about potential treatment options, but were always met with a refusal. Albeit a polite and jovial refusal, it was still a 'no'. Asked why he finally agreed to go into detox and rehab he answered, 'Because this place is for military veterans, and the only time I felt like I had a family was when I was in the army.'

Alcohol misuse has been an inescapable way of life for many who have served in the armed forces. Alcohol has always been associated with rituals and camaraderie and historically was seen as a means of managing difficult situations out in the field – the so-called 'rum ration' in the Royal Navy was only abolished in 1970. The levels of alcohol use and misuse during military service often increase when personnel return to civilian life, amplifying its negative effects both for men and women. It's why we see so many ex-service personnel within the criminal justice system, often for offences of drunkenness, fighting and spousal abuse. In the health services we see increased hospital admissions for poisoning, injury, dependency and addiction.

A member of the armed forces with a drinking problem is a major cause of concern in the military. Once the problem has been identified, commanding officers have to take action to correct it and this often leads to discharge, contributing to the numbers of early service leavers. Misuse of prescription medication and some illegal drugs are also on the increase, but there are very few statistics on this as the Ministry of Defence has not been as responsive as, for example, the USA Department of Defense. However, the MOD is working hard to start shifting the drinking culture and looking at new ideas, such as dry bars, coffee clubs and gaming and WiFi leisure activities on base. I have built up links with army Colonel David Wheeler and we both recently attended an all-party parliamentary group at Westminster, to discuss these issues raised by Alcohol Concern to the minister for the armed forces, Anna Soubry MP.

As head of service in my previous job I noticed that military veterans were not doing very well in treatment. They seemed to have a lot of difficulty engaging in interpersonal group therapy. Many got really agitated with some lines of enquiry made to them by the so-called 'civvies' in the group, and some would not go anywhere near expressing emotions.

One guy told us that he couldn't share his experiences in the group because he felt so ashamed of what he had been a part of when on a tour of duty in Northern Ireland. Other non-military people had asked him if he had ever killed anyone, and why he acted so aggressively against the Irish. Another described drinking a bottle of vodka most nights to help him sleep, as he couldn't remove the images and smells from an incident he'd been involved in during a tour in Afghanistan.

Having become known in Liverpool for setting up UK firsts in the recovery movement, I was contacted by Paula Gunn in early 2013. Paula, who had set up The Bridge House abstinence-based housing project, wanted to create something for ex-service personnel as she too had noticed a repeated pattern emerging through her work. She was very persuasive and passionate in asking me to come and work with her to lead on this new project and the result was Tom Harrison House (THH) – the first military veteran specific addiction treatment centre in the UK.

> **'The only time I felt like I had a family was when I was in the army...'**

Paula founded the charity and named it after her grandfather, Tom Harrison, a naval man who served during World War II. She has now been 17 years in recovery herself, but while in the grip of active addiction, she was comforted by her grandfather who told her of his experiences in the navy and gave her stories of hope and inspiration.

We set about gathering evidence of need for the centre. This proved to be an arduous task, as there was no UK-based evidence on the benefits of a military-specific treatment centre. So I looked to the USA, where far more research has

been done, even making a visit to the first ever veteran addiction treatment centre there, Ed Thompson House, which is part of the Samaritans Village services in New York City.

The experience of observing for a day in this treatment centre really blew me away. As I talked to all the guys in the centre and the staff who worked there, I had not one single doubt that THH would be as much needed in the UK as Ed Thompson House is in the USA. There was such inspiration there. I knew we could replicate what they had created, in the cultural context of the UK.

THH has been commissioned to run a pilot project of six months' treatment space for the new programme I developed. The programme is evidence-based, health and wellbeing-focused, with a clear and assertive linkage to mutual aid. Because of the risk of triggering any symptoms of other co-occurring disorders, the programme doesn't have a huge focus on psychotherapy – instead it promotes self-efficacy, physical and emotional health, discipline, structure, life skills and community engagement. The culture of the programme is kindness, co-operation, curiosity, generosity, honesty and acceptance. The team here comprises professionals from a variety of relevant backgrounds and brings a mixture of recovery, therapeutic and military experience.

Because military veterans are much less likely to seek out help for mental health issues and addiction due to feeling that this is a sign of weakness, THH sees people who are often very ill, have spent many years in active addiction, and many have co-occurring disorders and have been homeless for lengthy periods.

With Merseyside having more than 30,000 ex-service personnel and an increased cohort of reservists, plus at least an additional 4,000 returning service leavers coming back to the area, there is no shortage of referrals for the project.

The team at THH are receiving referrals from other areas of the country too. Given that participants in Combat Stress residential programmes have to be clean and sober to attend and many other veteran-focused mental health care requires sobriety to engage in appropriate post-traumatic stress disorder treatment, THH will be the first point of call for those needing additional help and support to take the first steps to recovery. Additionally, during the last few weeks many other agencies have approached THH as they now want to replicate this model in their geographical area.

Peter has just become the first ever graduate of a military-specific addiction rehab in the UK and the first to wear a THH medal of accomplishment. We will continue to fly the flag for him and other veterans who have found it hard to cope and used substances to self soothe, leading to loss, shame and chaos. Our aim is to walk with them on a road of honour, hope and healing.

Jacquie Johnston-Lynch is head of service at Tom Harrison House

TRUST IN ME

Gaining trust is one vital component of providing help to veterans, delegates at DrugScope's annual conference heard

'ONE OF THE DIFFICULTIES OF WORKING WITH VETERANS is being able to find out who they are, where they are, and engaging with them,' veterans' substance misuse case manager at Combat Stress, Matt Flynn, told delegates at DrugScope's conference. 'Trust is a substantial issue. You need to be able to understand the shared lingo and the humour – that's your way in.'

Combat Stress is piloting a network of substance misuse case management services across the UK, financed by the Big Lottery and the Armed Forces Covenant (Libor) Fund. As well as improving outcomes for veterans, the aim is to provide training to mainstream treatment services and become a specialist resource for any professionals working with veterans.

The organisation's Wiltshire pilot is run in partnership with Turning Point in 'a significant military area', said Flynn – himself a reservist – with veterans estimated to make up at least 12 per cent of the local population.

Well-managed expectations are vital to a successful service, he stressed, as 'veterans tend to come into treatment believing they're going to be fixed at the end', along with fluid care planning and regular reviews that allow people to 'remain engaged and understand what their care pathway will look like'. Referral can come from veterans themselves or their families, the voluntary sector, assertive outreach, veterans' agencies or the armed forces, and treatment ranges from guided self-help to residential and community detox, prescribing and one-to-one or group work.

'There's also a big role for exit planning,' he says. 'That's crucial in terms of managing expectations. There are lots of different agencies across Wiltshire, and the work now is about drawing them all together and creating really good referral pathways.

'Part of the challenge facing veterans is that they're no longer the squaddie or the airman they once were. In substance misuse services they have to mix with "civvies" and, to be honest, they hate it. Part of the skill on the part of the nurses is being able to manage that.'

www.combatstress.org.uk

ance

ON THE MARGINS

DrugScope's annual conference looked at equality and diversity in the sector at a time of shrinking budgets

'We seem to be living in an increasingly pinched and mean society, a political climate of intolerance towards marginalised groups,' said DrugScope's director of communications, Harry Shapiro, as he introduced *Access all areas: equality and diversity in drug and alcohol treatment,* the charity's annual conference.

The UK's treatment system had been shaped by the heroin epidemic of the 1980s and '90s, said chief executive Marcus Roberts, 'and I'd argue that we're in the long tail of that now'. An estimated 300,000 problem drug users was 'still a lot, but significantly less than the 450,000 at the height of the epidemic', and while the 2010 drug strategy was still built around a notion of dependency inextricably linked with deprivation, this no longer fitted 'with emerging issues such as drug use among men who have sex with men, or use of image and performance-enhancing drugs', he said.

These shifts were against a backdrop of an estimated 40 per cent reduction in local authority funding over the course of this Parliament, he pointed out. According to DrugScope's *State of the sector 2013* research, there were signs of disinvestment in services but 'no sense yet that we've reached a cliff edge', while the political debate was also entering a new terrain. 'On the one hand there's an increasing focus on the millions of people who take drugs without experiencing any significant harm, and another discourse focused on the role of drugs in deprived and marginalised communities.' There were left wing and right-wing versions of both, but the fact remained that in terms of public perception, addiction was seen as the primary cause of child poverty, and it was likely that this was where the focus would be in the run-up to the next election.

'UK drug policy is in many ways a success, and at a time when we're asking people to invest in it, it's important to focus on that,' he stressed. 'Discourses around winning and losing the "war on drugs" are not helpful. What happens next is partly dependent on what we say and do.'

Another issue that would be in the news 'a hell of a lot' before the election was immigration, said CEO of the Refugee and Migrant Forum of Essex and London (RAMFEL), Rita Chadha. Although access to treatment was a vital issue for her clients there were significant barriers, including difficulties with language and registering with GPs, fear of the authorities, and stigma, something that was also an acute issue with people involved the commercial sex trade, said team manager at Blenheim CDP, Maggie Boreham. 'What biases do we as practitioners hold?' she said. 'Do we know how to ask the right questions? What training do we need for our staff?'

'Many staff assume that a "white middle-class" culture is neutral, and appears nice and friendly to everyone,' echoed strategic director for addiction and offender care at CNWL NHS Foundation Trust, Annette Dale-Perera. 'It isn't. We need to match services to local needs, so you'll need "teams within teams", and local needs assessments are particularly important – if you don't look you won't see.' Stigma and 'nimbyism' were the risks that went alongside the opportunities presented by the localism agenda in a climate of ever falling per capita spend on health and social care.

'One of the things we've rather belatedly realised is that the way the state is structured – centralised, in silos – isn't designed to respond well to complex issues like people with multiple needs,' said associate director for public service reform at IPPR, Rick Muir. 'We need to end this fragmentation, and we need to ask people what they want – what will enable them to lead the lives they want to lead.'

'Discourses around winning and losing the "war on drugs" are not helpful. What happens next is partly dependent on what we say and do.'
Marcus Roberts, chief executive, DrugScope

Drug use was about three or four times higher in the LGB population, said Alastair Roy of the University of Central Lancashire, partly associated with 'significant self-esteem issues' but also changing patterns of use linked to 'chem sex' and injecting. 'Localism might be the name of the game in drug treatment now, but these agendas only move forward with national leadership,' he said.

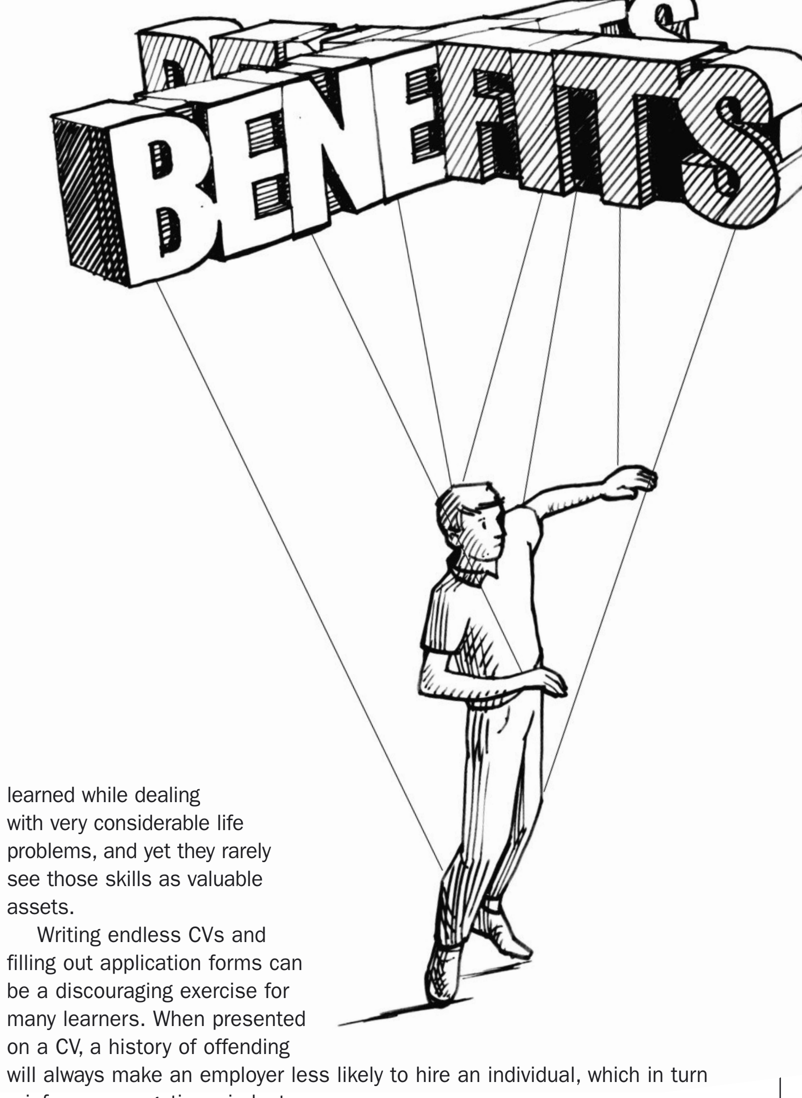
'We need a model that better understands and mobilises the social resources available to us in the community,' said the RSA's director of research, Steve Broome. This could mean more diverse partnerships or more co-commissioning, he said, as substance use was a 'collective, social inclusion' issue, with the 'constant cycle of re-commissioning arguably not helpful in this respect'. More investment was also needed in mental health, he stressed, where the gap between rhetoric and reality was 'shockingly large'.

'If you can't ensure that the most vulnerable and marginalised are going to be looked after, is the cost of localism to society too high?' asked Karen Biggs of Phoenix Futures. 'Decision making at a local level is generally better than a state, monolithic model,' said Rupert Oldham-Reid of the Centre for Social Justice, 'but marginalised groups tend to be less good at advocating for themselves. A statutory requirement for recovery champions on local health and wellbeing boards could be one answer'.

'We have a world-class treatment system and a lot to be proud of,' Marcus Roberts told the event's closing session. 'But we also have a lot to do and a lot to build.' **DDN**

BREAK FREE

With many service users struggling to find meaningful paid or unpaid employment, Peter Bentley tells DDN about a new educational course that encourages individuals to make the most of the skills they already possess



MOST OF THE BARRIERS to employment that people feel they encounter are self-imposed beliefs – the endless negative attitudes of, 'People like me never get a break,' 'There are no jobs anyway,' or 'I have a right to benefits'. These attitudes often become the excuse for inaction, leaving the individual further and further isolated and distanced from their real aspirations.

Skills-Tu Employment is an educational course aimed at skilling people who are distant from the labour market by exploring all of these commonly held beliefs and encouraging learners to adopt a more positive outlook.

We initially developed the course after we were approached by Working Links Wales in 2012 – they realised that their clients who had been through the Intuitive Recovery abstinence programme were doing well employability-wise, and had a much more positive outlook than some other clients.

The programme is aimed specifically at ETE (education, training, employment) and getting people into work. It is an accredited classroom-based course that is delivered by peers who have themselves overcome considerable challenges in their lives and gone on to forge meaningful careers.

Many of our learners have considerable challenges to gaining employment and volunteering opportunities. The programme aims to change their outlook, so that they see these challenges as opportunities to demonstrate problem-solving skills, which will impress potential employers.

Learners are encouraged to take control by accepting responsibility. The course introduces a rational, problem-solving process to learners, while challenging the negative self-imposed barriers often present in the mindsets of people who have experienced problems and disappointments in their lives.

Once learners start to look closely at their belief systems, they begin to recognise that they support inactivity over action, unemployment over employment, and continued dependence on the state over personal independence and responsibility. These individuals have amazing skills, often learned while dealing with very considerable life problems, and yet they rarely see those skills as valuable assets.

Writing endless CVs and filling out application forms can be a discouraging exercise for many learners. When presented on a CV, a history of offending will always make an employer less likely to hire an individual, which in turn reinforces a negative mindset.

We focus our learners on using their natural assets in a positive, constructive way. There are very few employers who would not be impressed by an individual who has turned their life around – it's all about how to communicate this in the right way.

It's also important to recognise that the vast majority of jobs are not advertised and therefore require a different route to approaching the employer. A big part of it is getting good intelligence of who is the real decision maker and then making a plan of action on how best to approach this individual and be remembered. The Skills-Tu course teaches learners to look at all of the channels of communication when job hunting, and addresses everything from body language to personal hygiene – anything that could pose a barrier to getting the job.

Since launching the course in August 2012, we now deliver the programme across Wales, the South East, London and our traditional home ground in the North West. We have also developed our relationships with the Work Programme providers and have a customer list that includes Working Links, G4S, A4e and Rehab Job Fit.

Our background in, and promotion of, abstinence, delivered by peers, means that we have also been able to identify new presentations and support them into treatment services. What we have found as we have developed the course within the Work Programme and at Job Centres is that we are able to open up drug and alcohol treatment to learners.

As a peer-led organisation, recruitment for programme tutors is done through the graduate base. That means that the programme is delivered by people who have been through the process themselves, and this makes all the difference – they have 'been there, done that', and create a positive model for learners at the beginning of the process. All tutors are paid, so they are living, breathing examples of the process working and of what can be achieved.

Peter Bentley is founder and managing director of Intuitive Recovery.

WHAT PRICE LIFE?

The failure to roll out naloxone distribution in England prompted a multidisciplinary group to meet in London to campaign for change. *DDN* reports

Last year there were 765 deaths related to heroin and morphine in England – a sharp rise of 32 per cent from the 579 deaths in 2012. The reasons for this failure are the subject of much debate, with many in the field suggesting that enforced detox and being encouraged to leave treatment too early are strong contributory factors.

But what is certain for the growing number of service users, treatment workers and medical professionals who have formed themselves into an action group – now called the Naloxone Action Group (NAG) – is that many of these deaths could have been prevented if naloxone had been available to use as an intervention to reverse overdose.

At the Action Summit on Naloxone (from which NAG was formed) held at Bleinheim's headquarters in London last month, the agenda was split between sharing information and updates on naloxone, looking at examples of good practice from areas of effective distribution, and forming an action plan to challenge every area of the country that was slow or reluctant to roll out distribution and training.

Before arriving at the summit, participants had been asked to complete a questionnaire about the availability of naloxone in their area, the drivers for availability and the barriers to distribution both locally and nationally.

'From participants' responses there's a marked variation,' said Dr Chris Ford, clinical director of IDHDP, who chaired the meeting. 'One area had total provision, most areas had nothing.... There is a definite postcode lottery. We're going back to the bad old days and it stinks.'

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The group identified those most at risk, with Professor John Strang referring to evidence that more frequent deaths happened during early stages of methadone treatment and early days of release from prison. One important factor to concentrate on was that many people died in the presence of friends, so the group agreed it was incredibly important – and an obvious move – to involve these potential 'first responders' with naloxone distribution and training. Families were also 'absolutely crucial' – 'we want to get away from it being revolutionary to it being normalised,' he said.

GPs would need to prescribe naloxone to patients and authorise family members to collect it and do the training. Oliver Standing from Adfam said that his experience of running a bereavement project had shown that families were 'desperate to be involved', while Jamie Bridge of the International Drug Policy Consortium (IDPC) and the National Needle Exchange Forum (NNEF) said 'having family voices in this will be invaluable – it will make commissioners care.' The idea of involving recovery assets such as family also 'fits beautifully into the recovery framework', said Fraser Shaw of Compass.

Elsa Browne of SMMGP added that her organisation had launched an e-learning module, written by Dr Kevin Radcliffe, to help with training. Around 100 people a month were doing it, 'and the evaluation is brilliant', she said.

John Jolly, Blenheim's chief executive, brought the discussion back to the critical lack of action in England.

'What's happened in politics?' he asked. 'In May 2012 the ACMD recommended that naloxone should be more widely available, that the government should ease restrictions on supply, and that people should be better trained to administer it.' The ACMD also commented on Scotland's strategy running, Wales' strategy being about to run, and England having no policy. 'There are some great areas of good practice in England, but it's very patchy,' he added.

A letter from the Department of Health was shown to the group. It was a response to Dr Judith Yates' letters to public health minister Jane Ellison, in which she pressed for answers on the lack of action. The letter assured Dr Yates that, following the ACMD's advice, PHE and the Medicines and Healthcare Products Regulatory Agency were 'working on amending medicines regulations to allow the wider distribution and administration of naloxone'. But new regulations would not come into effect until October 2015, 'the earliest practicable date' to avoid the distractions of the general election campaign.

The overwhelming reaction of the group was that this was 'choosing to do nothing' as October would not be within this government. 'We're not happy with the date that's been set,' said service user activist Kevin Jaffray. 'A date a year from now leaves space for another 32 per cent rise in deaths. There's been a constant rise since 2009.'

Steve Taylor, programme manager for alcohol and drugs at PHE, was invited to give a response to the situation. 'We're not kicking things into the long grass – things will have started to take place by October,' he said, agreeing that 'anybody walking out of the door with a methadone script and not naloxone is ludicrous.'

Any changes made in October would not make a huge amount of difference, he added, saying 'there are things you can be doing' that didn't require any change in legislation. It was our responsibility 'as doctors and clinicians' to prescribe naloxone to people on methadone treatment, he said, and it could be given to families for the named patient. 'What is it that's going to change, that we don't already do?, he asked.

PHE was looking to produce a briefing by the end of this year, using expertise to advise on what arrangements for wider provision might be. 'But,' he advised the group, 'there is not going to be a national programme in England because of localism.'

Rhian Hills from the Welsh Government and Kirsten Horsburgh from the Scottish Drugs Forum shared their experience of naloxone strategy in each

NA

country, both of which had shown a decline in drug-related deaths since the strategies' implementation. Wales had made a commitment back in 2008 to reduce drug-related harm and deaths, and had set up a national group that included police and paramedics. Demonstration sites had followed, evaluated by the University of South Wales, and the main recommendation to roll out the programme was completed in November 2011.

A decline in deaths of 53 per cent spoke for itself. 'I don't think it's rocket science,' said Hills. 'It's simple, it saves lives. It's down to commissioners – get your priorities right.' Involvement of service users – 'the experts' – had been really important in making risk logs, and from there, distribution had been increased to carers and their engagement encouraged. 'Naloxone should be second nature,' she said.

Kirsten Horsburgh acknowledged there had been 'challenges and barriers' in Scotland, starting from having one of the highest rates of drug-related deaths in Europe. But a national naloxone programme, launched at the end of 2010, had responded to common circumstances – that the average age of victims was 40, that they were not in treatment and likely to have had a recent period of abstinence, and that they were likely to die in their own or a friend's home with witnesses (other drug users) present.

A Patient Group Direction (PGD) had been sent out to nurses and pharmacists in community addiction teams, needle and syringe programmes, harm reduction teams and the Scottish Prison Service, and Lord Advocate's Guidelines allowed naloxone to be supplied by staff working for services in contact with people at risk of opiate overdose, such as in hostels. Anyone supplied with naloxone had to do training to make sure they were confident.

'The key messages are prioritise the supply of naloxone to people who use drugs, make it normal in services and ensure people on ORT [opioid replacement therapy] have a supply,' she said. 'Make the training brief – just a ten minute chat – and involve peer trainers. All this potentially saves hundreds of lives.'

On 4 November the World Health Organization (WHO) recommended expanding access to naloxone, from just medical professionals to people likely to witness an overdose in their community, including friends, family members, partners of people who use drugs, and social workers. The report emphasised the safety of the drug, the ease of administering it, and its potential to reduce 69,000 deaths a year globally from opioid overdose.

The group around the table in London agreed that action was needed now, and there was no need to wait for PHE's October 2015 directive to make each area of the country accountable for including naloxone in its localism agenda.

'I don't think it's rocket science... It's simple, it saves lives. It's down to commissioners – get your priorities right.'

RHIAN HILLS

Dr Judith Yates gave the example of Birmingham's progress – a process driven by doctors, nurses, pharmacists and service users, rather than commissioners.

'Naloxone kits have become normal – we hear about reversals every month,' she said. Dr Yates had trained drug workers from local service Swanswell, who were in turn carrying out training. 'We don't do risk assessments – we give naloxone to all first responders, we give it to everyone who uses drugs,' she explained. 'We have stories of residents in hostels saving each others' lives.'

'We're obsessed with controlled drugs, but this is like giving an asthma inhaler, not methadone,' added Emily Finch of SLAM. 'I've signed hundreds of naloxone prescriptions.'

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At NAG's second meeting on 21 November, the group prioritised the need to overcome the obstacle presented by localism, which prevented England from having a national naloxone strategy.

'PHE's October deadline is disappointing, but it's less than a year away. Of more concern is that we can't have a national strategy because of localism,' NAG chair John Jolly told *DDN*. 'We agreed the need to bring this to the attention of politicians as well as clinicians. Naloxone distribution is not a minority sport, it's day-to-day business. If you're giving opiate treatment, you should be giving naloxone.'

With thousands of doses administered by ambulances, clear messages on distribution from the ACMD, and the Medicines Act 'clearly empowering every citizen to use it', there should be no obstacle to making naloxone available in every part of the country, he said. The recovery agenda was directly relevant: NAG identified that those most at risk were those starting on a journey of recovery, and emphasised the need for training alongside naloxone distribution.

'We need to be identifying areas that are delivering good practice and naming and shaming areas that aren't,' said Jolly. **DDN**

CLOSE T

Bringing a busy day of presentations, debate and networking to a close, Emma reminded the recent *Families First* conference why family support is worth fighting for. Here's an extract of her story

For the first few years of my life I was unaware that my mum was any different to any other. She would be there to collect me from school; a beautiful vision of long dark hair and big brown eyes. I never noticed the slight wobble on her heels or slurred speech – these things meant little to a seven-year-old. She would be there every day to take us to school and waiting to walk us home. She would be there to cheer us on during sports day or see our nativity plays.

I was about 11 the first time she went 'away' to hospital for a rest. My little brother and I went to stay with nan – her warm comforting home was our place of sanctuary. Nan took care of everything and we thrived there.

I was a model pupil at the time and it didn't seem to matter too much that mum stopped showing up to watch performances, games or go to parents evening. My bubble burst when mum didn't collect my younger brother from school one day and the local vicar took him home to find she had overdosed on Valium and alcohol. She claimed it was accidental, but that was the moment my childhood ended.

An ambulance took mum away and she was sectioned to the dreaded D block – a place whispered about in hushed tones. Only dad could visit her and on Sundays she would come out and we would go to country parks. The vibrant woman that I adored so much as a little girl was gone; she was just a shadow. Her sadness was palpable even then and I would count the hours till it was time for her to return to her sanctuary and we could return to ours.

I could list the awful, embarrassing and sometimes violent moments that followed in the years after. There was the day I came in from horse riding and she went to slap me because I had muddy boots. In her drunken state she missed, but I was faster and full of anger and one slap from me sent her flying to the floor. She didn't get up. My brother and I stood over her. I thought I'd killed her – and for one tiny moment I hoped I had, stopping that feeling of unending dread of the increasing times she would turn into a drunken mess and seek attention through declarations of terminal illness, or attack us mentally, verbally or physically.

I hadn't killed her; she had just passed out drunk. We dragged her into her chair and left her to sleep it off. When she woke up she had wet herself, such

PUTTING FAMILIES FIRST

The third *Families First* conference heard how the will for family support was there – even if the money was hard to come by

THE LABOUR PARTY is totally committed to the families agenda, said Luciana Berger, shadow minister for public health. Addressing the Adfam/DDN Families First conference, she said her party was looking at how it could work with families further.

'We don't just see through the lens of the Troubled Families programme,' she said. 'We don't just see them as problems to solve.'

Megan Jones from Public Health England (PHE) said that while commissioning increasingly focused on delivery, outcomes and value for money, 'we can make a case for solid value for money for family services.' The needs of families were now being taken seriously, she said, and statutory requirements and treatment providers would play a key role in leading the drug and alcohol field into this brave new world.

'Why do commissioners always give the money to the big organisations, when we do all the work?' asked Maddy Vaz of the charity Sanctuary Family Support. Berger responded that clinical commissioning groups (CCGs) needed to be held to account. 'There's nothing to stop anyone in this room turning up at their health and wellbeing board,' she said.

Alex Boyt, service user coordinator in Camden, spoke of the 'really harsh environment out there', with just one family worker in his London borough, while Dr Martyn Hull said general practice was the ideal place to support families. 'Don't dismember shared care,' he said. Investment needed to take place in primary care, so that GPs knew how to help families deal with harder-to-spot problems such as dependency on new psychoactive substances.

Lisa Sturrock of WDP's children and families service pointed out that for many children school was a safe place – 'so exclusion's an issue'. Support also needed to be holistic, she said, and there was discussion about how families could draw strength from the recovery movement.

O HOME

was her stupor. My loathing for her at that moment cannot really be put into words, and yet she couldn't remember any of it.

I went from being a model student to disruptive one and teachers would ask what was wrong. My excuses were varied but never the truth – a shameful secret I kept from everyone. I couldn't tell them the reason I hadn't handed in my homework was because I had been busy cleaning up her vomit; or making tea for the family, desperately trying to restore some normality to our chaos; or that I had lain awake all night after a screaming match with a mad woman.

After leaving school I went to college and work. I went through a phase of going out on weekends and drinking to complete oblivion. I wanted to know what the attraction was; why she found such comfort in it. I found no comfort there, it only led to more vicious rows and after one particularly horrendous weekend, when I failed to come home, she threw me out.

I discovered I was pregnant on Christmas Eve 1986 and Laura Louise was born on 24 May 1987. That sweet baby saved my life. Finally all the love I craved from my own mother I was able to bestow on my perfect baby girl.

Sadly her father resented the fact that I had heaped the responsibility of being a parent on to him and our relationship slid into a cycle of mental and physical abuse. When a job came up with a local carpet company I applied hoping the extra money would make life better for us all and fix things. It was there that I met Glenn, who became my husband and a true father to my little girl – 20 years later we are still together and happy as a family.

Mum had a massive stroke at 59 and for a time she forgot she drank, and was sober. I visited and cared for her; we had a precious few months together with love and clarity. I had a mum, even if it was for a short time, and she was doing really well when sadly the wrong person stepped into her life again. She chose a path that led eventually to complete organ failure, dying alone in a hospital with no one there to hold her hand and tell it was okay to let go, or that she was loved.

I didn't grieve for mum, after all no one really expected me to. Was she worthy of grief? After all, she had chosen alcohol over her family. Then I read an article in a newspaper, which directed me to an online charity called COAP – a place where young people can talk openly and confidentially about their feelings, and seek help and advice. Finally I could reach out and turn my negative experiences into something positive.

> 'We dragged [my mum] into her chair and left her to sleep it off. When she woke up she had wet herself, such was her stupor. My loathing for her at that moment cannot really be put into words...'

I realised I wasn't facing my own demons or coping with my own grief, so I saw a Cruse counsellor who urged me to seek closure. I found mum's final resting place and wanted to ensure that those who loved her and needed closure could say goodbye, knowing she was finally at peace. Dad kindly bought a plaque for her, even though they had been divorced many years before. On a summer's afternoon recently we all gathered together and gave mum a fitting goodbye. Saying goodbye to mum and giving her forgiveness was a huge part of my journey; it helped enormously as forgiveness is easier to carry than bitterness.

Addiction has a ripple effect like a stone dropped on a pond, affecting everyone it touches. We need to break down those barriers of shame and silence, which is why groups like COAP and DrugFam are vital. Young people need to feel they are being listened to and that they are not alone. We can't change their lives, but we can listen, share experiences and support them, helping them find peace and closure.

'We need to make the case for people recovering at a pace that suits them,' said Boyt, while Maya Parker of Nacoa said 'we have to use what's already there – use each other.'

This kind of mutual support was demonstrated effectively by Claire Robinson, who explained how her organisation, Props, was formed for 'women to prop each other up'. From meeting in each others' kitchens ten years ago because of the lack of support and investment in family services, the group had became a close-knit team that made carers feel listened to.

'Respite is an important part of making sure people are physically and emotionally well,' she said. 'We had over 300 referrals last year and that's just the tip of the iceberg.'

The current landscape was 'challenging' with 'all of us expected to do more for less' and the threat of many small services disappearing. But Props was determined to survive, she said. 'With a small organisation you feel that personal responsibility and that gives you the edge and determination to make things happen.'

'We've heard about the challenges of the future,' said Adfam's chief executive Vivienne Evans, closing the conference. 'The need hasn't changed, though the way we deal with it might have.

'We're trying to combat stigma and we need to have a movement – like the recovery movement – to shout louder. Come on, let's think. Luciana Berger talked about hidden heroes in families, but there are also hidden sufferers.'

from

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and
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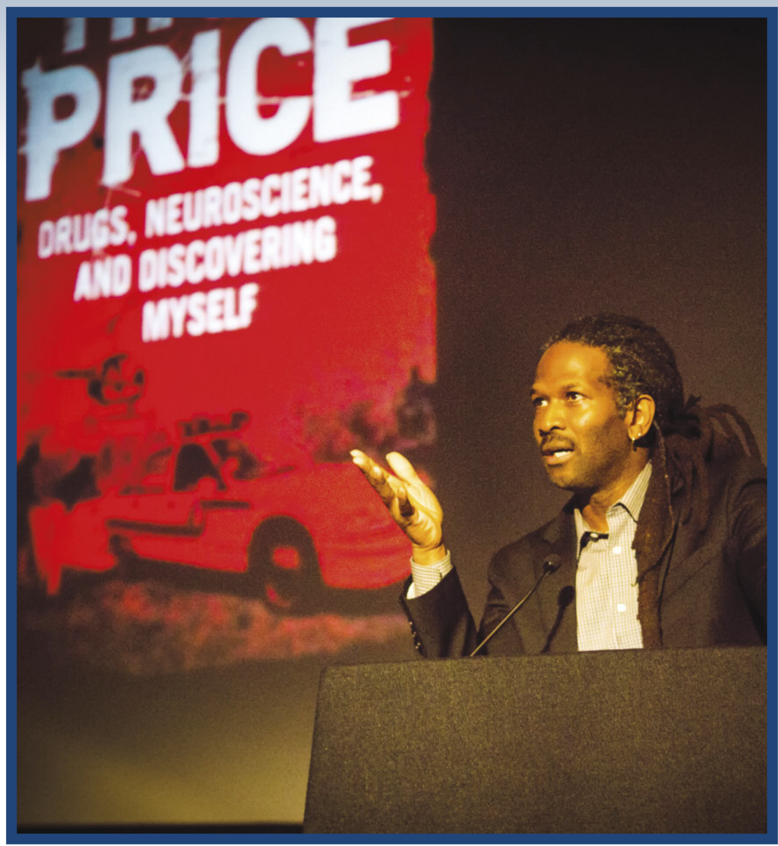

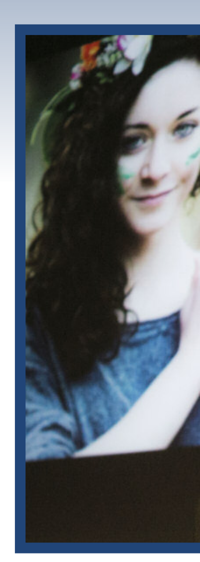

IN MIND AND BODY

This year's HIT Hot Topics conference delved into neuroscience to challenge our perceptions of drugs and drug taking. **Max Daly** reports

The fervour around crack cocaine reached such a level of hype in the US in the 1980s, neuroscientist Dr Carl Hart told the 2014 HIT Hot Topics conference, that at one point black civil rights activists teamed up with the Ku Klux Klan to combat America's new Public Enemy No.1.

In 1989 the KKK launched the 'Krush Krack Kocaine' initiative, to rid the streets of Lakeland, Florida of crack dealers. People selling crack were legitimate hate targets at the time – they'd been described by Jessie Jackson, the Democrat civil rights activist and Baptist minister, as 'death messengers' and 'terrorists'. Incredibly, the KKK initiative was 'welcomed' by the local National Association for the Advancement of Colored People.

Crack hit the black community hard. Around 80 per cent of those convicted for crack offences were black. Harsh new anti-crack laws introduced by President Ronald Reagan meant that those caught with crack received prison sentences up to 100 times more severe than for the powder form of cocaine, more commonly used by white Americans.

Dr Hart became curious about a drug that had so damaged his community in Miami. He wanted to know more about the drug being mentioned in such fearful tones by his heroes Gil Scott-Heron and Public Enemy. Dr Hart decided to leave his job in the US airforce, where he had spent time based over here in Swindon, and returned to the US to study neuroscience in order to understand crack's effect on people's minds and bodies.

The subsequent research he conducted into the psychology of crack cocaine use has since become famous. What he found blew holes in the accepted narrative – that crack cocaine was an entirely new drug that transformed addicts into mindless zombies intent on violence and getting their next fix. Hart's experiments, where crack users were given a choice between $5 and a rock of crack, found that half the time, these 'crack addicts' went for the money. In other words, they made rational decisions.

'A small amount of money was enough to shift their drug-taking behaviour. This made me rethink the crack narrative,' said Hart. A similar experiment he conducted among crystal meth users yielded the same kind of results – the drug users did not blindly lunge for the drugs. 'I realised that the vast majority of people who use this drug don't have a problem. Look at Rob Ford. He could use crack and be mayor of Toronto. He was a jerk, but he could use crack and be mayor.'

Dr Hart said exaggerations around crack and crystal meth – that they cause brain damage, obliterate rational thought and are uniquely novel compounds – are perpetuated more by design than by accident.

'The public has been misled about drugs. Why is this? It serves a function. It allows us to target people who we don't like. We can't say we don't like black people, but we can say we don't like an activity they are involved in, such as taking crack. This narrative helps to avoid dealing with the real problems of the poor, that if we get rid of crack, we don't have to talk about bad education, bad housing and so on.'

'The public has been misled about drugs. Why is this? It serves a function. It allows us to target people who we don't like...'

DR CARL HART

Our understanding of drugs is further skewed, Hart told the annual conference in Liverpool, because scientific research only looks at drugs from one angle. He said that America's drug science body, the National Institute on Drug Abuse, funds 90 per cent of global research on drug abuse. And the focus of NIDA's research is the pathology of drugs.

As a result, Hart said, there is a disproportionate amount of information in the media about the bad effects of drugs, 'creating an environment where drugs are seen as evil and there is a focus on eliminating drugs at any cost'. Hart says researchers fail to understand other aspects of drugs because their salaries depend on failing to understand them.

'The future is bleak if we rely on science to lead the way, because the story that goes with the data is often distorted.' He said the war on drugs had been a success for the criminal justice and health industries, which have raked in huge profits as a result.

But it's not all bad, said Hart whose book *High Price* was published last year. While admitting that providing attractive alternatives to drugs is 'a big job', there is a way people can change the narrative and reduce the harm. He sees decriminalisation and harm reduction as vital. Meanwhile drug users need to 'get out of the closet and admit their use', as President Obama has done, in order to normalise the use of drugs and get the debate into the mainstream.

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A MORE OPEN DISCUSSION ABOUT DRUGS will reduce the levels of what one speaker at the conference referred to as 'intoxophobia' – discrimination against people who use drugs. Russell Newcombe from 3D Research told delegates that while minority groups such as women, the BME community and gay people had gained legal rights in the UK, drug users had not. Despite a lack of laws to protect them, drug users are subject to discrimination across the board – including by employers, doctors, the welfare system and insurers. Newcombe suggested the government agrees to a drug users' charter.

But as the long-time drug commentator Sara McGrail pointed out in her speech, any changes to drug policy – despite the best intentions of the Lib Dems in the last few months – are unlikely anytime soon. The drug issue, she said, is not a vote winner, instead 'it has been kicked so far into the long grass that we can't see the pitch anymore'. That drugs will be off the agenda for the next election is a shame, said McGrail, because harm reduction has been 'decimated' and services have been cut at a time when austerity is preparing the ground for potentially more problematic drug use.

Katy MacLeod of the Scottish Drug Forum said that research she has carried out has revealed that it is among society's most socially excluded people that new psychoactive substances are gaining a foothold, not just young people. Research at a Glasgow night shelter found nearly a quarter of its clients had tried synthetic cannabinoids, although most admitted they didn't like it.

Despite being class C substances, GHB/GBL are the 'most dangerous drugs on the planet', according to David Stuart, substance misuse lead at 56 Dean Street, a drug charity based in London's Soho. He said the drugs represented a big danger to the gay community, as did the use of other 'chemsex' drugs such as crystal meth and mephedrone. Stuart said the emerging chemsex scene had necessitated a need to create closer bonds between the fields of drug harm reduction and sexual health.

According to Professor Gerry Stimson, one the biggest developments in drug harm reduction in recent years has been the rise and rise of vaping. E-cigarettes could, as some economists have predicted, overtake their deadly tobacco equivalents in less than ten years. However, the success of vaping in reducing the smoking population has been accompanied by familiar fears.

Professor Stimson showed delegates a recent Twitter post by the World Health Organization (WHO) declaring that e-cigarettes 'pose a risk to public health'. But he said fears that e-cigarettes could be a gateway to smoking and undermine government anti-smoking policy are reminiscent of opposition to clean needles and foil for heroin users.

He said it would be 'unethical' for governments to deny or discourage the use of life-saving products and said one of the 'perverse' consequences of over-regulating e-cigarettes was that there are now higher controls and constraints on them than on regular cigarettes.

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AT THE START OF THE CONFERENCE, organiser Pat O'Hare told delegates that now, almost all the taxi drivers he gets chatting to in Liverpool favour drugs legalisation. He said this represented a swing in the public mood. 'I never thought in my lifetime we would see drug legalisation, but now I think we will.' And few of those who listened to the final speaker of the day, Anne Marie Cockburn, whose 15-year-old daughter Martha died last year after taking MDMA, could deny that change is required.

She challenged the politicians who think current policy is a success to stand by her daughter's graveside. 'Martha became another face on a newspaper. I feel helpless when I see another death of a child. The law is past its sell-by date. I want drugs to be legalised because I want safety first. Please help me.'

As Dr Hart pointed out in his talk, before he died in 1987 the gay, black writer James Baldwin was marginalised for his views about drugs. He said no one should be sent to jail for drugs, that anti-drug laws were laws against the poor and that banning drugs did not stop people taking them. In fact, he said, lots of money was being made on the back of the dope laws. After hearing the latest evidence at this conference in 2014 it seems Baldwin, all those years ago, was something of a visionary.

Max Daly is a freelance journalist and joint author of Narcomania: How Britain Got Hooked On Drugs

'Competent compassion rises above all the arguments about harm minimisation v recovery, NHS v non NHS, script v abstinence etc...'

COMPETENT COMPASSION

I am writing in response to Chris Ford's letter (*DDN*, November, page 10) about 'misbehaving' in order to actually give people good and safe treatment. I am afraid that Chris is correct in believing it is time to make a stand. Things will only get worse unless we resist this focus on a numbers-based 'successful completion' culture and return to what makes good quality individual care.

I will declare an interest at this point. I recently 'misbehaved' and was made unexpectedly 'redundant' in an urgent 'restructure'.

The good news is that it enabled me to spend time developing a concept that I'd had in my mind for several years. There is now a (basic) website which explains it further – www.competentcompassion.org.uk

The concept is that whoever delivers whatever treatment, and wherever that is, the way to measure its quality should be 'does it demonstrate competent compassion'? If the person delivering help isn't competent, then disaster looms. If they aren't compassionate then it is unlikely to be helpful, and may well be ignored. Competence and compassion are not mutually exclusive – in fact they are both essential and in one phrase they sum up the essence of good quality care.

Wouldn't it be good if that was the first quality standard by which we measured ourselves and our services – not how many people we can get off a script (for example)?

Competent compassion rises above all the arguments about harm minimisation v recovery, NHS v non NHS, script v abstinence etc. I am looking for this to be taken up by as many people and organisations as possible – locally and nationally. I really hope that commissioners in particular can grasp and use this concept of what quality services should look like.

Please visit the website and do comment and give feedback. Perhaps we can make a change before it is too late – even if it involves some misbehaving.

Dr Joss Bray,
substance misuse specialist

WAKE-UP CALL

If funding for cancer prevention, treatment and recovery support was being cut while cancer mortality rates were rising there would be a national uproar, yet funding for the treatment of substance use disorders is being cut at a time when alcohol and other drug-related deaths are increasing.

The recently published *Review of drug and alcohol commissioning* from the Association of Directors of Public Health and Public Health England revealed that 48 local authorities in England will be reducing funding for drug and alcohol services either during 2014/5 or 2015/6, and 12 local authorities during both years. A further ten local authorities may reduce funding in 2015/6 dependent on local reviews and another 57 have not yet made a decision.

A third of local authorities reported uncertainty about future funding of residential services and some also reported 'little need for alcohol and drug services for young people'. The Association of Directors of Public Health has even attempted to spin a positive narrative around this disinvestment in the report.

After 2015/6 the public health grant in England will no longer be ring-fenced and cash-strapped local authorities will be free to spend the money on anything they wish. There is no statutory requirement for them to spend it on evidence-based prevention, treatment and recovery support interventions for substance use as there is for cancer, and they need to be funded in the same way.

The UK Recovery Walk charity is the leading national recovery advocacy organisation and we feel it is our duty to speak out when other service providers and charities don't, for fear of losing funding. We will provide support and work with any individuals and organisations who want to highlight and challenge plans to disinvest in local services. Please contact us on info@ukrecoverywalk.org if we can help.

Annemarie Ward,
CEO, UK Recovery Walk charity,
www.ukrecoverywalk.org

DISEASED THINKING

At the RiTC conference Rowdy Yates told mutual aid fellowships, 'Stop calling it (addiction) a disease...' (*DDN*, November, page 9).

AA co-founder Bill Wilson said, 'We AAs have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments or combinations of them. It is something like that with alcoholism. Therefore, we did not wish to get in wrong with the medical profession by pronouncing alcoholism as a disease entity. Hence we have always called it an illness or malady – a much safer term to use.'

Clearly addiction is not healthy; but even a layperson can tell the difference between being sick or unwell – and having a disease.

Laurie Andrews, Essex

PAUL'S GOSPEL

I have always admired Paul Hayes as a politician but never his policies in regard to recovery from addiction.

To spend 12 years on persuading politicians to move addicts from heroin to methadone (akin to moving whisky drinkers to free supplies of vodka) when he well knows that since 1966 there has been an addiction recovery training programme available at 169 centres (including prison units), indicates that he was either deaf to what has been succeeding in 49 other countries for 48 years, or that he had some other reason for pushing fail-to-cure 'treatments' in Britain.

The pretence that drug addiction is 'incurable' is based on the 25 to 30 per cent of heroin users with no intention or desire ever to quit their habit. But the other 70 to 75 per cent, having failed to quit on numerous – often daily – occasions, still want to quit, but just don't know how. Their problem is not willingness to quit, but lack of training in how.

The government's National Audit Office and Professor Neil McKeganey tell us that the average overall cost to

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.

the taxpayer of every methadone prescription user is over £47,000 per annum and also indicate that less than 3 per cent of such addicts will reach abstinence in their lifetime.

However, the cost of putting a drug or alcohol addict through a 26-week residential self-help addiction recovery training programme is under half that, and delivers relaxed abstinence for life in 55 to more than 70 per cent of cases first time through the programme, with another 5 to 15 per cent succeeding following a shorter refresher course.

Nearly four years on since psychiatric professor John Strang was appointed to run eight payment by results 'pilots' (which he based nearly exclusively on the OST medication principles promulgated by Paul Hayes), we have no report but only rumours that the OST gospel – according to both Paul and John – just doesn't work to deliver abstinence, relaxed recovery or other possibilities of payment by results.

Self-help addiction recovery training delivers all those results, so why are Paul and John trying so hard to pretend it doesn't exist?

Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS)

A PRIZE

FOR YOUR THOUGHTS

THANKS TO ALL OF YOU WHO HAVE FILLED IN OUR READERS' SURVEY SO FAR. We're very grateful for all of your feedback and suggestions and will be using them to plan next year's *DDN*. The closing date for winning our £50 Amazon voucher is 15 December, so go to www.drinkanddrugsnews.com now to fill in the survey and be in with a chance of the prize!

Thank you also to the truly wonderful individuals and organisations who have supported our Christmas card campaign (centre pages) to help fund this issue. With the magazine circulated free of charge to all our readers, and not paid for by subscription (not a lot of people know this, according to our readers' survey!) we are sincerely grateful for your help in mitigating the losses from the seasonal dip in advertising which normally helps us to pay for producing, printing and posting the magazine.

A very merry Christmas from the team at DDN!

COPENHAGEN CANNABIS

The Danish government has just rejected proposals for 'contained legalisation' of cannabis, designed to limit drug misuse and remove profit from the criminal market, deciding instead to step up policing. **Blaine Stothard** reports

On 26 May 2014 in a joint letter from the ministers for health and justice, the Danish government rejected the proposals submitted by Københavns Kommune (Copenhagen City Council) to establish a time-limited 'controlled legalisation' of cannabis in the city. The ministers' decision repeated previous reasons in response to similar past proposals. KK's re-submitted proposals followed wide discussion and debate, political and public, in the city, and majority support for the proposals in the city council formed after the November 2013 local elections.

The proposals acknowledged the negative health effects that the use of cannabis can have. The council's letter to the ministers, dated 19 March 2014, challenged the view that controlled legalisation would lead to greater availability and use of cannabis – one of the principal reasons for the government's rejection of earlier proposals. The letter emphasised that the current situation, with an easily accessible illegal drugs market controlled by criminal organisations, does not work in a preventive way and involves many young people, often marginalised, in the criminal activities of importing, trading and selling cannabis. The council asserted that evidence suggests that implementation of the proposals could result in a containment of the use and misuse of cannabis, and remove profit from the criminal market.

The entrance to the 'Green Zone' in Christiania, where cannabis is sold from tent-like stalls

The proposals included that:

- *The cultivation of cannabis become a legal activity based in Denmark.*
- *Designated retail outlets be established across the city, similar to alcohol outlets in Norway and Sweden.*
- *These outlets include staff able to give advice to potential purchasers and existing users who may be experiencing problems associated with their cannabis use.*
- *The council extend parallel prevention campaigns and activities.*
- *Assessment and evaluation of the impact of the scheme be undertaken, with a view to assessing whether the scheme should become permanent.*

The ministers' response rejected the proposals and the rationale. The principal reason, once again, was that the use of cannabis is associated with a range of negative health effects. This argument is part of a wider governmental view that the use of all euphoriant substances other than for medicinal purposes should remain prohibited. Doing so, the response claims, is in itself preventative. The second reason given was that the proposals, by giving approval to the use of cannabis, would increase accessibility, use and ill effects, and the reduction of criminality associated with the illegal drugs market is best countered by intense and targeted policing.

Current practice and legislation therefore remain intact. Research and evidence obtained by Københavns Kommune and others indicate that cannabis is widely available throughout the city; is frequently sold alongside other illegal drugs; and that the market is controlled by criminal groups, who have used violence and shootings to protect their market share. The drugs market situated in the Christiania district – 'Pusher Street' – continues to operate, implicitly separating the markets for cannabis and other drugs, and accepted or tolerated by the authorities, less so by local residents.

Blaine Stothard is an independent consultant in health education.

www.healthed.org.uk

VITAL CONNECTIONS

Communities and conversation are key to making recovery a reality, delegates heard at Addaction's annual recovery conference. **Jill Stevenson** reports

Communities working together was a central theme of Addaction's fourth National Recovery Conference last month. The annual get-together looked at how peer support and combined neighbourhood/group action could provide the catalyst to further recovery from addiction for thousands of individuals. It also helped launch the charity's new campaign, the Big Ambition, which seeks to empower communities to fight substance misuse from within.

Set in Glasgow, the two-day conference pulled in more than 500 delegates from throughout the UK and beyond. Key speaker on the first day was *Globalisation of Addiction* author, Professor Bruce Alexander.

Vancouver-based drugs and addiction researcher Alexander – who shot to fame through his celebrated 'rat pack' experiments – began by announcing that it would be the last time he travelled abroad.

He looked back on how much had been achieved in terms of drug treatment and recovery since his start in the field in the early 1970s, but warned against complacency, saying that there was much still to be done.

'I'm not saying the idea of the Big Ambition is wrong – far from it,' he commented. 'But rather it doesn't go far enough. More battles have to be won. We need to turn communities around and get people all thinking along the same lines.'

One of the battles to which Alexander referred was the ongoing tension between those who wholeheartedly believed in abstinence and those dedicated to harm reduction. He warned that it was important not to become embroiled in such tensions and urged both sides to work together as part of the same movement.

'There are many paths across the swamp,' he said. 'Some drug users will take the same path, others will advocate for another. The main thing to remember is that it's all about the individual, and it's whatever works for them that is important.'

He added that 'some people believe that if they fail at one path and find redemption in another then they believe that first path won't work for others either', and that was 'simply wrong'.

Alexander pointed to various historical milestones in the field of addiction including the introduction of harm reduction methods, the building of communities, widespread recognition of addiction recovery and the loss of credibility in the 'war on drugs'.

The 1940s and '50s were 'the Dark Ages of addiction' and even when he was growing up in '70s America, drug addiction was classed as 'evil' and 'sinful'. Police brutality was commonplace, he added, and prison was viewed as punishment rather than an opportunity for rehabilitation. It was accepted that any heroin user could expect to spend half of his or her life behind bars. Over the past few decades he had witnessed 'amazing changes' in the perception and treatment of addiction.

Reiterating the importance of local support he said, 'People recover from addiction better when they re-establish a place in their community.'

Launching Addaction's new Communities Fund – which will award £300 to individuals or groups for community projects – the charity's director of UK operations, Gervase McGrath, said he believed that recovery from addiction could extend beyond the individual to their community. The awards would seek to recognise local projects such as tidying up an elderly neighbour's garden or organising a sports day for local children.

'There are plenty of examples of community recovery out there,' he said. 'They didn't do it with the help of resources, experts or money but rather by harnessing a determination and commitment from within.

'Healthy communities are ones which have common goals and work together to face challenges. We want to help create the conditions which will allow this to take place.'

Former VSO head of UK volunteering, Michaela Jones – who celebrated six years in recovery this year – also advocated for communities, and particularly conversation.

'I don't know what made me sick,' she said, 'But I know what keeps me well, and that's getting out there and talking to people – and in doing so ignoring my natural instinct to remain isolated.'

Social connections, she said, were the cornerstones of our lives and her focus was now on a continual way of life rather than the active stages of addiction and recovery. This was made far easier, she said, with the existence of 'conversation cafés' which offered her both space and interaction with like-minded individuals.

Former *Coronation Street* actor Kevin Kennedy also extolled the virtues of conversation cafés and said he found the idea of a 'dry bar' a far more attractive meeting place than a 'dusty church hall with plastic chairs' – a step towards making recovery 'sexy'. 'I gave up drinking – not living,' he added.

Kennedy, who has been in recovery from alcohol addiction for 16 years and

‘Who better to deliver training than people who have been through the whole process of addiction themselves?’

YAINA SAMUELS

runs a charity that helps businesses manage the recovery of employees with addiction problems, told the audience he’d like to change the perception of addiction and other mental health issues.

He is also an advocate of the American idea of job applicants revealing they are in ‘long-term recovery’ on their CV – ‘chiefly because this says more about you as a person than any qualification ever could,’ he added.

Yaina Samuels, founder of Cardiff social enterprise Nu-Hi Training and winner of the Welsh Government‘s citizenship award earlier this year, explained how everyone working for her company – including herself – had personally experienced addiction and were now delivering training. They had recently rolled out a programme for more than 1,000 employees at Cardiff City Council.

‘Who better to deliver training than people who have been through the whole process of addiction themselves?’ she said, advocating a ‘conversation café’ approach. ‘To me, recovery meant getting my life back. It meant health and it meant having conversations with people which didn’t centre on drugs.’

Offering a personal perspective, comedienne Janey Godley – herself from Glasgow – revealed how heroin addiction had caused the death of her brother, prescription drugs had meant she’d regularly come home from school and find her mother ‘out cold on the kitchen floor,’ and her father had been in recovery from alcohol for 34 years.

It was a group of bereaved mothers in the East End who had started the biggest addiction recovery group in the city, and the initiative had made her look again at her own life.

‘I used to look down on drug addicts when I lived in the East End,’ she said. ‘Yet at the time I was a pub landlady selling booze. I asked myself what the difference was between the two and realised there really wasn’t one.’

Jill Stevenson is a freelance journalist based in Glasgow

POST-ITS FROM PRACTICE

Treatment complete?

Why are we failing so many people with hepatitis C, even those already in drug treatment, asks Dr Steve Brinksman

THERE IS still a lot of – sometimes heated – debate about whether drug services should be recovery or harm-reduction based. Yet I rarely hear the same passion when we talk about treating viral hepatitis.

Services will talk about high levels of BBV screening and uptake of hepatitis B vaccination and yet have tiny numbers of service users going into hepatitis C treatment. Now I admit that I am biased – a good friend and colleague, who did more than anyone else to show me how important it was to treat drug users, died of hepatocellular carcinoma, caused by his hepatitis C. To my mind the failure to get people into treatment that will not only potentially save their lives but also save large amounts of NHS funding is a travesty.

We have effective and ever-improving curative treatments and yet many people languish in primary care and community-based services knowing they have chronic hepatitis, without referral. Perhaps we should stop talking about ‘hard to reach patients’ and start accepting that we have ‘hard to access treatment services’ instead.

We need to acknowledge that the current provision of BBV care for those who are in drug treatment is failing. And if we can’t get those who are being seen regularly and supported by clinicians and key workers into treatment for their viral hepatitis then what hope of treatment is there for those who aren’t on substitute prescribing and who are not in established treatment?

Treating active people who inject drugs has been shown to be effective, and reducing the pool of people with chronic infection can help lessen the spread. We need to create systems to support people into and through treatment and these are the sorts of outcomes that should appear in primary care and community-based drug treatment tender specifications. Public health, primary and secondary care all working together – perhaps we could call it something radical like a National Health Service!

At the SMMGP conference in Birmingham in October we heard about a pilot project in Birmingham where the specialist hospital staff will be going out into primary care and delivering treatment alongside service users’ regular reviews and key working sessions. I know similar services exist in Newcastle, Nottingham and London.

The newer anti-viral treatments are producing cure rates of more than 90 per cent, even in the more difficult to treat genotypes of hepatitis C. Even newer treatments promise ‘tablet-only’ therapies that will minimise many of the side effects and adverse events seen in current treatment, albeit at greater financial cost, but these will still be cost-effective interventions. The only way we can advocate for these treatments to be available for our service users is to have the right systems in place to make sure that they are screened, referred and supported through treatment. The health gains for someone who has successful viral hepatitis treatment are immense and at least as important as them being ‘discharged treatment complete’.

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

CAUTIOUS OPTIMISM

Just because minimum pricing is on the back burner doesn't mean it's time to get despondent, hear delegates at Alcohol Concern's annual conference

'I THINK WE'RE ACTUALLY IN A BETTER PLACE to reduce the harm from alcohol than we have been for some time,' Alcohol Concern's president, Professor Sir Ian Gilmore, told delegates at the charity's annual conference, *Facing our alcohol problem: taking back our health and high street*.

'As professionals, our messages are much more joined-up and complimentary than they were a few years ago,' he said, plus there was much better sharing of evidence internationally and the media and public were more onside. 'Just because MUP [minimum unit pricing] has rolled into the long grass in Westminster and become becalmed in Brussels regarding Scotland, I don't think we need to be depressed.' It was a matter of 'being ready on all fronts', he stressed.

Two key fronts, however, were the general public and treatment services. In terms of the former, 'If you put it in the context of city centres and children being safer then they do get it', and a crucial area to focus on was harm to others. 'The harm to third parties is hugely greater than with passive smoking, which was what helped to swing public opinion there.' Regarding treatment services, it was vital to keep emphasising that they were 'incredibly good value' in terms of the cost savings to the system, and also to 'do a really good PR job on our colleagues', he told delegates. 'There's still a huge stigma around alcohol dependence.'

There was 'no doubt' that patients were suffering because of a 'judgemental and nihilistic' approach on the part of some professionals, agreed Dr Michael Glynn, NHS England's national clinical director for GI and liver disease. 'There's this sense of "well, you can't do anything for them". There's still a long way to go in terms of changing attitudes.' It was also essential that every health professional should be vigilant, he stressed. 'Everyone has to understand that they can make a difference – the concept of "every contact counts". Anybody involved in health – and other professionals – can give an intervention, even with very little training.'

'Too often the debate on alcohol is a debate on anti-social behaviour, rather than public health and prevention,' said shadow public health minister Luciana Berger. 'It's not like we're short on evidence on the damage that alcohol does.'

The government's responsibility deal showed that it was too close to vested interests to take the necessary action, she told the conference. 'There's a difference between listening to the concerns of industry and being dictated to by them,' with the scale of the challenge too great to rely on a 'non-binding and piecemeal' deal. Labour's approach would be to put the 'needs of the population, not industry' first, she said, with targeted action on pricing, labelling, licensing and education.

Although a Labour government would 'strengthen efforts' on higher-strength, low-cost products, when questioned on minimum pricing she said that her party was considering 'a range' of options. 'We don't think MUP as currently modelled is the way to go on this, but we're looking very carefully at this issue.' Labour was, however, committed to reviewing the licensing system and making public health a mandatory factor in licensing decisions.

Presenting the government's view, new crime prevention minister Lynne Featherstone told the conference that MUP was 'not permanently off the table, but we didn't feel it was sensible to proceed while it's being challenged in the courts' regarding Scotland.

The government had 'challenged the industry to do more, and it has responded', she stated, with six new responsibility deal pledges over the summer (*DDN*, August, page 4). 'We also want to cause a cultural shift in the nation's attitude to alcohol,' while moving public health to local authorities presented 'tremendous opportunities', including the framework for 'commissioning the right sort of responses' to alcohol problems. 'There's a massive appetite for partnership working and local solutions.'

> 'As professionals, our messages are much more joined-up and complimentary than they were a few years ago.'
> PROFESSOR SIR IAN GILMORE

In terms of tackling promotion it was vital that adverts were not targeting young people directly and 'encouraging them to be part of an unhealthy drinking culture' said Chante Joseph of the Youth Alcohol Advertising Council (YAAC), with social media in particular 'pushing the boundaries'.

'A lot of companies will target university students during Freshers' Week, for example,' she said. 'A lot of it is incredibly inappropriate, and there are no real deterrents.' Advertising regulations also were 'weak and vague', such as 'not using actors under 25 – it's these vague codes that allow them to tackle young people'.

'We've learned with tobacco that the only way to deal with the problem is to take away the marketing,' said Professor Gerard Hastings of the University of Stirling. 'It's like trying to deal with malaria without trying to deal with the mosquito. If we're really serious about this then the only solution is an outright ban.'

The problem was 'power', he told the conference. 'Massive companies that are so large they no longer just control us as consumers, they control our leaders as well. Corporations have the power to ignore, make up and break the rules, and with social media they now have the power to be my mate. More and more, they have the power to create our realities.'

Marketing became toxic when wedded to the massive power of corporate alcohol, he said. 'We desperately need red lines. We have to get serious and say, "marketing is driving this problem. The only solution is to remove marketing." The lesson from tobacco is that half measures just don't work, so we need to absorb some of that ruthlessness of the corporate sector and be really single-minded and determined about what we want and where we're going.'

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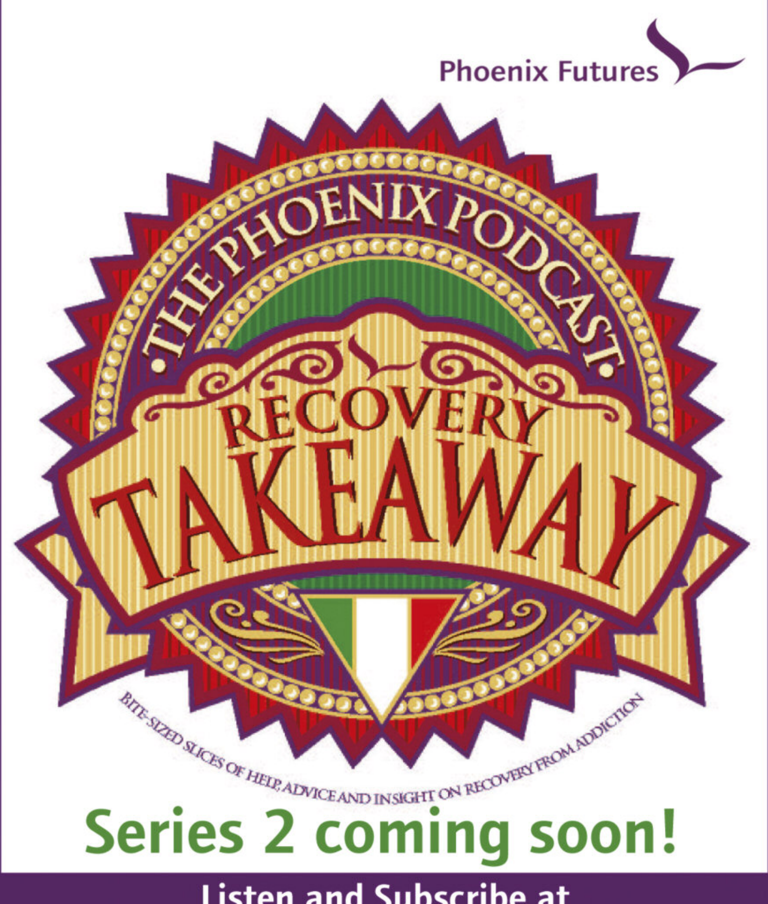

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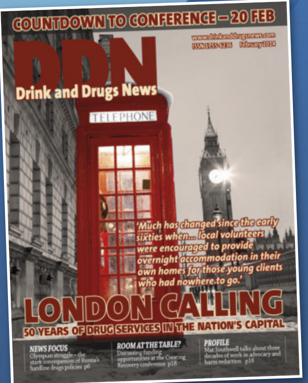
NEVER A DULL MOMENT

With a general election that could shape the sector for the next five years and beyond now looming, DDN looks back on another dramatic year in the drugs field



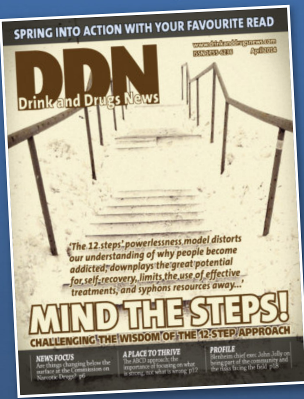
JANUARY
The year kicks off with the government announcing that its ban on the sale of below-cost alcohol is to come into force in the spring. The legislation is instantly derided as 'laughable', 'confusing' and 'close to impossible to implement' by Alcohol Concern chief executive Eric Appleby, whose organisation – along with many others – still wants to see minimum pricing instead. Alcohol charity Drinkaware, meanwhile, announces 'radical' changes to its governance arrangements following an independent audit and criticisms over industry links.

FEBRUARY
DDN's national service user conference chalks up a seventh successful event with *Make it happen!* in Birmingham – 'emotive speakers with real passion and drive', says PHE. As Russia prepares for the Sochi Winter Olympics, activist Anya Sarang tells *DDN* about the stark consequences of her country's ongoing opposition to opioid substitution therapy, and crime prevention minister Norman Baker accepts the ACMD's recommendation that ketamine be

reclassified to class B. Worryingly, more than a third of services surveyed for DrugScope's *State of the sector* report say their funding decreased in the previous year, while Nick Clegg tells the *Observer* that 'if you're anti-drugs, you should be pro-reform' and there's shock as actor Philip Seymour Hoffman becomes the latest high profile drug casualty.

MARCH
MPs demand action on liver disease, warning that 'today's complacency is tomorrow's catastrophe', with deaths increasing by a staggering 40 per cent in the space of a decade. Activists still have Russia in their sights as they warn that its annexation of Crimea means that the peninsula's drug users are now at the mercy of its 'highly repressive' and 'deeply punitive' approach, while harm reduction organisations brand the joint ministerial statement issued at the UN's Commission on Narcotic Drugs (CND) in Vienna a 'capitulation' to hardline states.

APRIL
A hard-hitting report from Adfam says that children are being put at risk by a lack of proper safeguards around OST prescribing, while NICE says needle exchange services need to do more to



support users of performance-enhancing drugs. Meanwhile, Stanton Peele casts a critical eye at the 12-step approach in the pages of *DDN*. 'Like carp infesting a lake drive out other species, AA and 12-step treatment rule out other, often more effective approaches,' he writes, ensuring a full-to-the-brim letters page in the following issue.

MAY
Positive trends in the use of long-established drugs risk being overshadowed by the relentless increase in new synthetic substances in an 'increasingly complex and damaging' drug market, says a comprehensive report from EMCDDA. PHE figures showing a continuing fall in the number of opiate and crack users leave 'no room for complacency', agrees the agency's Roseanna O'Connor, and home secretary Theresa May announces an overhaul of stop and search following Release's damning report from last year.

JUNE
Turning Point's medical director Dr Gordon Morse writes that it's time for commissioners to start considering 'evolution over revolution' in *DDN*, while more than 100 cities worldwide see demonstrations as part of the *Support. Don't Punish* campaign for more humane drug policies.

JULY
The government's announcement of a new set of pledges as part of its controversial 'responsibility deal' with the drinks industry leaves health campaigners unimpressed, while new figures show rates of drug use among secondary school pupils 'considerably lower' than a decade ago.

AUGUST
Scottish drug-related deaths fall by 9 per cent, after two years of record high figures, with the Scottish Government pointing to the success of their take-home naloxone programme. Legislation finally comes into force allowing drug services to provide aluminium foil, and an all-party group of MPs calls for health warnings to be put on all alcohol labels. There's also a sure sign that things are changing when a *Sun* editorial says it's time for a rethink on drugs policy.

SEPTEMBER
In contrast to last month's encouraging news from Scotland, a sharp rise in drug deaths in England sparks alarm in the field, with DrugScope expressing 'serious concerns'. The CQC sets out its new approach to inspecting drug and alcohol services and promises the sector that it will 'focus on the issues that matter', while the annual UK recovery walk hits number six in Manchester.

OCTOBER
The Home Office's study of international drug polices finds 'no apparent correlation' between the toughness of a country's approach and levels of use, setting off a media frenzy, and crime prevention minister Norman Baker accuses the government of 'suppressing' the document, which has been ready for months. Less than a week later he resigns, stating that working with home secretary Theresa May was like 'walking through mud'.

NOVEMBER
Fewer than half of those infected with hepatitis C know they have the virus, warns PHE, with around 90 per cent of the 13,750 hepatitis C infections diagnosed in the UK in 2013 acquired through injecting drug use, while the ACMD rejects the concept of time-limited substitution treatment. 'There's still an appetite in bits of government to re-ask the question about time-limited methadone, but the evidence remains the evidence,' ex-NTA chief Paul Hayes tells *DDN*. Right on cue, Iain Duncan Smith pens a *Sunday Telegraph* piece under the headline *Now fight the methadone industry that keeps addicts hooked*. Finally, *DDN* celebrates its tenth birthday with a special anniversary issue. 'I thought they'd taken leave of their senses,' writes ex-FDAP chief Simon Shepherd of the time DDN's publishers told him they'd quit their jobs to set up the magazine.

DECEMBER
As *DDN* looks to its 11th year, preparations are well underway for the next service user involvement conference, *The challenge: getting it right for everybody*, in Birmingham next February. See you there!

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Parliament's response to this week's report on the 1971 Misuse of Drugs Act shows that psychoactive substances are the last taboo to afflict Britain's elite. It has got over past obsessions with whipping, hanging, sodomy and abortion, but it is still stuck on drugs. There is no point in reading the latest research on drugs policy worldwide. It is spitting in the wind. The only research worth doing is on why drugs policy reduces British politicians to gibbering wrecks.
Simon Jenkins, *Guardian*, 1 November

My blood boils when I hear loony liberal politicians (I'm thinking Nick Clegg) and middle class do-gooders telling us that ALL drugs should be legalised... Don't these lettuce-munching liberals realise millions of mums and dads all over Britain are fighting tooth and nail to keep their kids away from drugs?
Carole Malone, *Mirror*, 1 November

The Lib Dems knew there was no hope of the Conservatives agreeing to change the law on drugs. They are so sure of this that they have not even bothered to work out whether they want to decriminalise or legalise cannabis. They are happy simply to pose as the party of opposition that they used to be, repeating old soundbites about 'losing the war on drugs'. Nick Clegg knows that there is a market for this comforting rhetoric among a minority of the electorate, and he knows that this minority is larger than the 8 per cent of voters currently intending to vote Lib Dem.
John Rentoul, *Independent*, 4 November

The special loathing I encounter for telling the truth about drugs is so virulent that it sometimes comes close to frightening me. This is an enormous campaign for selfish pleasure. If it succeeds in achieving the legalisation it dreams of, and which is the real aim of this relentless lobbying, there are gigantic profits to be made and huge taxes to be raised.
Peter Hitchens, *Mail on Sunday*, 2 November

The culture of prescribing methadone has proved incredibly stubborn and difficult to break. There is still a huge amount more that government must do, so that in practice treatment is about full recovery instead of maintenance... This approach requires that we fight vested interests and challenge the status quo.
Iain Duncan Smith, *Sunday Telegraph*, 16 November

Russell Brand is a classic dry drunk. He has that hyperactivity that characterises many of those who, having once relied on drink or drugs, find themselves restlessly sober, trying to fill that gap by furious over-production as a way of absorbing their new-found energy... In *Revolution*, he not only testifies to his belief in God and 'the power of people to manifest, here on earth, a society that represents holy principles', he actually puts forward the AA's own 'Twelve Traditions' as his best model for society at large. It's worked for him and so he ordains the same for everyone.
David Sexton, *London Evening Standard*, 4 November

Pregnant women with a drinking problem – like anyone with a drinking problem – need support rather than censure. Anyone who has the welfare of the child at heart, rather than the punitive desire to teach someone a lesson, can surely see that.
Joanna Moorehead, *Guardian*, 5 November

CALDERDALE DRUG AND ALCOHOL RECOVERY ORIENTATED SERVICE

As part of a new partnership, SMHS has been contracted to deliver medical interventions for a new drug and alcohol recovery orientated service within Calderdale.

The contract starts in February 2015 and we are seeking to expand our clinical team of talented, experienced, passionate individuals who can work alongside service users, peer mentors and volunteers and would be interested to hear from suitably qualified individuals for the following positions:

- **SESSIONAL GP's/GPwSI** (up to full time)
- **SESSIONAL LOCUM GP's/GPwSI**
- **NON-MEDICAL PRESCRIBERS** (full and part-time)
- **LOCUM NON-MEDICAL PRESCRIBERS**

All roles will be responsible for specialist prescribing, medical interventions for both harm reduction and abstinence-focused clients, including BBV testing and immunisations and liaison with our partner agencies delivering Psychosocial services to deliver care to people with drug or alcohol related problems

Please note that TUPE may apply to these new contracts. In this case, our recruitment needs may vary according to the number and type of employees who transfer to SMHS from other services.

We are an equal opportunities employer and are committed to anti-discriminatory employment practices and service provisions. All positions require DBS clearance.

For an application pack please contact:
Emma Haigh, St Martins Healthcare Services, Mill 2,
First Floor, Mabgate Mills, Mabgate, Leeds LS9 7DZ
Tel: 0113 2444102 or Email: ehaigh@nhs.net

Closing date for these vacancies is 9am 12th December 2014
Interviews will take place on the Friday 19th December 2014

Broadreach House is an innovative and dynamic registered charity, offering treatment and support services for men and women whose lives have been adversely affected by addiction. We currently have the following exciting opportunities to join our team:

Unit Manager: Closereach (Men Only House)

c. £30,000 per annum

We are seeking a skilled manager with experience of working in the substance misuse field. You will need to be positive, proactive and flexible in your approach. You will be responsible for the ongoing development and supervision of the team.

To meet the demands of this role, you will have:

- Substantial management experience;
- Experience of managing a multi-disciplinary team;
- Experience of implementing and monitoring appropriate treatment intervention and systems;
- Proven ability to work in partnership with other agencies and individuals.

Counsellor (Peripatetic)

£18,000 - £23,000 per annum

We are seeking a trained counsellor to join our team. This is a peripatetic role with the potential to cover any one of our four sites.

To meet the demands of this role, you will have:

- Experience of working with evidence based counselling skills and practice;
- Experience of working in a multi-disciplinary team and of working alone within a supervised framework;
- Knowledge of the effects of drug and alcohol dependency;
- Evidence of continued professional development.

A relocation package will be considered, if required, for the successful candidates.

For an application pack, please call 01752 566219 and leave your details, stating which post you are interested in. Alternatively, email Liz Fox: liz@broadreach-house.org.uk

Closing date: 24th December 2014.

www.broadreach-house.org.uk

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www.intuitiverecovery.com

Inspiring Recovery Communities

As part of Reach Out Recovery – Birmingham, we are seeking to employ a team who are passionate about making a difference, willing to take responsibility for making things better, creative and daring enough to innovate and determined to persist when things get tough. We are recruiting for the position of

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www.emerginghorizons.org

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Interviews will take place the week beginning: 19th January 15

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THE CHALLENGE:

GETTING IT RIGHT FOR EVERYBODY

8th DDN national service user involvement conference

19 FEBRUARY 2015, BIRMINGHAM

PROGRAMME

9.00am-10.00am: Registration and refreshments

10.00am-11.15am: Opening session

WORKING WITH SERVICE USERS AT ALL LEVELS...
Linda Chan from **Build on Belief** (BoB) uses her own life, treatment, recovery and work experiences, including managing a drop-in, to look at how we can involve service users in every stage of support and recovery.

BUILDING SOCIAL CAPITAL...
Changes UK, a user-led community interest company, share their innovative ways of integrating care pathways and supporting independent and healthy living.

MEANINGFUL ACTIVISM...
Tony Lee draws on 30 years' experience with addiction and homelessness to share how he set up the support group **REPS** to give peer support, education and advocacy.

11.15am-11.45am: Refreshments

11.45am-1.00pm: Session two

NALOXONE – KEEPING UP THE CAMPAIGN...
Kevin Jaffray looks at how people power – including essential service user voices – is being harnessed to galvanise distribution of this life-saving intervention.

WHERE DO WE FIT WITH PUBLIC HEALTH?...
The change from NTA to PHE has removed the ring fence on treatment funding. **Public Health England** give us the state of play and answer questions.

MEANINGFUL ALCOHOL SERVICES...
A personal perspective on keeping services relevant to the individual.

1.00pm-2.15pm: LUNCH, BAND, MINGLING – AND OUR FAMOUS EXHIBITION, featuring service user groups from all over the country, skills-sharing displays and demonstrations, and a chance to relax in the therapy zone.

2.15pm-3.45pm: Session three

A robust debate on the state of the sector and the right to health. What are the challenges and opportunities? How can we get it right for everybody?

CLOSING SPEAKER...
Richard McCann offers his remarkable life story to show how he met the challenge of tackling what life threw at him to explore his full potential.
An unmissable slice of inspiration.

Programme and online bookings at www.drinkanddrugsnews.com
For exhibition and sponsorship packages email ian@cjwellings.com